

WHEN IT IS NO LONGER YOUR CALL: MANAGING THE ERODING PUBLIC HEALTH
NURSE ROLE

by

Megan Elise Kirk

BScN, Queen's University, 2007

MSc., Queen's University, 2009

A Dissertation Submitted in Partial Fulfillment of the
Requirements for the Degree of
DOCTOR OF PHILOSOPHY
in the School of Nursing

© Megan Elise Kirk, 2020

University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy or other means, without the permission of the author.

WHEN IT IS NO LONGER YOUR CALL: MANAGING THE ERODING PUBLIC HEALTH
NURSE ROLE

by

Megan Elise Kirk

BScN, Queen's University, 2007

MSc., Queen's University, 2009

SUPERVISORY COMMITTEE

Dr. Marjorie MacDonald, Supervisor

School of Nursing

Dr. Rita Schreiber, Departmental Member

School of Nursing

Dr. Anita Kothari, Outside Member

School of Health Studies, Western University

Abstract

The purpose of this study was to explain how public health renewal has shaped public health nursing practice, how public health nurses have managed these changes, and the perceived impact of such changes on health outcomes. I used the grounded theory method to develop a theoretical explanation of how public health nurses navigated the changing organizational milieu in British Columbia. I interviewed 29 public health nurses and three public health nursing managers in three health authorities to explicate the impact of healthcare reform initiatives on public health nurses and public health nursing practice.

Over the last few decades, there have been several organizational and policy changes in British Columbia, intended to strengthen the health system and health service delivery. These changes have eroded the nature of the public health nurse role and negatively influenced public health nursing practice, undermining the ability of public health nurses to improve population health and health equity. Many participants were concerned about changes in their practice and reported that leaders restricted their role, particularly in their broad health promotion and community development efforts. Nurses in this study highlighted specific organizational and policy changes that have undermined their effectiveness. For example, nurses talked about cuts to the public health budget, the disbanding of health unit structures, the appointment of leaders who lacked public health or public health nursing knowledge and experience, and the increase in mandated targeted public health nursing programs with a corresponding decrease in universal programs.

As a result, participants engaged in the process of *managing the eroding of the public health nurse role*, which comprises five strategies. In *standing tall*, a number of nurses in this study advocated for their practice and pushed back against decisions that jeopardized the quality

of public health nursing programs and services with varying degrees of force. Public health nurse participants also worked within organizational expectations and constraints in the process of *getting by*. In *going underground*, several public health nurses engaged in various activities in secret by harnessing their community connections and attended to community issues they believed went unaddressed. A number of nurses, dissatisfied by the state of their role, were *contemplating getting out* and considered other employment possibilities. Throughout the process of navigating external changes affecting practice, many nurses restored their dedication to the public health nurse role in *reaffirming commitment*. Given the limited research exploring the impact of healthcare reform and public health renewal on public health nursing practice, this research helps to provide an initial glimpse into the effects of such change on public health nurses in British Columbia.

Key words: Public health nursing; public health reform; population health; health equity.

Table of Contents

SUPERVISORY COMMITTEE	ii
Abstract	iii
Table of Contents	v
List of Tables	ix
List of Figures	x
List of Abbreviations	xi
Acknowledgments.....	xii
Chapter 1 - Introduction.....	1
Situating the Research.....	1
Background.....	2
Public Health Nursing.....	3
Historical Overview.....	4
Guiding Practice Documents.....	5
Nature of the PHN Role.....	6
Autonomous Practice.....	7
Multiple Levels of Practice.....	8
Development and Maintenance of Trusting Relationships.....	9
Public Health.....	10
Population Health and Health Inequities.....	10
Public Health Reform in Canada.....	12
Public Health Reform in BC.....	13
Study Purpose	15
Significance of Study.....	16
Dissertation Outline	18
Summary	20
Chapter 2 – Literature Review.....	21
Healthcare System Change and Service Delivery	23
Regionalization of Healthcare Systems	25
Shifting Management Models.....	27
Hospital Restructuring	29
The Impact of Organizational Change on Nursing Practice, Nurses, and Patient Outcomes ...	30
Organizational Change and Nursing Practice	32
Nurses’ Roles.....	33
Nurses’ Workload.....	35
Nurses’ Control Over Work.....	36
Organizational Change and Nurses’ Wellbeing.....	39
Organizational Change and Patient Outcomes	41
The Impact of Organizational Change on Public Health Nursing Practice, PHNs, and Client Outcomes	43
Effectiveness of Public Health Nursing Practice	44
Home Visitation.....	45
Breastfeeding.....	49
Child Immunizations.....	51
Organizational Change and Public Health Nursing Practice	52

PHNs' Roles.	54
An International View of PHNs' Roles.	64
PHNs' Workload.....	66
PHNs' Control Over Practice.....	68
Organizational Change and PHNs' Wellbeing.....	71
Organizational Change and Client Outcomes.....	74
Summary.....	77
Chapter 3 – Methodology.....	81
Philosophical Perspective.....	81
Ontology of Critical Realism.....	81
Epistemology of Critical Realism.....	82
Applying Critical Realism in Nursing Research.....	83
Applying Critical Realism in my Dissertation Research.....	84
Applying Critical Realism to Grounded Theory.....	86
Theoretical Perspective.....	87
Social Ecological Theory and Grounded Theory.....	88
Symbolic Interactionism and Grounded Theory.....	89
Applying a Theoretical and Philosophical Perspective in Grounded Theory Research.....	91
Grounded Theory Method.....	93
Constant Comparison in Grounded Theory.....	94
Grounded Theory Method in my Dissertation Research.....	94
Grounded Theory Method Informed by Critical Realism in my Dissertation Research. .	96
Conducting my Grounded Theory Study.....	97
Ethics Application.....	98
Data Collection Methods.	98
Recruitment Process.....	98
Inclusion and Exclusion Criteria.....	100
Informed Consent.....	100
Participant Sample.	101
Sampling.	102
Additional Data Sources.	103
Interview Design and Questions.	104
Confidentiality and Privacy Steps.....	107
Data Analysis Process.....	108
Grounded Theory Analytical Process.....	108
Data Coding.	108
Memoing.....	115
Establishing Rigour in a Grounded Theory.....	116
Summary.....	118
Chapter 4 – Findings.....	120
Basic Social Problem.....	120
Loss of Support.....	122
Loss of Autonomy.....	130
Loss of Flexibility.....	135
The Basic Social Process: Managing the Eroding PHN Role.....	140
Standing Tall.....	145

Conditional Factors.....	152
Years of PHN Experience.....	153
Social Justice Lens.....	154
Appetite for Risk.....	155
Health Unit Culture.....	155
Changing Leadership.....	156
Financial Constraint.....	158
Organizational Culture.....	159
Summary.....	160
Getting By.....	161
Adjusting to Change.....	163
Conditional Factors.....	169
Years of PHN Experience.....	169
Changing Leadership.....	169
Mandated Programs.....	170
Provincial Directives.....	171
Finding a Way.....	172
Treading Cautiously.....	176
Summary.....	181
Going Underground.....	182
Conditional Factors.....	186
Social Justice Lens, Years of PHN Experience, Appetite for Risk.....	186
Changing Leadership.....	187
Summary.....	188
Contemplating Getting Out.....	188
Summary.....	191
Reaffirming Commitment.....	192
Summary.....	197
Chapter 5 – Discussion and Conclusion.....	200
Key Study Findings.....	200
The Basic Social Problem.....	200
Public Health Restructuring within Healthcare Reform.....	204
Public Health Restructuring in Canada.....	205
An International View of Public Health Restructuring within Healthcare Reform....	213
Managing the Eroding PHN Role.....	215
Silencing Nurses.....	226
Navigating a Moral Landscape.....	231
Implications for Practice, Education, Policy, and Research.....	237
Implications for Practice.....	238
Implications for Education.....	240
Implications for Policy.....	243
Implications for Research.....	247
Strengths and Limitations of this Study.....	250
Strengths.....	251
Limitations.....	253
Applicability Beyond Borders.....	254

Concluding Thoughts..... 255

References..... 258

Appendix A..... 298

 Ethics Approval 298

Appendix B..... 299

 Participant Recruitment Email..... 299

Appendix C..... 300

 Study Protocol..... 300

Appendix D..... 305

 Participant Consent Form 305

Appendix E 309

 Interview Questions 309

List of Tables

Table 1	Recent BC Healthcare Reforms	13
Table 2	Demographic Characteristics of Study Sample	102
Table 3	Additional Data Sources	103

List of Figures

Figure 1. Conditional Matrix of Study Phenomenon..... 114

Figure 2. A Theoretical Model of PHNs Managing the Eroding PHN Role in BC..... 142

List of Abbreviations

BC	British Columbia
CHNC	Community Health Nurses of Canada
CNA	Canadian Nurses Association
CPHA	Canadian Public Health Association
ELPH	Equity Lens in Public Health
HA	Health Authority
LHIN	Local Health Integration Network
NFP	Nurse Family Partnership
PHAC	Public Health Agency of Canada
PHN	Public Health Nurse
PHNSg	Public Health Nursing
RePHs	Renewal of Public Health Systems
US	United States
WHO	World Health Organization

Acknowledgments

There are many people who supported and encouraged me along this PhD journey, to whom I am forever grateful. At times, it was the quick statement, “you got this,” to the more arduous support of sitting with me, discussing, problem solving, and oftentimes, believing in me when I lost belief in myself, that helped me to keep going. This journey has been an academic pursuit punctuated by personal triumphs and losses. It has been no joke. For that very reason, I stand strong on my own two feet with a firm sense of who I am, what I have to offer, and what is important to me.

First off, I was fortunate to have the opportunity to move to BC and surround myself with a group of exceptional academics. I always had a public health slant; however, I was not fully aware of this leaning until I had the opportunity to work alongside others passionate about population health and health equity. It was through these experiences that I surfaced and cultivated my own passion and vision. In particular, I want to thank my supervisor, Dr. Marjorie MacDonald, for the opportunity to work on multiple national research projects that offered me invaluable learning experiences. Dr. MacDonald created an excellent learning climate, providing students with the opportunity to interact with leading public health experts, to learn and develop within a team of dedicated researchers, and to present at both national and international conferences. She also supported a number of doctoral students, including myself, by offering doctoral awards from her research grants.

This body of work, and my intellectual development, is greatly a reflection of the commitment of Drs. Marjorie MacDonald and Rita Schreiber, without whom I would not be where I am today. Although they did not always tell me what I wanted to hear, I have learned a great deal and my scholarship and research is a testament to their continued insight and feedback

on my work. Their dedication to nursing excellence is unsurpassed. I would also like to thank Dr. Anita Kothari who encouraged me to think beyond nursing and ensured that I fully considered the rigour in my research process. Thank you all for your continued support.

I have an incredible support network. My friends and family provided me with tireless support and encouragement throughout completing this PhD. Long-life long friends and new friends would look at me with such belief in their eyes. The way they would often look at me inspired and pushed me to be the best version of myself and not to give up. I also appreciated their laughter when I needed to lighten up.

One friend, in particular, deserves special recognition, and holds a dear place in my heart. Dr. Mary Hill, you are an incredible mother, grandmother, friend, and are the definition of what you call a “true blue public health nurse.” At my lowest moments, you were there. At my highest moments, you were there. Your consistency, patience, and unrelenting commitment to those around you is a testament to the strength and quality of your character. I am doubtful I would have completed this journey without you. You are more than a friend to me, you are family.

My family is a strong pillar in my life for which I am incredibly grateful. I want to thank my parents because they helped to set me up for success and to be a voice for others. By supporting me to go university, they created a platform for continued opportunity in my life. I want to thank my siblings for the hugs, high-fives, glasses of wine, pictures of my nieces and nephews, old movie quotes, all of which put a smile on my face. Cooper, my boy, you are a girl’s best friend. You made long days a bit easier when I looked into those big brown eyes and with a quick wag of your tail. Darcy, I am not sure what I did to deserve a love like this. You are kind in your words, thoughtful in your approach, and steadfast in your commitment. I am so excited about what the future holds.

Lastly, I want to thank the public health nurses who took the time to discuss their practice with me in this research. I was moved by your words and inspired by your commitment to providing high quality care in your communities. I have the upmost respect for the work that nurses do day in and day out to improve the health and wellbeing of others. This dissertation is dedicated to you.

Chapter 1 - Introduction

In this opening chapter, I set the stage for this dissertation research exploring public health nursing (PHNsg) practice in the face of historical and recent public health reform initiatives. To begin, I recount personal experiences that guided me to study this topic area in *Situating the Research*. Then, I offer background details explaining PHNsg practice, as well as detailing some historical components and the nature of the public health nurse (PHN) role. At this point, I discuss the context of public health reform that has taken place in Canada over nearly the last three decades, and the significance of this reform process for PHNs delivering programs and services in their communities. The discussion of public health reform and PHNsg practice is followed by the purpose and significance of this study. To end, I offer an overview of the dissertation and a short summary before delving more deeply into components of the research project.

Situating the Research

During my doctoral education, I volunteered in a local health unit in British Columbia (BC) and worked alongside PHNs every Saturday morning for two years. The time I spent with these PHNs was instrumental to my learning about PHN concerns, and significantly shaped my dissertation research. Because I established trusting relationships with PHNs in the office, they began to include me in many of their conversations, providing me with insights into their issues and perspectives. PHNs would tell me about the things they were working on, share practice stories, and discuss some of their concerns. They asked me questions about what I was doing in school, and were interested to learn about my research focussing on PHNsg practice. It was in these moments that they talked about ideas and insights into the challenges facing PHNs in their practice, and offered suggestions for my research.

I was eager to learn about PHNsg and to listen to PHN stories. This volunteer experience was complemented by my time working on a large research project studying the renewal of public health systems and services in BC and Ontario, titled Renewal of Public Health Systems (RePHs). Reading through PHN interviews collected for that project was helpful as a preliminary step in understanding and continuing to explore PHN experiences related to policy and organizational change. Together, these experiences played a significant role in shaping the focus of my research project. I decided to delve more deeply into this area of exploration by studying PHNs' practice concerns related to public health system reform in three health authorities (HAs) in BC.

Background

PHNs have been delivering programs and services intended to improve population health in BC since the early 20th century (Green, 1984). In BC, the provincial government currently provides funding to five regional HAs, one provincial HA, and the recently formed First Nations HA to govern healthcare organization and delivery across the province. Regional HA responsibilities include the funding and delivering of PHNsg services. PHNs work across health regions to promote and protect health, and to prevent disease, disability, and injury, while assessing and monitoring health (Canadian Public Health Association [CPHA], 2010). PHNs support health through means such as connecting people to resources in communities, and building the capacity of individuals, families, and groups (Community Health Nurses of Canada [CHNC], 2019). In this way, health is “seen as a resource for everyday life, not the object of living” (World Health Organization [WHO], 1986, p. 1). Health is promoted in everyday settings where people learn, work, play and love (WHO, 1986). PHNs have been described as having a

central role in protecting and improving the health of communities and populations (Canadian Nurses Association [CNA], 2006; CPHA, 2010).

Public Health Nursing

PHNsg is considered a specialty practice within nursing, in which nurses synthesize knowledge from public health, nursing, and the social sciences (Battle Haugh & Mildon, 2008; CHNC, 2019; CPHA, 2010; MacDonald, 2004). In fact, PHNs were the first nurses in Canada to require a baccalaureate degree for entry-level practice (Duncan, 2016). Central to PHNsg practice is the recognition of the inextricable link between individual and community health and environmental conditions (CHNC, 2019). PHNs have an important role in reducing health inequities by examining and addressing broad causes of poor health, commonly referred to as the social determinants of health (Reutter & Kushner, 2010).

The title PHN is, at times, used interchangeably with the title community health nurse, however, there is a distinction. Community health nurse is an umbrella term used to include all community-based nursing practice. Within community health nursing there are distinct nursing subspecialties and bodies of knowledge (King et al., 1995; McKay, 2012). PHNsg is one subspecialty focused on population-based practice, with a key focus on health promotion and disease and injury prevention, and with activities directed at many levels from individuals to populations (Olson-Keller et al., 2004).

Confusion surrounding the titles likely stems from the fact that community health nursing originated as a single, distinct practice that branched into multiple subspecialties – home care nursing, PHNsg, parish nursing, and outpost nursing, among others (Community Health Nurses Association of Canada, 2002). Defining subspecialties within nursing is important, however, to recognize the work of distinct groups of nurses. Some believe confusion regarding the PHN role

may also be attributed to the diverse nature of PHN roles in the community (Underwood, 2003), given that PHNsg programs generally evolve to meet community and population needs in different contexts and settings (CPHA, 2010; CHNC, 2019).

Historical Overview.

PHNs have been in our communities improving population health for decades; in fact, in 2019 we celebrated the 100th anniversary of the PHN role in BC (Green, 1984). PHNs have first-hand knowledge of social, environmental, and economic factors shaping community health through interacting with people where they live, work, and play. Lillian Wald, who coined the term PHNsg, argued that it was impossible and undesirable to separate technical clinical service from that of social service (Fitzpatrick, 1975). Other nurses, such as Florence Nightingale, Jeanne Mance, and women in religious orders, such as the Grey Nuns, as well as nurses in the Victoria Order of Nurses (CHNC, 2011), provided care in communities, and acknowledged the symbiotic link between individual, social, and environmental health. Throughout history, PHNs have been well positioned to improve the health and wellbeing of individuals and communities through advocating and raising awareness for social change (Duncan, 2016; Falk-Rafael, 2005).

As social inequities in Canada continue to grow, leading to poorer health (Wilkinson & Pickett, 2009), the need for PHNs to address inequities remains (Reutter & Kushner, 2010). In fact, PHNs have been encouraged to bolster their roots of social activism (Falk Rafael, 1999). Historically, PHNs provided leadership in caring for sick and impoverished citizens through connecting with the community and challenging contextual forces negatively affecting the health of clients (Duncan et al., 1999; Duncan, 2016). PHN practices rooted in social justice and equity values remain today, however changes in organizational policy and structure have hindered their advocacy efforts and, at times, their activities go unnoticed (Falk-Rafael & Betker, 2012b). The

Canadian Nursing Code of Ethics (CNA, 2017) denotes that “Ethical nursing practice addresses broad aspects of social justice that are associated with health and well-being. These aspects are focused on improving systems and societal structures to create greater equity for all” (p. 18).

Nurses have been encouraged to engage in activities to alleviate inequities and are supported by several guiding practice documents reflecting values of social justice and equity.

Guiding Practice Documents.

The scope and depth of the PHN role are clearly articulated in the CHNC Standards of Practice (2019) and are detailed in several practice documents from Canadian organizations. Authors have articulated the role and functions of PHNs in Canada through various CPHA statements, stemming back to the 1960s. There are multiple other guiding documents that support PHNs in practice such as, *Core Competencies for Public Health in Canada Release 1.0* (Public Health Agency of Canada [PHAC], 2007), and *Public Health Nursing Discipline Specific Competencies Version 1.0* (CHNC, 2009). Leaders at CHNC (2011) have developed resources supporting and guiding PHNsg practice since the establishment of the CHNC in 1987.

The nature of PHNsg practice in Canada is particularly evident in two guiding practice documents, *Canadian Community Health Nursing Professional Practice Model and Standards of Practice* (CHNC, 2019) and *Public Health ~ Community Health Nursing Practice in Canada: Roles and Activities* (CPHA, 2010). The authors of these documents were clear that PHNs have an important role in connecting with, and working in collaboration with partners to support individuals, families, communities, and populations to strengthen health promotion and disease prevention practices and services. PHNs are expected to engage in numerous activities, such as capacity building, advocacy, skill development, case management, and education to improve health (CHNC, 2019). They work with individuals and families to achieve mutually agreed upon

goals and support groups within the population who may be a risk for poor health outcomes, by focusing on issues of social justice and empowerment (Aston et al., 2006).

Nature of the PHN Role.

The authors of the CHNC Professional Practice Model (2019) outline components of PHNsg practice, including the values base, theoretical foundations, and the process of delivering care. These supporting PHNsg practice documents provide extensive detail regarding how PHNs promote health and wellbeing at multiple levels (e.g., individuals, families, groups, communities, populations, and systems) and in a variety of locations (e.g., health units, homes, schools). PHNsg practice has even been called a practice without walls (Registered Nurses Association of Ontario, 1998). These guiding resources help to communicate the role PHNs have in addressing a range of factors that affect health in the community, particularly the determinants of health.

Throughout their day-to-day activities, PHNs are guided by a strong theoretical foundation, weaving together philosophies, broad theoretical perspectives, and conceptual models and frameworks from both within and outside of nursing (Betker et al., 2016, 2020; CHNC, 2019). Falk-Rafael (2005) describes theory as the roots of PHNsg practice and research, anchoring the discipline and practice. It is this theoretical basis, the melding of a variety of theories and frameworks, that provides a lens for and guides PHN activities. Betker et al. (2016, 2020) represent the theoretical foundations of PHNsg practice visually, as a fan graphic, demonstrating the interconnected nature and range of knowledges informing PHN work.

By working at a high level of *autonomy*, PHNs draw on their professional and community knowledge, and continually evolve their role to respond to and promote community health (CHNC, 2019; CPHA, 2010). At the same time, PHNs direct their activities at multiple *levels of practice* to advocate and effect change. They also aim to initiate and maintain

relationships, central to the PHN role, because these connections help to keep them abreast of local issues and influence the effectiveness of their practice (Falk-Rafael & Betker, 2012a).

Building trusting relationships enables nurses to deliver appropriate and meaningful care, and informs their activities across levels (Falk-Rafael & Betker, 2012b). I elaborate on the nature of each of these three characteristics, that is, PHN autonomy, working across levels of practice, and building relationships, to enhance our understanding of the PHN role. I discuss each feature separately, but in reality, they overlap and interconnect.

Autonomous Practice.

PHNs are autonomous practitioners who work independently, visiting families and community groups, often having to make decisions on the spot without additional resources at hand. They use their professional judgement to anticipate and respond to local health issues, and shift their day-to-day activities to reflect need, integrating a proactive and reactive approach. PHNs work in partnership with community organizations and agencies to promote health in their communities, considering health through a socio-environmental lens (CHNC, 2011). Through this lens, PHNs consider the complex interplay between individual and family health and the health of the entire community. By working autonomously, PHNs often have multiple points of contact with individuals and families to develop and maintain trusting relationships to ensure continuity of care (Falk-Rafael & Betker, 2012b). PHNs require the flexibility and time in their day-to-day practice to establish and maintain trusting relationships with individuals, families, groups, and community partners to build capacity and promote the health of their communities (CHCN, 2019; Falk-Rafael & Betker, 2012a).

Multiple Levels of Practice.

PHNs operate at multiple levels of practice, and direct their activities at individual, family, group, community, population, and system levels. This approach of working across multiple levels of practice is clearly articulated in the CHNC Professional Practice Model (2019), the Theoretical Foundations Model (Betker et al., 2016, 2020), and in the Public Health Nursing Intervention Wheel Model (Olson-Keller et al., 2004). The Intervention Wheel, developed in the United States (US), is a model that guides population-based PHNsg practice and is used extensively in Canada. Falk-Rafael and Betker (2012b) call this working across levels in PHNsg practice the trombone slide. The trombone slide is essential in guiding PHNsg work, and affects PHNsg effectiveness in their role, because their work at the individual and family level informs their advocacy efforts at organizational and policy levels. Likewise, PHNs' community and population knowledge and expertise influences their work with clients and families.

By working across levels, PHNs are guided in their activities directed at clients and families to community and population levels. PHNs need to be familiar with communities and be engaged with them in direct and active ways to be positioned to improve health inequities (Drevdahl, 1995). Throughout their day-to-day activities, the focus of PHNs evolves from individual and family care to a broad population focus (Diekemper et al., 1999a; Diekemper et al., 1999b). A PHN's population efforts, for example, could address issues of poverty and housing that often lead to poor-health outcomes. Working across levels provides PHNs with knowledge and insight into the realities of citizens' day-to-day lives, which they bring to policy table discussions and dialogue (Falk-Rafael & Betker, 2012b). It is by working closely in trusting relationships with individuals, families, and groups that PHNs are able to implement health promotion and empowering strategies (Falk-Rafael, 2005).

Development and Maintenance of Trusting Relationships.

By developing relationships throughout their communities, PHNs integrate their learning and understanding of local community issues with theoretical knowledge, to guide their activities to promote and protect health (Falk-Rafael & Betker, 2012a; Falk-Rafael & Betker, 2012b). The centrality of the trusting relationship PHNs develop with individuals and families in their communities is a common thread in the literature (Aston et al., 2009; CHNC, 2011; CPHA, 2010; Falk-Rafael & Betker, 2012a; Jack et al., 2005; Porr et al., 2012; Reutter & Kushner, 2010). Several researchers have indicated what PHNs have long known, that developing relationships with individuals and families helps to lay the foundation for PHNs to delve into deeply rooted social issues, such as lack of housing or food insecurity (Browne et al., 2010; Falk-Rafael, 2001; Falk-Rafael & Betker, 2012b; Moules et al., 2010; SmithBattle et al., 1997). This relationship provides intimate knowledge of people's lives in the community and informs PHNs in their activities.

PHNs draw on relationships and connections to work at the individual level, but also to support their work at the broad organization and system levels as they promote health and prevent disease (Falk-Rafael & Betker, 2012a). PHNs are encouraged to attend to contextual factors in the physical, social, and economic environment shaping health and wellbeing, through social justice efforts (CPHA, 2010; CHNC, 2019; Schim et al., 2007). For PHNs to be effective in their practice improving population health, they require time in their communities to build trusting relationships with individuals, families, and communities (Aston et al., 2009; Falk-Rafael & Betker, 2012a). Unfortunately, organizational changes within healthcare do not always support or allow time for PHNs to establish those relationships (Falk-Rafael & Betker, 2012a; Meagher-Stewart et al., 2010; Underwood, 2003). Nonetheless, PHNs continue to take strides to

develop connections within their community as well as to work in collaboration with other professionals both inside and outside of public health to create synergy to improve health. In this study, I focus on PHNs within the public health workforce because it is important to understand unique contextual factors that support and/or hinder this specialty role in bringing communities to health.

Public Health

Public health has been defined as our collective action as a society to assure the conditions in which people can be healthy (Institute of Medicine, 1988). Over the last century, the average lifespan of Canadians has increased by 30 years, 25 of those years attributable to advances in public health and the work of public health professionals (CPHA, n.d.). PHNs are the largest group of the public health workforce (Naylor et al., 2003). To protect and promote the health of Canadians, public health professionals, including PHNs, work to reduce health inequities and improve population health (CHNC, 2019; PHAC, 2008).

Population Health and Health Inequities.

The authors of a WHO report, the *Commission on Social Determinants of Health* (2008), highlighted growing and avoidable health inequities, and urged governments, organizations, and societies to improve conditions perpetuating those inequities. Health inequalities are described as “systematic differences in one or more aspects of health status across socially, demographically, or geographically defined populations or subgroups” (Starfield, 2001, p. 546). Health inequalities can lead to unfair, avoidable differences in health created by human action, referred to as health inequities (WHO, 2008). The use of the term inequity is a normative valuation, rooted in ethics, indicating that differences in health are unfair and morally unacceptable (Labonte et al., 2008).

Addressing health inequities is about creating opportunities and removing barriers for populations to achieve full health potential (Whitehead & Dahlgren, 2006).

Health inequities continue to grow in Canada, which leads to poorer health (Wilkinson & Pickett, 2009). What is clear is that factors outside of the healthcare system, such as income, education, and social support, play a significant role in determining the health of the population (Evans et al., 1994; Federal, Provincial, Territorial Advisory Committee on Population Health, 1994; Raphael, 2004; WHO, 1986; WHO, 2008). The public health sector, including PHNs, has an important leadership role in addressing these broad influences on health, commonly referred to as the social determinants of health (CHNC, 2019; PHAC, 2008).

PHNs are well positioned and urged to address individual, family, and community health needs, as well as social, political, and environmental contextual factors influencing health (Diekemper et al., 1999a). PHNs work to promote equity by facilitating access to health services, as well as by improving the conditions of people's lives, and are equipped with the skills to address underlying conditions affecting health (Reutter & Kushner, 2010). By addressing the systemic influences on health, public health professionals can reduce health inequities and improve population health, potentially relieving pressure on the healthcare system (PHAC, 2011; WHO, 2014).

PHNs need to be supported to work upstream to address the structural determinants of poor health (Butterfield, 1990; National Collaborating Center for Determinants of Health, 2014). For example, PHNs are encouraged to attend to the socio-political conditions central to health through political action (Drevdahl, 1999; Hardill, 2006; Spenceley et al., 2006; Whitehead, 2003), and social justice and advocacy (Barnes, 2005; Boutain, 2005; CNA, 2006; de Chesnay et al., 2005; Drevdahl, 2002; Drevdahl et al., 2001; Duncan, 2016; Falk-Rafael, 2005; Kirkham &

Anderson, 2002; MacDonald, 2013; Nauright, 2005; Peter et al., 2016; Reutter & Kushner, 2010). Although PHNs are well situated to address the social determinants of health, they often face organizational factors restraining their efforts (Falk-Rafael & Betker, 2012a; Pauly, Shahram, et al., 2017; Underwood, 2003).

Public Health Reform in Canada.

Over the last few decades, various healthcare reforms have taken place across Canada, often in response to significant events, such as political shifts, economic turns, and health crises. For instance, reductions in federal government investment into healthcare in the 1980s, led to the creation of several commissions throughout the 1990s (e.g. *Royal Commission on Health Care and Costs*, commonly referred to as the Seaton Commission [1991]). A common theme across these reports was the recommendation for health system restructuring to improve system efficiency to lower costs in the face of reduced healthcare budgets (Black & Fierlbeck, 2006; Hurley et al., 1994). As a result, healthcare system restructuring took place across much of Canada that had negative effects on the public health system, such as loss of infrastructure, reduced funding, and diversion of resources to the acute care sector (Benoit et al., 2002; Lomas et al., 1997; Naylor et al., 2003). Then, a series of public health crises (e.g., Severe Acute Respiratory Syndrome [SARS], Walkerton) led to efforts to strengthen the public health system across the country (Naylor et al., 2003; O'Connor, 2002; The Standing Senate Committee on Social Affairs, Science and Technology, 2003). However, these efforts to strengthen the organization and delivery of public health have been buffeted by political forces, funding shortfalls, and shifting priorities.

Public Health Reform in BC.

The province of BC has not been immune to such events. The government began restructuring the provincial health system in the 1990s, creating regionalized HAs responsible for the organization and delivery of health services. The provincial healthcare system was restructured in a few stages throughout the 1990s, when the public health system was amalgamated with the healthcare system, which included hospitals. Regionalization was thought to be a solution to addressing escalating healthcare costs and enhancing the coordination of services (Lomas et al., 1997). Then, since 2005, there have been multiple iterations of provincial policies related to the delivery of public health programs aimed to strengthen the public health system (e.g., Core Public Health Functions Framework in 2005; BC’s Guiding Framework for Public Health in 2013, later updated in 2017). In Table 1, I outline significant healthcare reforms affecting public health services in BC, all of which have had a bearing on the role of PHNs. How these changes have influenced PHNsg practice is poorly understood, however, and is examined further in this dissertation study.

Table 1
Recent BC Healthcare Reforms

<i>Year Government</i>	<i>Health Policy & Healthcare Structure Change</i>	<i>Provincial Organizational Change</i>	<i>Impact on Public Health</i>
1993 New Democratic Party	New Directions for a Healthy British Columbia Provincial Ministry of Health (MOH), 20 Regional Health Boards (RHBs), 82 Community Health Councils (CHCs). A three-tiered structure.	Launch of health system reform: Set stage for regionalization, devolved healthcare organization and decision-making from the province to regionalized governing bodies. MOH set priorities and provided funding. Decision-making authority intended to be “closer to home,” with elected CHCs.	Once-separate public health funding and decision-making integrated within broader health sector.

<p>1996 New Democratic Party</p>	<p>Better Teamwork, Better Care</p> <p>Provincial MOH, 11 RHBs, 34 CHCs, 7 Community Health Services Societies (CHSSs). CHCs abolished.</p>	<p>Revised reform: Boards to be elected by community members were appointed by the MOH. Regionalized bodies became accountable to the MOH instead of to the local community - weakening public participation and enhancing government control.</p>	<p>RHB provided the spectrum of services in urban areas, while CHCs and CHSSs delivered services in rural and remote areas, the latter also responsible for public health.</p>
<p>2001 BC Liberal Party</p>	<p>A New Era for Patient-Centered Health Care: Building a Sustainable, Accountable Structure for Delivery of High-Quality Patient Services.</p> <p>Provincial MOH, 5 geographic Regional HAs, 1 Provincial Health Services Authority (PHSA).</p>	<p>RHAs were responsible for organizing and delivering healthcare services. The PHSA was responsible for planning, coordinating, and evaluating specialized health services with RHAs, such as cancer care, communicable disease, and perinatal services, across the province. One of the intended aims of the reform was to “save and renew healthcare” while protecting services.</p>	<p>RHAs were responsible for organizing and delivering healthcare services, including public health.</p>
<p>2005 BC Liberal Party</p>	<p>Core Functions Framework for Public Health</p>	<p>Initiation of public health renewal: <i>Core Functions</i> outlined 21 core public health programs, strategies to guide implementation, and a population and equity lens to apply to programs. This policy was the first step to address the growing national concern about public health system inadequacies. Each RHA was advised to evaluate public health services in the region, and develop an improvement plan to strengthen service delivery.</p>	<p>National interest in public health surged with two public health crises: the SARS outbreak in the country, and the e. coli water emergency in Walkerton, ON. Media coverage of the events raised public concern, fuelling government action to strengthen public health. The BC government followed suit.</p>
<p>2013 BC Liberal Party</p>	<p>Guiding Framework for Public Health</p>	<p>The <i>Guiding Framework</i>, was the next iteration of public health renewal, later updated in 2017. Instead of</p>	<p>Efforts to strengthen public health were often stalled, with limited resources along</p>

		21 core programs, the <i>Guiding Framework</i> stipulated seven goal areas that RHAs were expected to operationalize.	with the growing demand from the acute care sector. At the same time, the Ministry established the First Nations HA, to organize and deliver health services in alignment with First Nation priorities and vision of health.
--	--	---	--

Health system reform throughout the 1990s reconfigured the organization and delivery of health services across the province. The restructuring of the health system, combined with policy shifts intended to strengthen the public health system, influenced the provision of services. How these organizational and policy changes affected PHNs and PHNsg services in BC is poorly understood and is the focus of this dissertation study.

Study Purpose

The purpose of this study was to explore how contextual factors, such as historical and recent health system reorganization and policy change, have affected PHNs in their efforts to promote and protect health in their communities. The research question guiding this study was: How do PHNs manage organizational and policy changes affecting the nature of their practice? In using the phrase, organizational and policy changes, I am referring to changes in the organization, funding, and delivery of PHNsg programs and services. I explored changes at the local level, often a public health unit, as well as at the HA and provincial level. By studying the PHNsg experience of public health organizational and policy changes, we can begin to develop a fulsome understanding of how reform measures have affected PHNs in practice, how they have managed such change, and the perceived impact of these initiatives on the clients they serve.

Using the grounded theory method, I explored PHN experience, reasoning, and action in the context of healthcare reform and change.

Significance of Study

In conducting this study, I examined how organizational and policy changes at multiple levels have affected PHNs and their ability to enact the full scope of their role. PHNs have voiced concern over the changing nature of their practice due to organizational factors affecting their role, often described as the erosion of their scope of practice (Underwood, 2003). PHNs have reported that recent organizational restructuring, and changes in service delivery, have diminished PHN points of contact in their communities, weakening their relationships and hampering their ability to perform their role (Falk-Rafael & Betker, 2012a; Underwood, 2003). However, there is limited Canadian research concerning how such efforts to improve public health systems and services at provincial and organizational levels have shaped PHNsg practice and the services they provide, particularly within BC.

The nature of public health reform and PHNsg service delivery have varied across the country, underscoring the need to examine and understand the effects of the broad organizational context influencing PHNsg practice. Few empirically-based insights into the effects of policy changes on PHNsg practice are available, but researchers have suggested negative effects on PHNsg services (Falk-Rafael & Betker, 2012a; Meagher-Stewart et al., 2010; Underwood, 2003). It is possible that these changes in public health service delivery may counter the overall efforts of public health practitioners to improve population health. Without data exploring how organizational and system changes have shaped PHNsg practice, and how PHNs have responded to such change, we are left uninformed about the state of the PHN role, and the effects on

population health. We have little understanding of how PHNs have been able to continue their efforts toward improving population health and reducing health inequities amid such change.

How organizational and policy change has influenced the PHN role, and how PHNs managed such change, have important implications for how they, and the public health system, meet the goals of improving the health of the population and reducing health inequities (CPHA, 2010). As a result, Canadian nursing researchers have called for more PHNsg research to evaluate and develop an evidence base for PHNsg practice (Falk-Rafael & Betker, 2012b). By beginning to collate data on the ways in which PHNs manage the changing nature of their practice, given the changing organizational context, we can begin to understand the effect of such organizational changes on PHNsg practice, and subsequently, the impact on community and population health. This will position us as we move forward to ask questions such as: How are PHNs currently being utilized to improve population health? How could PHNs be better utilized to improve the health of populations? Further, how do we know when PHNsg programs and services are making a difference to health outcomes?

Nursing scholars in the US have also shown interest in advancing our understanding of, and the contributions of the PHN role. Through a series of publications, several authors have proposed a PHNsg research agenda describing multiple research aims (Bigbee & Issel, 2012; Issel et al., 2012; Monsen et al., 2012). They suggest that researchers direct efforts at developing population-focused PHNsg practice, explicating the role and contribution of PHNs within the public health system, and studying how PHNs improve population health. These scholars argue that PHNs have an important role to play in improving health through the public health system, and that this role ought to be population-focused. With many similarities between the two countries, the same could be said of PHNs in Canada. These authors also argue that further

research is needed to help explicate the PHN role and link their practice to improved health outcomes. My dissertation is aligned nicely with the intent of this proposed research agenda and is a preliminary step in improving our understanding of the PHN role within BC.

A common recommendation intended to strengthen public health systems and services, specifically directed at public health practitioners, is to build the capacity of the public health workforce. Leading Canadian public health researchers conclude that, in order to ensure a robust public health system, an educated and competent public health workforce is key (Regan et al., 2014). However, alongside developing public health workforce capacity as a means to strengthen systems and services, it is also imperative that we develop a better sense of the factors that are at play shaping PHNsg practice. If PHNsg programs and services operate within a context that does not support reducing the gap in health inequities and improving population health, then the PHN role will not reach full potential.

Dissertation Outline

In the next chapter of this dissertation, I review relevant literature and examine accounts of healthcare reform and the impact on PHNsg practice, focussing on the Canadian context. Where there is scant literature, I expanded my search and explored a broader range of literature to draw insights. For example, minimal research was available regarding the impact of public health reform on PHNsg practice, so I reviewed literature on how organizational restructuring has affected nurses in general. This approach helps to provide some insight into the potential effects of recent public health reform and policy change on PHNsg in BC.

Moving into the third chapter, I describe the methodological approach that I used to conduct this study. Before getting into the details of the grounded theory and my use of the method, I discuss my philosophical positioning in alignment with critical realism, and how this

philosophical stance is congruent with both the theoretical framework and the methodological approach employed in this research. Finally, I address the specifics of the research process, including the ethics approval process, the recruitment process, and the collection and analysis of PHN interview data.

In the fourth chapter of this dissertation, I reveal the findings from this grounded theory research project. Throughout this chapter, I tell the stories of PHNs from three HAs in BC by detailing the theory, *Managing the Eroding PHN Role*. PHNs in this study engaged in five strategies to manage the changing nature of their practice. Several conditional factors shaped PHN responses to organizational and policy change. For example, level of PHN experience, health unit culture, PHNsg leadership, and PHN tolerance for risk taking influenced PHN action. PHN participants were creative and strategic, knowing when to push back against a change, when to keep their head down and do what they needed to do to get by, and when and how to find a way around a change that diminished PHNsg programs and community support. Many PHNs were frustrated, and some were devastated by the erosion of their role. Consequently, several PHNs explored potential roles outside of public health, others looked to take early retirement, while the majority hung on amid change, searching for job satisfaction, and reaffirming their commitment to the PHN role.

In the fifth and final chapter, I place several key findings within the relevant literature. I provide an update to the literature review to report on recent accounts of public health reform and implications for public health, PHNsg services, and population health. I delve into the implications of organizational and policy changes affecting the PHN role, the eroding of the PHN role, as well as the silencing of nurses. I also discuss the five PHN strategies and explore each strategy in relation to the literature. Then, I look beyond my study and discuss the

implications of this research for practice, education, policy, and research. At this point, I critically reflect on the study processes and procedures and provide a synopsis of both study strengths and limitations. I finish off by providing concluding thoughts on this research project.

Summary

The introductory chapter helps to set the stage for this research project examining PHNsg practice amid historical and recent public health reform initiatives. In the background section, I detail the PHN role and provide an overview of healthcare restructuring and policy change affecting the organization and delivery of PHNsg programs and services. How these changes have influenced PHN practice is poorly understood, and is the purpose of this dissertation study.

Chapter 2 – Literature Review

Provincial and territorial healthcare systems across Canada have been depicted as perpetually shifting landscapes, which has significant implications for the provision of healthcare (Dickson et al., 2012). Organizational change within the health sector, such as altering decision-making structures and service delivery models, shapes the planning and delivery of services. The province of BC has not been immune to such change, where significant healthcare reforms and policy shifts have influenced the organization and delivery of services. Researchers examining health system change have tended to focus on financial and system outcomes, and have paid less attention to the implications for healthcare providers such as nurses, and for client care (McMillan, 2016). Where literature is available, researchers have largely focussed on the impact of organizational change on nurses within the acute care sector (Aiken et al, 2001; Jantzen et al., 2017; Kullen Engstrom et al., 2002; Spence Laschinger & Leiter, 2006; Suominen et al., 2011). Currently, there is a paucity of research examining the effect of organizational and policy change on PHNs, leaving us with a poor understanding of how healthcare change has influenced PHNs in their role, particularly in BC.

Healthcare reform across BC has unfolded as a series of organizational and policy changes, shaping the context in which nurses work. The organizational context is an important factor influencing the ability of PHNs to protect and promote health, and in determining whether PHNs meet their national standards of practice (Underwood et al., 2009). There are clear recommendations for organizational structures and management practices to support PHNs in practice (Ganann et al., 2010; Underwood et al., 2009), competencies for public health (PHAC, 2007) and PHNsg practice (CHNC, 2009), and standards of PHNsg practice (CHNC, 2019) to guide public health renewal. Public health renewal, intended to strengthen public health systems

and services, has unfolded within the broader context of healthcare reform aimed at improving the overall functioning of the health system, all of which affects the organization and delivery of public health services in BC. Currently, we know very little about how PHNs have experienced public health renewal in BC, and how they have navigated this changing organizational terrain, the aim of this dissertation research. From the limited research that is available, PHNs have voiced their concerns about several changes impeding their ability to improve health and reduce disease and injury in their communities (Cohen, 2006; Falk-Rafael & Betker, 2012a). Due to the limited body of research exploring implications of public health renewal on PHNsg practice, in this literature review I take a broad approach and begin by examining healthcare system change and implications for nursing practice, before focussing in on the impact of healthcare system and public health system change on PHNsg practice.

Over the past several decades, nursing researchers, nationally and internationally, have raised concerns about healthcare system change and the impact on nursing practice (Aiken et al., 2001; Debesay et al., 2014; Jantzen et al., 2017; Kullen Engstrom et al., 2002; Kuokkanen et al., 2007; McMillan, 2016; Purdy et al., 2010; Spence Laschinger & Leiter, 2006; Spence Laschinger et al., 2009; Suominen et al., 2011). These researchers have reported on a number of system changes that significantly affect the work environment and delivery of healthcare services, such as downsizing the nursing workforce, changing the workforce composition, redesigning care models, as well as changing management structures (Salmela et al., 2013; Spence Laschinger & Leiter, 2006). Often within a context of restricted budgets, administrators restructure and reorganize the health system through a number of mechanisms purported to improve operational efficiencies and reduce healthcare costs. When politicians cut the healthcare budget, the reverberations are experienced throughout the healthcare sector (Salmela et al.,

2013). All too often measures to tighten healthcare resources are directed at public health, eliminating staff and services that some believe are arbitrary decisions by ill-informed politicians promising tax cuts (Rutty & Sullivan, 2010).

In this chapter, I review the literature to shed light on this area of scholarship, examining the impact of healthcare reform on nurses and their practice. I begin by discussing healthcare restructuring across several democratic countries, with a focus on the Canadian context and on changes with implications for nursing practice. I then delve into the work of researchers reporting on the influence of organizational and policy change, predominantly within the hospital setting, and the impact on nurses and nursing practice. I do so because there is limited research available on the impact of health reform on PHNs and PHNsg practice, and there is a significant body of rigorous research examining the effects of hospital restructuring on nurses, nursing practice, and patient outcomes. Thus, I discuss contextual changes and the effects on nurses and nursing practice more broadly before narrowing in on the specialty area of PHNsg practice. In the last section, I collate effectiveness research on select PHNsg programs to provide insight into PHNsg practice and demonstrate the difference PHNs make, before exploring the influence of organizational and policy change on PHNs and PHNsg, again, with a focus on the experiences of Canadian PHNs. From this vantage point, we are well positioned to detect whether there are similarities and differences across practice settings, and are sensitized to key concerns of nurses before delving into this dissertation research examining the situation of PHNs amid public health reform.

Healthcare System Change and Service Delivery

Healthcare systems globally are characterized by constant organizational restructuring and change (Jantzen et al., 2017; Suominen et al., 2011). Perhaps a hallmark of progress, health

system reform is typically carried out in the name of improved population health and optimized service delivery (Denis et al. 2015). Organizational restructuring is often intended to reduce or control healthcare costs through improved operational efficiency, but it has also been driven by other motives. For instance, Norrish and Rundall (2001) outlined varying waves of restructuring, and noted motives, such as improved use of registered nurses' time, as well as enhanced patient care through patient-focussed care, in addition to saving healthcare dollars.

Healthcare system changes frequently come in the form of reorganizing the delivery of services, usually as a result of amalgamation, unit closures, system redesign, and shifting organizational vision, but changes also come from technological developments, advances in scope of practice, and changing population demands (Dickson et al., 2012; Jantzen et al., 2017). Some changes are structural, such as merging organizations or units, flattening administrative structures, or regionalization of health services. Others are non-structural, such as reductions in the number of staff, or shifting organizational priorities. Again, these changes are typically introduced in the name of reducing costs of services, while maximizing efficiency and effectiveness within care delivery (Ingersoll et al., 2001). These shifts in vision, or proposed advancements in healthcare, have implications for the organization and delivery of nursing care.

Over the last few decades, there have been several significant healthcare changes that have unfolded across Canada and elsewhere, shaping the organization and delivery of services, including nursing. I now discuss three examples of healthcare system changes noted in the literature, with implications for the organization and delivery of nursing practice. More specifically, I address regionalization of health systems, shifting management models within healthcare, and hospital restructuring that have affected nurses delivering care. As Choiniere

(2011) points out, significant forces outside of nursing are at play shaping healthcare work environments, with direct implications for nursing practice and nursing knowledge.

Regionalization of Healthcare Systems

Regionalizing health systems was a notable healthcare shift in the 1990s that was not isolated to Canada, but unfolded across several countries, such as Australia (Duckett, 2016) and Brazil (de Lima et al., 2012). Regionalization of health systems had significant implications for the organization and delivery of services (Marchildon, 2019). In Canada, most provincial governments regionalized the organization and delivery of health services during the 1990s, with Ontario being an exception. It was not until two decades after the wave of regionalization across the country that the Ontario government implemented a variation of regionalization with the creation of Local Health Integration Networks (LHINs) to coordinate services, although the public health system was not included in these networks.

This restructuring of health systems comprised both centralization and decentralization of healthcare processes and services (Black & Fierlbeck, 2006). In BC, the governance once provided by local boards of health shifted to regionalized HAs, and healthcare organization and decision-making was devolved from the Ministry of Health to the regionalized bodies. Regionalization did lead to transfer of decision-making authority for service delivery to HAs, however, the provincial government continued to set priorities, establish targets, and control the global budget, steering regional level decisions. Marchildon (2019) explains that regionalization introduced a shift toward provincial governments indirectly managing service delivery through regional HAs. Nursing services, including PHNsg, were subsumed under the purview of regional HAs across most Canadian provinces. Once again, Ontario was an exception, where public health, and PHNsg, remained outside of the LHINs.

Marchildon (2019) noted that the regional HAs within Canada operated quite similarly to the health boards in New Zealand and the local health districts in New South Wales, Australia. However, comparison of health systems proved to be difficult within Canada, let alone across other countries, because of varying forms of regionalization and the frequently shifting terrain. For instance, despite the fact that nine Canadian provinces implemented regionalization by the end of the 1990s, since then, multiple provinces (e.g., Prince Edward Island, Nova Scotia, Alberta, Saskatchewan) have eliminated regional HAs, and created one provincial HA. To some, the mixed reviews of regionalization led leaders in these provinces to abandon regionalized governance, while others believe it has been a useful political tool for government to be seen addressing systemic healthcare problems (Fierlbeck, 2016; Marchildon, 2019).

In BC, regionalization led to the integration of various health sectors, such as mental health and addictions services, acute care, along with public health, all under the same governance structure. This amalgamation had implications for the delivery of nursing care in terms of funding allocation, decision-making authority, and governance of programs and services. Regionalization was intended to improve coordination of services and health outcomes, and reduce inefficiencies (Lomas et al., 1997), but some have highlighted the difficulty in determining any real outcomes (Fierlbeck, 2016). Fierlbeck (2016) viewed regionalization as a mechanism to shift responsibility away from provincial governments, as well as a strategy to destabilize the power of key stakeholder groups, such as the influence of local providers. PHNs from Manitoba and Quebec have voiced concern about the negative influence of regionalization on practice (Beaudet et al., 2011; Cohen, 2006). Thus, there is some evidence to suggest that the regionalization of health systems has led to factors that have compromised nurses' practice, narrowing the PHN role. However, there appears to be inadequate evidence to determine optimal

governance structures for supporting healthcare professionals in the organization and delivery of programs and services, as well as for improving population outcomes. PHN researchers have also discussed the negative implications of the adoption of business management models on PHNsg practice (Falk-Rafael & Betker, 2012a).

Shifting Management Models

As noted above, forces outside of nursing have had a significant influence on nursing practice. In the mid- to late 1990s, Canadian nurses witnessed another form of healthcare change with the introduction of managed care models across Canada. The adoption of managed care models have had significant implications for the nursing profession (Choiniere, 2011). Nurses described how these care models, informed by business ideals, led to the increased use of mechanisms to account for and control nursing care, privileging efficiency, standardized processes, and numerically based indicators, thus constraining their role (Choiniere, 2011). Internationally, nurses have also raised concerns regarding the use of industrial and business-oriented approaches in restructuring healthcare, which they claim simplify an inherently complex practice (Aiken et al., 2001; Duffield et al., 2007; Roan et al., 2002). These industrial models, however, have come under scrutiny. Private sector businesses are being encouraged to move toward forward thinking models based on notions such as sustainability and innovation that are geared toward adding human value (Bocken & Short, 2016). It seems that healthcare operations have often been based on outdated business models.

Some have portrayed the shift in management models as a form of “neoliberal restructuring” (Choiniere, 2011, p. 330). That is, healthcare restructuring has been shaped by neoliberal forces, characterized by the weakening role of the public sector, the deregulation of markets, and increasing privatization (Cartier, 2003). From this frame, administrators closely

monitor and manage healthcare inputs, outputs, and outcomes, with a propensity towards prioritizing efficiency of services over what nurses deem as effective care (Cartier, 2003). The neoliberal approach is contentious, and some suggest that it is less efficient and is actually a more expensive and management-heavy approach to healthcare (Paton, 2014), with significant implications for growing inequities in health (Labonte & Stuckler, 2016).

Within the context of healthcare reform, nurses have discussed the philosophical and ideological conflict underlying many reform initiatives, and the subsequent foundering of healthcare culture (Aiken et al., 2001). Several authors have attributed this conflict to the adoption of New Public Management ideals in healthcare, and discussed the negative implications for healthcare providers (e.g., Debesay et al., 2014; Rankin, 2009). New Public Management is described as the reorganization of the public sector, using managerial regimes and strategies derived from the private sector (Griffith & Smith, 2014). For instance, with restructuring healthcare services in Norway, in line with New Public Management ideals, home care nurses explained how they struggled to comply with changing efficiency and accountability demands while meeting patient needs (Debesay et al., 2014). These nurses described experiencing weakening involvement in decision-making, an imposed time regime, and standardization of nursing tasks that reduced their role and autonomy. Traces of New Public Management were also reported closer to home, reflecting similar workplace implications for nurses in Canadian hospitals (Rankin, 2009). To some, the adoption of several management models have silenced or subordinated nursing knowledge and voices, by controlling nurses and nursing practice (Aiken et al., 1997; Buresh & Gordon, 2013; McMillan, 2016; Rankin & Campbell, 2006).

Another example of a business-driven management approach used to guide healthcare restructuring in Canada was the implementation of the Lean model. This model has also been purported to negatively affect nurses' work (McMillan, 2016). Derived from the Japanese manufacturing industry, specifically Toyota, the Lean methodology is aimed at eliminating waste, improving quality and operation efficiency, whereby leaders apply linear cause and effect problem solving and thinking in production and delivery of service (Kim et al., 2006). Once again, this industry model was adopted with the intent to improve quality and cost efficiency in healthcare (Kinsman et al, 2014). This management approach has been espoused by leaders in several Canadian provinces in the health sector, including in the Saskatchewan Ministry of Health (Kinsman et al, 2014), but has been criticized for its inability to address adequately contextual and human complexity within organizations (McMillan, 2016). Some believe the implementation of these management models in healthcare reform jeopardized nurses' ability to provide competent care resulting in worsening patient outcomes, placed the nursing profession at risk, and negatively affected nurses' wellbeing (Choiniere, 2011).

Hospital Restructuring

The debt crisis throughout the 1990s was a precursor to the regionalization of health systems across much of Canada, the adoption of various management models, as well as significant hospital restructuring across North America during this timeframe (Aiken et al., 2002; Baumann & Blythe, 2003; Spence Laschinger & Leiter, 2006). In the face of financial constraint, administrators made efforts to reduce healthcare costs through hospital restructuring, and at times, hospital closures (Baumann & Blythe, 2003; Blythe et al., 2001; Institute of Medicine, 2004). Hospital restructuring had significant implications for nurses in their role, including nursing layoffs.

Several nursing researchers reported the effects of hospital restructuring on nurses and nursing practice during that time (Aiken et al., 2001; Baumann et al., 2003; Duffield et al., 2007; Greenglass & Burke, 2001; Spence Laschinger et al., 2001). These researchers examined the impact of changes, such as nursing layoffs, minimum nurse-to-patient ratios legislation, and the reduction of nurse managers and their role within organizations (Aiken et al., 2002; Spence Laschinger & Leiter, 2006). The authors of an Institute of Medicine (2004) report raised concerns regarding the negative effects of hospital restructuring on nursing work environments and patient safety, and drew attention to changes in organizational management practices, work design issues, and organizational culture in this setting.

There is a significant body of research detailing hospital restructuring and the impact on nurses, nursing practice, and patient outcomes that I explore in more detail in the following section. Nursing researchers, to date, have largely focussed on how healthcare changes, such as shifting management models and reform mechanisms, have influenced nurses in hospital settings. This has left us with a limited understanding of how healthcare reorganization and more specifically, public health restructuring and renewal initiatives, have affected PHNs, influenced PHNsg practice, and shaped community health. By examining the implications of healthcare reform on nurses in the hospital, we can explore whether similar effects of reform have influenced PHNs and PHNsg practice in the community, an area of nursing that has received much less attention in the literature.

The Impact of Organizational Change on Nursing Practice, Nurses, and Patient Outcomes

Healthcare systems continue to evolve rapidly to meet changing demands, such as technology developments, new management structures, and shifting organization targets. These changes often unfold within a context of stringent budgets and with direct implications for

healthcare providers delivering services (Dickson et al., 2012). A number of nursing researchers have explored associations between changing work characteristics in the hospital, such as level of nurse education, changes in staffing mix and nursing roles, or staffing levels, and nursing practice, as well as patient outcomes (e.g., Aiken et al., 2001; Dubois et al., 2014; Ingersoll et al., 2001; Spence Laschinger & Leiter, 2006; Suominen et al., 2011).

The influence of hospital changes has been quantitatively studied in nursing across multiple countries by measuring levels and dimensions of nursing services (e.g., Aiken et al., 2001; Estabrooks et al., 2005; Ingersoll et al., 2001; Spence Laschinger & Leiter, 2006). These researchers have documented the degree of impact of restructuring on nurses, patient care, and patient outcomes. There are also a growing number of published qualitative studies in which researchers have explored inductively the experiences and perspectives of nurses within organizational change (e.g., Blythe et al., 2001; Choiniere, 2011; Kramer & Schmalenberg, 2003; Salmela et al., 2013). These researchers enhance our understanding of the human experience of hospital restructuring by describing the personal and professional toll of restructuring on nurses. Hospital restructuring often resulted in changes such as a reduced number of hospital beds, merged units/departments, hospital closures, and staff reallocation and layoffs. Some demonstrated how hospital restructuring compromised nursing practice and negatively affected nurses' ability to provide effective care (e.g., Blythe et al., 2001).

Several authors have also published literature reviews examining the impact of organizational change on nursing practice (e.g., Flodgren et al., 2011; Flodgren et al., 2012; Norrish & Rundall, 2001). From the Cochrane database, I retrieved two quantitative systematic reviews (Flodgren et al., 2011; Flodgren, et al., 2012) and one qualitative systematic review protocol (Jantzen et al., 2017), wherein the researchers examine, or are planning to examine the

impact of organizational change on nursing practice. The findings from the quantitative reviews are limited, however, because the reviews only included two studies due to the narrow inclusion criteria. These authors call for further investments into this area of inquiry to strengthen the current evidence base. In the following section, I explore the work of researchers examining the implications of organizational change on nursing practice, the physical and psychological wellbeing of nurses, and patient outcomes.

Organizational Change and Nursing Practice

Many healthcare changes require nurses to adapt their practice, such as with technological advancements and telehealth innovations (Jantzen et al., 2017). Nursing researchers have reported on the implications of various organizational changes on nursing practice. For instance, a team of researchers found that the implementation of Lean healthcare models negatively affected nurse retention, autonomy, and safety (Aiken et al., 2001). Other restructuring mechanisms, such as flattening management hierarchies and eliminating nurse manager positions, were reported to dismantle the professional support and leadership for nurses in practice (Baumann & Blythe, 2003; Institute of Medicine, 2004; Spence Laschinger et al., 2001; Roan et al., 2002). Whether individually, or taken together, these mechanisms of organizational change have shaped the delivery of nursing care.

Researchers, nationally and internationally, have been critical of healthcare trends because they believe the implications of organizational change on nursing practice are often overlooked, and that nurses are often presented with limited opportunity for input (Choiniere, 2011; Duffield et al., 2007). Some nursing scholars are concerned about organizational change and believe healthcare restructuring has often led to the deprofessionalization of nursing, eroding nursing infrastructure and relationships within the organization (Duffield et al., 2007).

Restructuring effects are exacerbated when the implementation of change is top-down, without consultation and employee participation (Roan et al., 2002).

In a substantial review of the literature, Norrish and Rundall (2001) reported on three key effects of hospital restructuring on nursing practice. These authors discussed changes in nurses' roles, workload, and control over their work, and the importance of these key characteristics in defining nursing practice and in understanding the impact of organizational change on nursing practice, nurses, and patient outcomes. The findings from this literature review are consistent with other and more recent accounts in the literature, which I discuss below. By exploring each of these key effects on nursing practice, that is, nurses' roles, workload, and control over their work, we can enhance our understanding of the impact of various healthcare changes on nursing practice.

Nurses' Roles.

Hospital restructuring has affected nurses' roles and responsibilities in several ways (Norrish & Rundall, 2001). For instance, after the redesign of two hospitals in the US, researchers conducted focus groups to capture the perceptions of 48 nurses who described spending less time with patients, providing less teaching and support to patients and families, and having more management and oversight responsibilities of new staff (Ingersoll et al., 2001). The hospital redesigns had a stated intent to improve the quality and delivery of patient services, and were restructured through mechanisms such as merging units, reducing staff, and flattening administrative structures.

Nurses in this study reported struggling to understand their role amid organizational changes (Ingersoll et al., 2001). In these changes, they witnessed the loss of nurses to other units or leaving the organization, along with the influx of unfamiliar staff from other units, and the

hiring of non-professional care providers and licensed practical nurses, part time staff, and the introduction of other roles, such as case managers. As a result, nurses in this study stated that they were hindered in providing high quality care because they spent less time with patients. When nurses were not conducting the total health assessment, because parts of their role were provided by others, they believed they were less likely to detect changes in patients' status, such as signs and symptoms of complications. Participants also discussed weakening coordination of care between physicians and nurses, who were to collaborate with case managers for care planning. As a result, these nurses felt disconnected from patient decision-making and communication, and were concerned that their weakening control over and input into patient care could lead to overlooking necessary care (Ingersoll et al., 2001). The findings from this study of two US hospitals echo results from the study of three Canadian hospitals undergoing restructuring. These researchers collected focus group and interview data from a sample of 59 nurses working in three Ontario hospitals, many of whom had been relocated over the year prior to data collection, and found that nurses reported challenges in skill mix and role confusion for nurses after hospital restructuring (Blythe et al., 2001).

Nurses not only discussed changes in their own role, but they also commented on the impact of recent hospital restructuring on nursing leadership roles (Aiken et al., 2001; Ingersoll et al., 2001; Salmela et al., 2013). For instance, nurses in several studies stated that the number of nursing leadership roles had been reduced with the flattening of administrative hierarchies, minimizing nursing input into decision-making and weakening nursing control over nursing practice within the organization (Aiken et al., 2001; Choiniere, 2011; Ingersoll et al., 2001). When nursing managers were eliminated, nurses not only lost mentorship and support in their day-to-day practice, but they were expected to pick up additional administrative tasks that were

once the responsibility of managers. Middle managers who did remain had a broader area of responsibility, distancing managers from nurses providing care (Blyth et al., 2001). The number of nursing executives was also reported to be cut back, eroding nursing representation at decision-making levels and leaving nurses with limited power to influence their work environments and advocate for change at policy levels (Aiken et al., 2001; Institute of Medicine, 2004; Patrick & Spence Laschinger, 2006). Thus, it seems that nurses in different roles within the organization were negatively affected by hospital restructuring.

Nurses' Workload.

In addition to changes in their roles and responsibilities, findings from several studies indicate that hospital restructuring resulted in increasing nurses' workload (Choiniere, 2011; Ingersoll et al., 2001; Spence Laschinger & Leiter, 2006). With fewer resources, nurses often described having to do more with less, caring for more complex patients, as well as assuming additional responsibilities, such as the supervision of healthcare aides (Choiniere, 2011; Ingersoll et al., 2001). Using content analysis to analyze focus group and interview data from 53 nurses in five Canadian provinces (BC, Alberta, Saskatchewan, Manitoba, Ontario, and New Brunswick), Choiniere (2011) explained how many nurses, after hospital restructuring, cared for higher acuity patients with shorter hospital stays, and believed that managers dictated their practice. A team of researchers in Quebec, after analyzing questionnaire data from 96 healthcare providers, including nurses, also found that reorganization resulted in heavier workloads due, in part, to providers adapting to new practices, protocols, and responsibilities, in a context of fewer supports and resources (Dubois et al., 2014).

With hospital restructuring often increasing nurses' workloads, as well as frequently altering team composition, nurses reported having less time to assist one another with patient

care, compromising team culture and care (Blythe et al., 2001). Once again, nurses discussed how organizational change interfered with nursing leadership, affecting nursing workload. For instance, with the elimination of charge nurses in some contexts, or when charge nurses were assigned a patient load, nurses had less support if a patient was deteriorating, or to cover nurses to take breaks (Choiniere, 2011). In fact, some nurses reported workload to be the most significant predictor of stress level in nurses amid hospital restructuring (Greenglass & Burke, 2001).

Nurses' Control Over Work.

Nurses' control over their practice, described as a combination of professional and clinical autonomy, is an important function of a professional nurse (Kramer & Schmalenberg, 2003). In addition to changes in nurses' roles and workload, nurses have also reported on the impact of hospital restructuring on their control over nursing practice (Kullen Engstrom et al., 2002). For instance, nurses in one study explained how, with the hiring of non-professional providers and licensed practical nurses within a hospital redesign, they had less control over patient care (Ingersoll et al., 2001). That is, they had less responsibility over direct patient care but the same level of accountability (Ingersoll et al., 2001). These nurses indicated that, as a result of hiring less expensive personnel, a common cost cutting mechanism in healthcare restructuring, nurses were spending less time with patients and were concerned that they would be less effective detecting subtle changes in patient status (Ingersoll et al., 2001). Once again, these changes are reflective of factors outside of nursing influencing nurses' work.

In another study, a serial case study, researchers examined nurses' control over nursing practice by collecting interview and questionnaire data from 279 nurses from 14 magnet hospitals in the US (Kramer & Schmalenberg, 2003). These researchers found that organizational

infrastructure to support nurses' control over their practice had been significantly disrupted during hospital restructuring in half of the hospitals studied (Kramer & Schmalenberg, 2003). In fact, almost 60% of nurses in this study stated they had little or no control over their practice. This subset of nurses described how there was no organizational structure in place to empower nurses. Instead, they indicated that nursing practice was dictated by regulations and physicians, and authority and decision-making remained with management. These authors reported that nurse autonomy was a prerequisite for control over practice, which was highly correlated with both quality of care and job satisfaction (Kramer & Schmalenberg, 2003). Organizational infrastructure, whereby nurse executives support nurse managers to empower staff, through means such as credible and effective communication, was key to develop nurses' control over practice (Kramer & Schmalenberg, 2003). Strong nursing leadership is an important mechanism in creating a supportive work environment for nurses, enabling nurses to meet patient needs (Institute of Medicine, 2004).

Nursing researchers in Sweden also reported on nurses' control over their work (Kullen Engstrom et al., 2002). Kullen Engstrom and colleagues interviewed 31 hospital staff, including nurses, to explore healthcare employee experiences of a hospital merger. Using grounded theory methodology, the researchers found that healthcare professionals described feeling like pawns in a political game, where providers were moved around with little consideration and respect. The staff in this study described little control over, or input into the hospital merger. For example, some participants explained how, as a result of the merger, they were responsible for closing wards or developing new forms of care delivery, with minimal information or guidance. One nurse stated that she was a better nurse before the merger, and that because she was no longer in her specialty area, she was losing her craft. Some staff indicated that when employees are not

given the opportunity to influence their work, they are likely to leave the organization.

Findings from this study point to the importance of including employee perspectives' in change processes that affect staff roles.

Several authors have pointed to forces outside nursing, such as managerial control, that have limited nurses in using their professional knowledge and expertise, compromising nurses' control in their practice and quality of nursing care (Cartier, 2003; Choiniere, 2011; Spence Laschinger & Leiter, 2006; Suominen et al., 2011; Wall, 2013). Norrish and Rundall (2001) explained the importance of nurses' roles, workload, and control over nursing practice, which affects the quality of patient care and nurses' work satisfaction. The fact that nurse autonomy and accountability are susceptible to change during restructuring, has led some to advocate for shared governance models within healthcare, a management system providing nurses with increased participation in decision-making that has been effective in promoting improved patient and nurse outcomes (Kutney-Lee et al., 2016; Norrish & Rundall, 2001). Nurses' control over their practice is supported in an empowered organizational structure where nurses participate in decision-making at the hospital, departmental, and unit level (Kramer & Schmaleberg, 2003; Suominen et al., 2011). Nursing researchers have proposed a connection between empowered nursing work environments and positive nurse and patient outcomes (Spence Laschinger et al., 2010), but this remains an area that requires further investigation.

Norrish and Rundall (2001) explained how nurses' control over their work ebbs and flows with organization change, making it vulnerable during times of healthcare restructuring. Nursing has frequently been a target of cost cutting measures in healthcare restructuring (Aiken et al., 2014). Researchers have demonstrated how hospital restructuring has affected nursing

practice, often altering nurses' decision-making and authority, as well as influencing nurses' wellbeing (Spence Laschinger & Leiter, 2006).

Organizational Change and Nurses' Wellbeing

There are several accounts of healthcare changes that have had negative repercussions on nurses' physical and psychological wellbeing, thereby hindering the quality of nursing practice (Cummings & Estabrooks, 2003; Choiniere, 2011; Dubois et al., 2014; Kuokkanen et al., 2007; Suominen et al., 2011). Common effects reported in the literature are frustration, anger, despair, burnout, powerlessness, and abandonment (Aiken et al., 2002; Ingersoll et al., 2001; Spence Laschinger & Leiter, 2006). Spence Laschinger and Leiter (2006) explained that major sources of nurse burnout are the result of organizational changes that have led to increased workload, lack of control over their practice, the requirement to carry out activities that conflict with a nurse's values and beliefs, loss of a community of practice, and unfair management practices, such as inadequate staffing levels. Organizational change negatively affected empowerment of healthcare staff when carried out in ways that demonstrated strong organizational bureaucracy and hierarchy, authoritarian leadership, poor staff access to information, and little opportunity for staff advancement in relation to restructuring (Kuokkanen et al., 2007). These researchers found that such organizational attributes led to employee dissatisfaction, burnout, and absenteeism.

Nursing researchers reported that organizational restructuring often results in nurses feeling devalued with a reduced sense of professionalism (Ingersoll et al., 2001; Norrish and Rundall, 2001). They also described that changes have led to a weakened community of practice, negatively affecting the wellbeing of nurses. In fact, the level of stress resulting from these changes led some nurses to consider leaving their place of employment (Aiken et al., 2001; Choiniere, 2011; Ingersoll et al., 2001). Researchers from a large research study involving five

countries, including Canada, surveyed more than 40,000 hospital nurse participants, and reported that one in five nurses stated they intended to leave their job within a year because of dissatisfaction in their work (Aiken et al., 2001). These study findings highlight the significant issue of nurse dissatisfaction in their role related to changes in the work environment and quality of care.

Changes in the organization and delivery of nursing care have led to job dissatisfaction, low morale, and mistrust of administration among hospital nurses (Aiken et al., 2001; Choiniere, 2011; Ingersoll et al., 2001). The frequency and nature of change in their workplace has created a sense of uncertainty about their role and future change, weakening nurses' morale (Kullen Engstrom et al., 2002). Aiken and colleagues (2001) reported that nurses were some of the least satisfied workers, and the level of dissatisfaction was growing. Nurses explained that they were dissatisfied, not with providing complex care, but with changes in their work environment, particularly the increases in workload and stress, deteriorating managerial support, and weakening control in their role, thus leading to a deterioration in the quality of care (Aiken et al., 2001; Choiniere, 2011). Nurses also experienced increased burnout and job dissatisfaction with high patient-to-nurse ratios (Aiken et al., 2002). Interestingly, Aiken and her team (2001) collected data in many different health systems, and yet, nurses reported common barriers to providing care. Several Canadian nurses described a sense of dissatisfaction in their practice that largely stemmed from the conflict between their responsibility to patients and organizational factors limiting nurses in using their professional knowledge to meet patient needs (Choiniere, 2011).

In a prospective longitudinal study of healthcare workers in Quebec, researchers found that work reorganizational initiatives reduced resources and affected employees' psychological

state and reaction to change (Dubois et al., 2014). These researchers collected questionnaire data at two intervals, 12 months apart, from 96 healthcare workers, including nurses. Work reorganization consisted of changes such as the introduction of support workers, revision of roles, new forms of supervision, and changes to work processes. Dubois and colleagues used multivariate models to test hypotheses and reported that the perceived loss of resources was correlated with emotional exhaustion (burnout), which was negatively associated with commitment to change and positively associated with cynicism. The findings from this study suggest that reorganization resulted in perceptions of loss among frontline staff, as measured by the loss of autonomy, opportunities for stimulating work, workplace cohesion, and informal power. They described a complex set of factors affecting the psychological state of healthcare providers, operating at individual, interpersonal, and organizational levels.

Organizational Change and Patient Outcomes

Many nurses have reported significant levels of job dissatisfaction, in large part, due to the reduction in the quality of care and services provided within their organizations (Aiken et al., 2001; Ingersoll et al., 2001). Nurses described how healthcare changes impoverished the care nurses provide to clients in hospitals, as well as in long-term care settings (Choiniere, 2011; Coughlan & Ward, 2007). In the US, researchers reported that California hospitals with high patient-to-nurse ratios had higher rates of patient mortality (Aiken et al., 2002). In a cross-sectional analysis, this team of researchers collected survey data from over 10,000 nurse participants, linked this data with patient discharge and administrative data, and found that each additional patient per nurse was associated with a 7% increase in the likelihood of patients dying within 30 days of admission, and a 7% increase in the odds of patient failure-to-rescue (mortality following complications) (Aiken et al., 2002). These researchers reported significant effects of

nurse staffing levels on preventable deaths, indicating that increasing nurse staffing could result in substantial decreases in patient mortality rates. Although there was a reported 52% response rate in this study, indicating a potential for response bias, the authors compared demographic characteristics of study respondents to nurse data at the state and national level, and found that they closely matched. The authors, therefore, explained that they did not believe their findings were specific to their sample. Aiken and colleagues have extended their research nationally (Aiken et al., 2000) and internationally (Aiken et al., 2014), to explore associations between nursing staffing characteristics and patient outcomes.

Within the Canadian context, Estabrooks and colleagues (2005) studied the effect of nurse characteristics on patient outcomes. In a cross-sectional analysis, these researchers examined the influence of varying hospital characteristics on 30-day mortality for over 18,000 patients discharged from 49 hospitals in Alberta (Estabrooks et al., 2005). After adjusting for institutional factors and individual patient characteristics, this research team found that four hospital nursing variables were statistically significant predictors of mortality in the multivariate model. The researchers reported that hospitals with a higher proportion of baccalaureate-prepared nurses and those with a higher skill mix (i.e., high RN to non-RN ratios) were associated with lower rates of 30-day patient mortality (Estabrooks et al., 2005). Hospitals with a higher proportion of casual and temporary nurses were associated with higher rates of 30-day patient mortality. They also found that hospitals with a higher score on collaborative nurse-physician relationships were associated with lower rates of 30-day patient mortality. Organizational restructuring initiatives affecting hospital nursing characteristics can influence rates of patient mortality, demonstrating the need to address nursing work environments to improve patient outcomes.

Nursing researchers have provided substantial insight into the experience and outcomes of restructuring initiatives on nursing practice in hospital settings. Nursing practice environments are significant to nurse wellbeing, but they also influence patient outcomes (Aiken et al., 2008). We have far less understanding of the impact of such change on nursing practice in other settings, in particular, public health. A handful of researchers have captured PHN concerns regarding the influence of organizational change on their practice (Cohen, 2006; Falk Rafael & Betker, 2012a). This dissertation research contributes to our understanding of the impact of organizational and policy change on PHNsg practice. After reviewing the literature above, one can hypothesize about the transferability of these research findings to other nursing settings subject to similar forms of healthcare restructuring. I now examine PHN experiences and explore whether their experiences have paralleled the experience of nurses in hospital settings.

The Impact of Organizational Change on Public Health Nursing Practice, PHNs, and Client Outcomes

There is a growing body of literature demonstrating the significance of contextual factors on the way that nurses deliver PHNsg programs and services (Schofield et al., 2010; Underwood et al., 2009). The impact of healthcare restructuring on PHNsg practice, however, is often a point of discussion, not the unit of analysis in published research. Researchers investigating PHNsg programs and services often treat organizational change as peripheral to the project, presented as background information or a point of consideration in the discussion section, but not part of the research question itself. Therefore, a search of the literature to investigate the effect of restructuring on PHNsg practice, PHNs, and health outcomes is somewhat limited and yields few studies. The relative inaccessibility of the scant evidence may limit one's ability to draw conclusions about this area of study.

Considering the frequent reorganizations in the architecture of healthcare delivery across Canadian provinces (Denis et al., 2015), very little work has been done to understand how organizational and policy change has affected PHNs providing care in their communities. Before delving into the literature to develop an understanding of what is known regarding the impact of healthcare reforms on PHNsg practice, I take a brief excursion into the effectiveness scholarship in which researchers evaluate the difference PHNsg interventions make. I do so to enhance our understanding of the role PHNs play in promoting and protecting health and preventing disease and injury at the individual, community, and population levels. Several researchers in the US stipulate that we need to improve our understanding of PHNsg interventions to advance the science of PHNsg, so we are better equipped to provide evidence on PHN effectiveness to administrators in times of fiscal restraint (Hassmiller, 2014; Monsen et al., 2011; Swinder et al., 2017).

Effectiveness of Public Health Nursing Practice

I begin this exploration of organizational change and PHNsg practice by providing an overview of the PHN effectiveness literature, focussing on three staple PHNsg programs and services. In a recent review, focussing on PHNsg effectiveness over a 20 year period, the authors found that PHNsg interventions made a statistically significant difference in health outcomes in close to half of all studies reviewed (Swinder et al., 2017). However, Swinder et al. (2017) cautioned those attempting to draw conclusions regarding the effectiveness of PHNsg interventions, noting the limited documentation of PHN practices and outcomes. Researchers are somewhat constrained in their conclusions about PHNsg effectiveness when drawing on administrative data because of inconsistent recording of PHN day-to-day activities, differences in documentation between regions, as well as ongoing changes to documentation systems (Hill,

2017). Nurses' involvement in group or community activities often remain undocumented because charting forms and tools are based on individual client activities and outcomes. Swinder and colleagues (2017) also discussed the difficulty in documenting PHNsg practice because PHNs provide care at a variety of levels of prevention, directed at vulnerable populations as well as the population as a whole. Despite the clear evidence of the effectiveness of many PHN interventions (Swinder et al., 2017), the wide variety of interventions and outcomes for PHNsg practice can make it difficult for PHNs to capture components of practice in information systems. The complex nature of PHNsg is a challenge for defining PHN tasks (Meagher-Stewart et al., 2010) and affects the ability to draw conclusions about the overall effectiveness of PHNsg practice.

PHNs provide population-based programs and services delivered across individual, community, and system levels, and engage in a range of activities, as outlined in the Minnesota Public Health Nursing Intervention Wheel (Olson-Keller et al., 2004). Here, I focus on literature examining the effectiveness of PHN interventions related to home visitation, breastfeeding, and child immunizations. Although there are subtle differences in PHNsg practice between countries, one common aim of PHNsg programs is to improve outcomes for children (Doi et al., 2017), thus I focus on PHN interventions targeted at this aim. As an illustration of the effectiveness of PHN work, I discuss three areas where PHNs are involved.

Home Visitation.

PHNs, at times in conjunction with paraprofessionals, provide prenatal and postnatal support to women with a variety of psychosocial risk factors, such as poverty, mental health issues, alcohol and drug use, and social isolation. Nurses deliver home visitation services to improve maternal health and foster infant and child health and cognitive development by

providing support, education, and connecting clients to resources (Carter, 2005; Olds et al., 2002). PHNs tailor interventions based on the needs of clients, providing more visits and interventions to higher priority women (Monsen et al., 2011).

The effectiveness literature on PHNs home visitation programs dates back to the 1960s (Byrd, 1997). Some of the earlier evaluations of home visitation programs by PHNs demonstrated modest results, such as increased birth weights and use of prenatal care, but were limited by small sample sizes, poorly defined interventions, and inadequate testing of measures (Baldwin & Chen, 1989; Combs-Orme et al., 1985). During this timeframe, however, researchers completed a number of high quality studies exploring PHNs' home visitation and maternal-child health (Olds et al., 1988; Starn, 1992). In the US, Olds and colleagues developed the Nurse Family Partnership (NFP) program, focussed specifically on PHN interventions with young, single, and poor women during the pre- and postnatal period, and made significant contributions to evidence on the effectiveness of PHN home visitation.

In one NFP study, Olds and team members conducted a randomized trial in New York and followed 324 pregnant low-income, unmarried women for up to 15 years after the birth of their first child (Olds et al., 1997). The study purpose was to examine the long term effects of prenatal and early childhood home visitation by PHNs on maternal and child health (Olds et al., 1997). On average, participants in the NFP program received nine prenatal home visits and 23 postnatal home visits up until the child's second birthday. When compared to similar women who were not enrolled in the NFP program, researchers reported that PHN interventions prenatally and postnatally were associated with improved long term outcomes on maternal and child health, such as decreased rates of abuse and neglect, reduced number of subsequent

maternal pregnancies, decreased use of welfare, and reduced rates of criminal behaviour (Olds et al., 1997).

In another, more recent, randomized trial by Olds and colleagues, they examined the effect of pre- and postnatal nurse home visiting on maternal and child mortality during a two decade period in Memphis, Tennessee (Olds et al., 2014). The team of researchers used a computer program to assign participants randomly to treatment and control groups, and then examined National Death Index records to study the mortality of women and children participants. Study findings suggested that nurse home visits reduced all-cause mortality in mothers and preventable-cause mortality (sudden infant death syndrome, unintentional injury, and homicide) in their first born children living in disadvantaged communities (Olds et al., 2014). In this program of research, they measured an array of outcomes measures, such as childhood injuries, maternal/child attachment, language development, subsequent pregnancies, maternal workforce participation, and dependence on public assistance and food stamps. The NFP program is a heralded PHNsg program because the program has been demonstrated to be successful by rigorous longitudinal research (Olds, 2006).

In a recent realist evaluation of an enhanced home visitation program in Scotland, researchers examined what works for whom, how, in what circumstances, and why, in regards to nurses providing increased, structured home visits in one Scottish health board (Doi et al., 2017). After an initial assessment in the enhanced program, families were categorized as core (provided a minimum of 11 postnatal home visits ending when the child enters preschool) or additional (provided core services, plus additional programs of care). The authors explained how this approach was in alignment with proportionate universalism, in which home visitation was offered universally, and services increased based on levels of disadvantage (Doi et al., 2017).

The researchers collected focus group data with eight managerial staff involved in program development and implementation, and interview data with 25 health visitors (akin to PHNs) who delivered the service, and 22 parents who received the service. Three key program theories were identified, tested, and refined: a) by increasing home visits, families develop trusting relationships with health visitors, which can lead to greater awareness of needs and support offered in a timely fashion; b) home visits offer health visitors a holistic perspective of the home environment and can facilitate early identification of concerns and the provision of additional, tailored support; and c) the introduction of universal assessment pathways offers systems and structures to support practice and ensure that the health visitors' role is defined and clear to families, agencies, and to nurses themselves. Doi et al. (2017) found these theories useful in explaining study results. For example, with enhanced home visitation, families were more open and willing to discuss sensitive issues and more engaged with wider services. Even though 11 home visits seems ambitious as a universal service, the findings highlight the key benefits, such as opportunities for monitoring, early identification of health and wellbeing concerns, and support (Doi et al., 2017).

The authors of a recent systematic review of home visiting intervention literature disseminated between 2005 and 2015 reported that home visitation can reduce health disparities by addressing the social determinants of health (Abbott & Elliott, 2017). Several other researchers have also demonstrated the difference PHN home visitation can make on maternal and child outcomes (Heaman et al., 2006; Kearney et al., 2000; MacMillan et al., 2005). It is the work of Olds and the NFP program of research that has provided a substantial evidence base for PHN home visitation. However, with strict enrolment criteria for this program everywhere, participation in NFP has been limited. There has been a recent effort to establish the credibility

of another enhanced home visitation program, an approach to traditional PHN home visiting for families ineligible for NFP, which focuses on the effects of adverse childhood experiences (Ballard et al., 2019). The mounting evidence supports PHN home visitation as an effective nursing intervention improving health outcomes in their communities. One aspect of postnatal home visiting is PHNs supporting mothers to initiate and maintain successful breastfeeding.

Breastfeeding.

The health benefits of breast milk feeding, to both mother and infant, have been well documented (Ip et al., 2007). Such health benefits include reduced risk of ear infections, gastroenteritis, respiratory infections, eczema, asthma, sudden infant death syndrome, and both type 1 and type 2 diabetes in children, as well as decreased risk of breast and ovarian cancer in women (Ip et al., 2007). Health Canada recommends exclusive breastfeeding for the first six months of life, and up to two years or beyond in duration (Health Canada, n.d. a; Health Canada, n.d. b). The WHO and UNICEF have identified breastfeeding as the ideal nutrition for infant development and important in reducing the incidence and severity of infectious diseases in infants (WHO, 1990).

The authors of a Cochrane review of 52 randomized controlled studies from 21 countries reported on the important role of skilled healthcare professionals in providing routine in-person support for breastfeeding women, increasing duration and exclusivity of breastfeeding (Renfrew et al., 2012). PHNs, located in and working in close connection with the community, have been proven useful in supporting breastfeeding mothers, resulting in increased rates of breastfeeding in the US (Fetrick et al., 2003), longer duration of breastfeeding in Australia (Kemp et al., 2011), and improved teen breastfeeding knowledge, skill, and success in Canada (Nesbitt et al., 2012).

Researchers have demonstrated a positive association between PHN involvement and breastfeeding initiation and duration (Fetrick et al., 2003; Kemp et al., 2011). Fetrick and colleagues conducted a retrospective chart review of 55 low-income women in Nebraska to determine whether PHN home visits improved health outcomes (Fetrick et al., 2003). After comparing the health outcomes of mothers who received four or fewer visits to those who received five or more visits, researchers found that mothers who received more PHN visits had higher rates of breastfeeding, however, there was little mention of breastfeeding duration achieved (Fetrick et al., 2003). In a randomized controlled trial, researchers examined the effects of a long-term nurse home visiting program (n=111) and usual universal care (n=97) in Australia (Kemp et al., 2011). This research team found that, in this sample of socially disadvantaged mothers, those who received long-term nurse follow-up breastfed for significantly longer durations.

A group of Canadian researchers used an exploratory mixed methods design to explore the experiences of mothers and perceptions of PHNs about breastfeeding late preterm infants, the largest proportion of preterm births, who at risk for various health complications (Dosani et al., 2017). These researchers collected quantitative data from a convenience sample of 122 mothers with late preterm infants. They also gathered interview data from 11 mothers and ten PHNs, which they analyzed using an interpretive thematic analysis to identify themes and relationships between themes. The research team found that PHN experiences aligned with mothers' reported challenges in breastfeeding late preterm infants. Several mothers in this study explained how PHNs were helpful in guiding them through breastfeeding late preterm infants and in providing anticipatory guidance about potential challenges and strategies to support breastfeeding (Dosani et al., 2017).

Some study authors were restricted in the strength of their conclusions based on limitations in size and nature of a convenience sample (Kemp et al., 2011; Dosani et al., 2017), but the value of PHNs supporting women in breastfeeding during the perinatal period is well documented (Dosani et al., 2017; Fetrick et al., 2003; Kemp et al., 2011, Olds, 2006; Pugh et al., 2002). Other authors, however, have cautioned researchers in drawing conclusions about a causal relationship between breastfeeding and infant health, after they demonstrated that a mother's advantage might also contribute to infant health (Raissian & Su, 2018). These researchers suggest that knowledge about infant feeding could advantage mothers who did not breastfeed and is one potential mechanism that could lead to positive childhood health outcomes. Nonetheless, PHN contact in the prenatal and postnatal period has been beneficial to women with regards to their decision-making about infant feeding, as well as in the delivery of childhood immunizations (Koniak-Griffin et al., 2002).

Child Immunizations.

Immunization is a central strategy in preventing the spread of vaccine-preventable disease and avoidable deaths (PHAC, 2003). The findings of a few research studies indicate that PHNs make a positive difference in the uptake of childhood immunization (Koniak-Griffin et al., 2002; Schaffer et al., 2012). However, given the longstanding PHN involvement in immunization delivery, I am surprised by the seeming paucity of research investigating PHN implementation of vaccinations. When the overall goal of immunization programs is herd immunity to stop transmission and protect those unvaccinated, it is important to have an accurate depiction of immunization rates in communities. PHNs play an important role not only in immunization delivery, but also in public health surveillance of communicable diseases and follow up, especially of vaccine-preventable diseases, as well as documentation of

immunizations to monitor population levels, central for monitoring disease trends in both Canada and the US (Meagher-Stewart et al., 2009; Zahner, 1999).

Researchers have completed two experimental studies that demonstrated a positive difference in improving immunization rates when PHNs are involved. For example, the NFP Program, noted above, demonstrated promising results in improving immunization rates (Olds, 2006). In another randomized controlled trial, researchers compared the effect of an intensive PHN home visitation program to standard care with a sample of 144 high priority teen mothers (Koniak-Griffin et al., 2002). The team reported statistically significant higher immunization rates in mothers who received additional PHN support, compared to mothers receiving standard care. Schaffer and colleagues (2012), in an evaluation of a PHN home visiting program for teens in the US, also demonstrated increased infant immunization rates among mothers with PHN involvement. Despite only a few studies demonstrating PHN effectiveness in immunization programs, PHNs have reported immunization delivery to be a significant part of their role, particularly childhood immunizations (Schaffer et al., 2015). Many of these studies support the role of PHNs and PHN effectiveness in delivering various interventions, whether it be home visits, breastfeeding support, or childhood immunizations, however, the role of the organization in shaping PHN effectiveness is often overlooked.

Organizational Change and Public Health Nursing Practice

Underwood and colleagues (2009) demonstrated that the organizational context is an important factor in shaping PHN effectiveness and influencing whether PHNs meet their national standards of practice. In a Canada wide study, these researchers used mixed methods to examine community and PHNsg capacity. They collected national level demographic data from the Canadian Institute for Health Information nursing databases, surveyed over 13,000 community

health nurses, and held 23 focus groups with PHNs and public health policymakers (Underwood et al., 2009). Twelve of the 23 focus groups consisted of PHNs. Using an appreciative inquiry approach, these researchers revealed organizational attributes PHN participants deemed central to practice (Underwood et al., 2009). PHNs in this study discussed the importance of flexible and adequate funding for PHN services, public health champions, a supportive culture, and good management practices to promote optimal PHNsg practice (Underwood et al., 2009). These PHNs were clear about key organizational attributes affecting their practice, but we are left questioning how organizational and policy change have influenced PHNsg practice, particularly in BC.

Findings from a few Canadian studies suggest that nurses are concerned about the reorganization of public health services, along with cuts to PHNsg programs and services, and the potential outcomes of these changes (e.g., Cohen, 2006; Falk-Rafael et al., 2005; Falk-Rafael & Betker, 2012a). These authors described organizational changes, many of which negatively affected PHNsg practice, focussing largely on public health restructuring in Manitoba and Ontario. Currently, however, there is a paucity of research exploring the impact of public health renewal on PHNs delivering local programs and services, particularly in BC, the focus of this dissertation research. We have little evidence to demonstrate whether renewal initiatives have compromised or enabled PHNs in promoting and protecting health, and preventing disease and injury. In the following section, I explore the literature to examine how public health system reform has shaped PHNsg practice, affected PHN wellbeing, and influenced health in their communities. I use the same headings as above to compare the impact of organizational change across nursing settings, and discuss particular features of PHNsg practice or organization factors that PHNs deemed important in the provision of care.

PHNs' Roles.

In two nationwide Canadian studies, researchers examined the state of community health nursing practice and reported on several organizational changes that PHNs deemed important to their role (i.e., Schofield et al., 2010; Underwood et al., 2009). Although these researchers did not specifically examine the impact of organizational change on PHNs practice, these studies are helpful to understand organizational factors PHNs deemed significant in delivering care. These researchers highlighted the influence of contextual factors, such as organizational values and management practices, on PHN roles. Even though the authors did not attribute these factors specifically to public health system reform, some of the mechanisms reported in these studies were discussed by PHNs in other studies of PHNs practice pertaining to reform initiatives (Falk-Rafael et al., 2005). Thus, the findings from these studies could provide insight into PHN experiences and perceptions of their roles in light of organizational change within the public health system, that is, that component of the health system responsible for delivering public health programs and services.

Schofield et al. (2010) conducted a descriptive qualitative study, collecting data in focus groups and key informant interviews from community health nurses across Canada (which included PHNs). The purpose of the research was to understand priority issues currently facing community health nurses. The team of researchers framed the study within the rhetoric of shifting healthcare delivery and services from predominantly hospital based to more community based care, and the effect on community health nurses. Study participants, totalling 80 community health nurses (e.g., home care nurses, PHNs, parish nurses, occupational health nurses, street nurses, community health nurses), discussed the challenges of working in the healthcare system, and described how their roles were becoming less defined and how their

scope of practice was being reduced (Schofield et al., 2010). This sample of nurses expressed concern that their role was poorly understood and devalued by administrators, and that they were being replaced by other disciplines. PHNs in the study, in particular, raised the issue that nursing managers were being replaced with non-nurse administrators, however, there was no mention of the impact of this change on PHNsg practice. The nurses in this study explained how reduced and unstable funding hindered practice and resulted in a sense of uncertainty among nurses about their ability to provide adequate services in the community. They also explained how levels of funding do not meet the existing need for services in the community, and how their levels of funding are threatened when governments change or when there are competing demands for funds. Many nurses in this study were unsatisfied with their current practice, and stated that they desired the autonomy to use their professional knowledge and skill in their role.

In the *National Community Health Nursing Study*, briefly discussed in the opening paragraph of this section, the researchers reported on several organizational factors PHNs deemed important in their role (Underwood et al., 2009). These authors situated their research within a context of significant healthcare change over the two prior decades, again emphasizing the healthcare rhetoric proposing a shift from predominantly hospital based to more community based care and the need to ensure community health nursing capacity. PHNs in this study discussed the need for stable, long-term support for programs, with the flexibility to adapt programs if needed. PHN participants highlighted the importance of organizational culture, and explained the need for room to be creative, flexible, and provided with opportunities to learn and share information. They also emphasized the importance of trusting relationships in their role, the need for a shared vision and goals with leaders based on values such as prevention, and the time and support to build partnerships in the community. Nurses stated that management

practices were the most important organizational attribute supporting PHNs in their role.

Nurses in every focus group reiterated the need for visionary, empowering leaders who respect, trust, and value public health and PHNs, and support nurses' autonomy and working to their full scope of competencies. Nurse participants explained that managers need to engage in clear public health planning grounded in community needs, open communication, and local knowledge to guide their decision-making. One group of nurses discussed the challenges of working with a manager who had no public health or nursing background because the manager could not provide the support or guidance that nurses required.

There are, however, a few researchers who have explored how public health restructuring has affected PHNsg practice. Falk-Rafael et al. (2005) used a descriptive mailed survey in 1999 to collect systematic information on the number of PHNs working in the province and the types of PHNsg services provided by these nurses. These researchers mailed questionnaires to all PHNs (n=1744), and to one PHN senior manager (n=32) in each of Ontario's 37 public health units (at that time) in the province. They reported a 77% response rate for PHNs and an 87% response rate for senior managers. Falk-Rafael et al. (2005) aimed to collect baseline PHNsg services data because no provincial discipline-specific data were available to monitor changes occurring in practice.

In the background section of the article, Falk-Rafael et al. (2005) described provincial and organizational restructuring as the context within which the study was developed. They explained how public health restructuring in Ontario unfolded during the implementation of primary health care systems. Primary health care, as set out in the Alma-Ata Declaration (WHO, 1978), is grounded in principles of social justice and equity, emphasizing health promotion, community participation, intersectoral collaboration, and a multidisciplinary approach. Primary

health care is congruent with PHNsg, but was compromised by the narrow interpretation of the term within the organization, which they proposed directly affected the nature and scope of PHNsg practice, limiting PHN involvement in their communities (Falk-Rafael et al., 2005).

Falk-Rafael et al. also discussed how public health restructuring began in 1983 after the passage of the Health Protection and Promotion Act, the Ontario provincial legislative authority for public health, and accelerated throughout the 1990s when services were reorganized from disciplinary to programmatic units. Falk Rafael et al. (2005) argued that restructuring destabilized public health when the provincial government passed legislation making municipal governments fully responsible for funding public health programs and services, and making them compete for provincial funding with other public services. In 1998, public health funding in Ontario shifted from largely 75/25% provincial/municipal, to municipally funded, and then settled at 50/50% funding one year later (Falk-Rafael et al., 2005). After this study, funding returned to 75/25%, and will likely shift again with proposed changes by the current provincial government. This series of events had a significant influence on the organization and delivery of PHN services.

Falk-Rafael et al. (2005) hypothesized that provincial and organizational turmoil, along with primary health care, negatively affected PHNsg because nurses spent less time in their communities, which is important to inform their population health work. In her study, she asked PHNs about the nature and scope of their practice, how it had changed over the last five years, and whether they believed it had improved or weakened. Over this five year period, 1994-1999, PHN participants reported significantly less time spent on home visiting and school health, however, there were differences across regions (Falk-Rafael et al., 2005). Nurses in the study also described increased PHN involvement in activities such as clinics and drop-ins, community

development, social marketing/media work, and program planning and evaluation that took place from within the health unit. The authors, however, discussed significant regional disparities in services. Participants also noted an overemphasis on population health activities at the expense of individual and family health promotive services that were backed by evidence and imperative to their effectiveness. They also highlighted that, with the shift to program-focussed services, some nursing leadership positions, such as director of nursing, had largely been eliminated. Despite the potential for recall bias in this study, the findings from this study provide a comprehensive account of PHNsg practice during a period of healthcare reform in Ontario. Based on recent conversations with several PHNs in one health unit in Ontario, their practice remains focussed at the population level, with less one-on-one support in the community.

Another team of researchers explored how the adoption of a population-based health promotion model was reflected in community health nursing practice in Quebec (Beaudet et al., 2011). In the introductory section, the authors of this study describe the structural and paradigmatic reorientation of the provincial healthcare system, providing context in which to understand the study findings. As part of healthcare reform, in 2004, the provincial government implemented a population-based approach, emphasizing the need to address the social determinants of health within health promotion, as well as the need to provide adequate services along the continuum of care (Beaudet et al., 2011). The implementation of this population-based approach led to increased funding for health promotion and disease prevention services (Beaudet et al., 2011). In addition to the paradigmatic reorientation, the provincial government also regionalized healthcare delivery, devolving responsibility for programs and services to regional and subregional health networks. Health promotion and prevention services were under the purview of the subregional bodies, called Centres Locaux de Services Communautaires (Local

Community Service Centers) (Beaudet et al., 2011). In this study, the researchers focused on the implications of the population model, however, regionalizing service delivery likely also affected nurses' practice.

Beaudet et al. (2011) examined community health nursing practice, as well as organizational and professional constraints on the integration of the population approach into nursing practice. Community health nursing practice consisted of nurses working in infant-child programs, home care, general clinic services, and working with specific populations (e.g., drug use, homeless, sex workers). The team of researchers conducted a collaborative, qualitative study and collected in-depth interview data between 2006 and 2007 from a purposive sample of community health nurses (n=41) and managers (n=28). Eighteen managers had nursing backgrounds and ten did not. The study team included community health nurses, researchers from the regional bodies, and a representative from a public health agency, along with university researchers.

Using constant comparison, the team found that, despite the intention to strengthen population-based health promotion, nurses discussed few changes in their practice and explained that their interventions were often focussed on individual, family, or small group care (Beaudet et al., 2011). Nurses in the study reported that this was because the leaders prioritized clinical services in a context of competing priorities and limited resources. Participants partially accounted for the discrepancy in practice, that is, the misalignment between the rhetoric of health promotion and actual practice, to the lack of indicators to reflect health promotion and prevention activities, unclear mandates, and an organizational culture grounded in curative services. Despite the implementation of the population health model, emphasizing the need for interventions that address the social determinants of health, the medical model within the

regionalized bodies was dominant. Nurses explained that they were tired of a seemingly endless succession of reforms, and stated that in order to succeed in their capacity to bring these health promotion efforts to fruition, they required some stability, along with additional support for professional development, and mentorship in population-based health promotion (Beaudet et al., 2011).

Another nursing researcher completed a descriptive, exploratory study to determine PHN perspectives on the nature of their health promotion practice in three health regions of Manitoba (Cohen, 2006). In the introductory section, Cohen (2006) set the stage for the study and described the implementation of two provincial directional documents. She states how one government document released in 1997 provided a framework to shift healthcare from a system focussed on sick individuals, to a system focussed on health promotion for groups and populations. Then, she indicated, one year later, after regionalization of health services across Manitoba, the provincial government defined PHNs as leaders in health promotion. Although Cohen does not frame these documents as part of provincial healthcare restructuring, these initiatives were in accordance with reform efforts taking place across the country. In this study, Cohen (2006) aimed to determine whether PHNs' practice fit with the proposed health promotion vision.

The researcher collected data from 24 PHNs using a standardized open-ended interview approach and analyzed the transcripts using question analysis, a form of content analysis (Cohen, 2006). Cohen found notable similarities in PHN experiences across the three geographically and demographically diverse health regions. PHNs in this study discussed barriers to population-focused health promotion, at the individual, organizational, and community or provincial level. At the individual level, PHNs discussed differing personalities among nurses, leading some away

from the political aspects of health promotion (Cohen, 2006). Many PHNs in this study discussed the potential conflict of engaging in advocacy while being a government employee and going against organizational policy.

PHNs in this study discussed the lack of commitment at the organizational level to health promotion values and strategies among directors and senior administrators (Cohen, 2006). Even within their local health units, nurses believed that their supervisors did not view population-focussed health promotion as a priority, despite provincial rhetoric. Some nurses explained that their public health managers lacked the background and skill in health promotion to support and mentor nurses in this pursuit. Lack of human resources, with inadequate staffing, also constrained health promotion activities (Cohen, 2006).

PHNs in this study discussed several factors outside the organizational level influencing PHN practice, such as the increase in the number of mandatory provincial public health programs, particularly the expansion of immunization programs, introduction of the provincial Baby First program (involving PHN assessment and supervision of home visitors), and early postpartum discharge of mothers and infants from hospital (Cohen, 2006). These provincial changes resulted in less PHN time for health promotion and community development, and reinforced an individual and family focus of PHN care (Cohen, 2006). PHN participants from all regions also commented on the loss, after regionalization, of a centralized health promotion infrastructure, which reduced the availability of support and resources, leaving many nurses feeling isolated in their health promotion activities. Cohen highlighted that there are few first-person accounts of PHN views as to the barriers in their role, particularly in the context of the healthcare system, which she addressed in her study and which I address in my dissertation research.

On the east coast of Canada, Aston et al. (2009) explored PHNs' role in fostering citizen participation in the community. This team of researchers stated how the study unfolded at a time of significant healthcare restructuring. They described how restructuring involved a move toward greater citizen participation, one of the five principles of primary health care. The authors also explained that there had been a shift from professional to client and community decision-making, an important aspect of decentralization of healthcare decision-making with provincial governments (Aston et al., 2009). The authors did not include a description of how these principles were adopted and implemented by eastern provincial governments or healthcare bodies under study.

In this interpretive qualitative study, Aston et al. (2009) conducted semi-structured interviews with PHNs (n=43) about their primary healthcare practices, including PHNs with diverse experiences from both rural and urban practice settings. They also collected data using five focus groups (n=31), which included some PHNs who participated in the individual interview (Aston et al., 2009). Aston and colleagues analyzed their qualitative data using thematic analysis. This team of researchers provided extensive evidence of PHNs' important role in fostering citizen participation and empowering relations in their practice with individuals, groups, and communities, particularly with those most vulnerable. All PHN participants discussed how their practice evolved in the last decade, from a focus on individuals to a population-focussed approach (Aston et al., 2009). Participants described how they worked to encourage others, clients and partners, to think from a broad health perspective, and addressed the social determinants of health (Aston et al., 2009). One notable difference with this sample of nurses, compared to other study samples, was that most PHN participants indicated that they felt their public health managers understood and supported their role. However, PHNs who stated

that their manager did not fully grasp their role described how they felt they did not receive appropriate guidance and direction, creating confusion over priorities (Aston et al., 2009).

In a multisite comparative case study, Falk-Rafael and Betker (2012a) examined the relevance and fit of a midrange PHN theory, critical caring theory, with a sample of expert PHNs (minimum of 10 years PHNsg experience) between 2005 and 2011. In phase one, the researchers collected interview data from PHNs (n=10) in Ontario. In phase two, they collected focus group data from PHNs (n=16) from several Canadian provinces.

In discussing the aspects of the theory, PHN participants expressed the centrality of relationships to PHN effectiveness, and their concern over the disconnect between nurses, and among nurses and their communities (Falk-Rafael & Betker, 2012a). Several participants discussed changes in the PHN role that kept them in their office as opposed to in the community, such as limited time visiting schools and families. This finding aligns with previous study findings in Ontario (Falk-Rafael et al., 2005). Many PHNs in this study believed the population-based work was at the expense of individual and family level interventions, interfering in the development of relationships (Falk-Rafael & Betker, 2012a). Nurses in this study emphasized the need to be out in their communities to build connections with individuals and families, to inform their population level work (Falk-Rafael & Betker, 2012a). Thus, they believed it was important to work across levels in their practice. Participants also explained how the shift from generalist to a specialist practice eroded their role because they lost the “big picture” of their community. Participants placed responsibility for such practice changes on government policy and diminished resources, as well as on mandated programs and services in health units. They pointed to the infiltration of a corporate ideology, often framed as improving efficiency that has influenced organizational restructuring and their practice. Once again, this sample of PHNs also

addressed the importance of administrators who valued PHNs and supported PHN autonomy, professional judgement, and scope of practice (Falk-Rafael & Betker, 2012a).

Despite the fact that many of these nursing researchers did not set out to examine the impact of healthcare restructuring on PHNsg practice, the depiction of their study findings draws attention to the significance of factors outside of nursing that influence their practice. In particular, the implementation of mandated provincial programming, the reorganization of public health units to program-specific practice, the hiring of non-nurse managers, and inadequate resources, have shaped PHN roles in Canada (Falk-Rafael & Betker, 2012a). Just as Norrish and Rundall (2001) discussed how nursing practice is vulnerable to the ebbs and flows in hospital restructuring, PHNsg practice is also subject to organizational and extra-organizational flux. The intent of this dissertation study is to understand how provincial and organizational changes, such as public health renewal across BC, have influenced PHNsg practice in three HAs.

An International View of PHNs' Roles.

Concerns regarding changes to PHNsg practice are not isolated to Canada. In the US, several researchers described how budget cuts have negatively affected PHNs in practice, underscoring the importance of funding to support the effectiveness of PHN interventions (Bekemeier, et al., 2016; Hassmiller, 2014; Kub et al., 2017; Swinder et al., 2014; Swinder et al., 2017). These authors also highlighted how PHNs are decreasing in number, due to the elimination of PHN positions and the hiring of less expensive providers to deliver programs previously provided by PHNs, leading some to call into question the future of the role. This, however, is not a universal experience. Recently, there was a proposed increase in funding of health visitor (akin to PHN) programs in Scotland (Doi et al., 2017). After the release of several national level policy documents (e.g., Getting it Right for Every Child agenda, Public Health

Nursing Services – Futures Focus), the Scottish government introduced an enhanced health visiting program, outlined in the review of the realist evaluation above, in which health visitors provide increased structured home visits (Doi et al., 2017). The Scottish Government committed to hiring an additional 500 health visitors, corresponding with the implementation of the enhanced home visiting program (Scottish Executive, 2005; Scottish Government, 2012; 2016). External forces, such as key policy documents and government funding, are critical to PHNsg practice to improve and protect health and reduce injury in communities.

After reviewing studies by researchers examining nursing practice within the context of healthcare restructuring, I can see parallels across nursing settings. For example, nurses in both hospital and public health settings discussed the introduction of management models and the focus on efficiency, often implemented in the form of measured indicators, as negatively influencing nursing care. Several nurses in both settings also noted the hiring of managers, whom they deemed to lack the requisite background to guide nurses in practice. Some researchers were concerned about the nature of these changes because, not only did they constrain PHNsg practice, but also because the rhetoric at the organizational and policy level of improved health promotion did not fit with what was actually unfolding in practice (e.g., Beaudet et al., 2011; Cohen, 2006).

The nature of PHNsg practice, however, is quite different from the practice of nurses in other settings. With the aim of improving population health and promoting health equity, PHNsg activities are directed at individuals, families, groups, populations, and communities. PHNs initiate and maintain relationships and work in partnership with community organizations to promote health and prevent disease and injury (CHNC, 2019). Nurses in other settings tend to work with individuals, and, at times, families, initiated by the assessment, diagnosis, and

treatment of disease processes or injuries in individuals requiring medical attention. Patients enter into the health system based on a health concern or need. PHNs, on the other hand, often seek out their clients, based, in part, on community knowledge and relationships, and by working in partnership and through outreach, guided by principles of social justice and equity. If healthcare reform efforts reduce PHN reach in the community, restricting their access to communities, this could have negative effects on community and population level health, such as increased rates of depression and communicable disease. Falk-Rafael and Betker (2012a) argued that many changes in the nature of PHNsg practice were driven by government ideology and economics, and not by community need.

PHNs' Workload.

Along with changes in the PHN role, nurses across several of these studies indicated how healthcare reform has contributed to an increase in PHN workload (e.g., Falk-Rafael & Betker, 2012a; Cohen, 2006). There was agreement among PHNs from various regions in Canada that the expansion of mandated provincial public health programming, in particular, has led to less time for other parts of their role, such as community development work (e.g., Aston et al., 2009; Cohen, 2006; Falk-Rafael & Betker, 2012a). For some PHN participants, mandated programming has resulted in a narrowing of their health promotion roles, and an increasing focus on clinically mandated services, such as immunizations (Cohen, 2006; Falk-Rafael, 2012a). One PHN participant in Manitoba described how new responsibilities were being added to her practice without a corresponding decrease in other responsibilities (Cohen, 2006).

The increased workload experienced by some PHNs could be attributed to the shortage in PHN staff (Cohen, 2006). Beaudet et al. (2011) also discussed the impact of the nursing shortage on community health nurses in Quebec. In their descriptive study, outlined above, Falk-Rafael et

al. (2005) reported an 11% reduction in PHNsg full-time equivalents between 1988 and 1998 in Ontario. They also stated there was a 32% increase in the population-to-nurse ratio from 3710:1 to 4910:1 (Falk-Rafael et al., 2005). Without more recent data, however, we have little insight into how PHN workload in this province stands today. Changes in funding and hiring practices led to fewer nurses to cover a larger portion of the population, likely influencing PHN workload. With limited resources and competing demands, several nurses discussed how clinical services were often prioritized over health promotion and prevention programs, reflective of the predominance of the medical model privileging curative services (Beaudet et al., 2011).

Some PHNs also expressed concern over practice documentation influencing nursing care. For example, several participants across three regions in Manitoba expressed concern regarding the workload measurement system because the focus on individual client contacts created a barrier to population-focussed health promotion (Cohen, 2006). Based on my volunteer experience alongside PHNs in one health unit, multiple PHNs expressed their concern regarding the difficulty in capturing all that PHNs do in a day within the current documentation system. These PHNs described how the documentation system was based on individual care, and did not address the range of PHN activities. They offered examples, such as high priority family caseloads, that were not closely monitored and accounted for. It is often up to the discretion of the PHN whether she or he can manage supporting another family, in addition to other required activities, resulting in unpredictable and potentially high workloads. This is quite different in hospital settings, where nursing workloads are usually monitored via patient assignments. For example, researchers have examined the impact of high workload on hospital nurses and found increased levels of burnout and dissatisfaction with high patient-to-nurse ratios (Aiken et al., 2003).

PHNs' Control Over Practice.

PHNs in Ontario expressed concern about the increased bureaucratic control over their practice (Falk-Rafael et al., 2005). In studying the nature and scope of PHNsg practice, Falk-Rafael et al. (2005) explained how a series of events that occurred in restructuring the public health system had weakened PHNs' control over practice. For instance, Falk-Rafael et al. (2005) noted that the passing of the Health Protection and Promotion Act in 1983, with which public health units were required to comply, afforded provincial control over public health. This provincial act was exercised through shared provincial/municipal funding mechanisms and the creation of the Mandatory Health Programs and Service Guidelines (Falk-Rafael et al., 2005). These authors also discussed the reorganizing of service delivery from disciplinary to program specific units, and the loss of senior nursing positions at both the provincial and local levels, reducing the nursing voice in planning and decision-making.

When asked about who influenced the type and extent of nursing services in a health unit, both PHNs and managers in this study reported that the chief executive officer or medical officer of health (often a physician) had the most influence on service provision (Falk-Rafael et al., 2005). These participants rated the community to have the least amount of influence, and placed their own influence slightly above the community's (Falk-Rafael et al., 2005). Falk-Rafael et al. (2005) explained how PHNs' control over their practice, and ability to exercise their professional autonomy to address local issues, was limited. PHNs work in a bureaucratic system, affecting PHNs' access to resources and influence on decision-making in practice (Falk-Rafael et al., 2005).

Community health nurses in Quebec echoed similar concerns as PHNs in Ontario regarding control over practice (e.g., Beaudet et al., 2011). Several community health nurses in a

collaborative, qualitative study, reviewed above, discussed the nature of centralized decision-making within the regionalized bodies as taking place separate from nurses who deliver services (Beaudet et al., 2011). Quebec health reform was intended to be an opportunity to re-evaluate professional practice, with the adoption of a population-based approach, however, community health nurses in this study reported limited involvement in decision-making processes regarding priority setting and resource allocation (Beaudet et al., 2011). Beaudet et al. (2011) point out that nurses were not included in the planning or evaluation of population-based health promotion and prevention in practice, undermining their capacity to contribute to the ongoing reform.

When healthcare reform limits PHN autonomy, nurses are hindered in building trusting relationships in their community, which are central to the effectiveness of their role (Falk-Rafael & Betker, 2012a). Some researchers suggested that limitations in nurses' control over their practice could hinder their ability to respond to emerging community health needs in the future (Falk-Rafael et al., 2005). Falk-Rafael and Betker (2012a) suggest that critical caring theory, explored in their article, could be useful to PHNs not only to guide their practice, but as a tool to counter ideological and administrative forces impinging on PHN autonomy and decision-making in practice to communicate what they do and what they know. PHNs from across Canada have discussed the important role of leadership in fostering PHN autonomy in their practice to ensure responsive, adequate, and quality care is provided to meet community need (Underwood et al., 2009).

Nurse academics in the US also acknowledged the reality that PHNs work in complex and bureaucratic health systems that influence PHN services and programs (Baldwin et al., 2011). Nurses in all settings appear to face organizational complexity (Aiken et al., 2001; Choiniere, 2011; Coughlan & Ward, 2007; Ingersoll et al., 2001). Nurses are accustomed to

shifting their practice on an ongoing basis, guided by their professional knowledge and skill, to reflect patient needs or to address issues arising in the community. Where the difficulty seems to surface is in adjusting their practice to meet organizational requirements that they deem detrimental to patient or community health and wellbeing. This seems to be a shared position regardless of practice setting. For example, hospital nurses from two studies discussed in the first half of this chapter explained how they were dissatisfied in their role, not with providing complex patient care, but with organizational changes weakening managerial support, increasing nurses' workload, and reducing control in their role, resulting in the deterioration of the quality of care (Aiken et al., 2001; Choiniere, 2011). PHNs in both Manitoba and Ontario, also had to navigate external influences that narrowed their role and undermined the quality of their care (e.g., Cohen, 2006; Falk-Rafael et al., 2005; Falk-Rafael & Betker, 2012a).

Since healthcare reform, and in particular, since the regionalization of the health system in which public health has been integrated into the larger system in several provinces, PHNs seem to have lost some of their authority and independence in governing PHNsg operations and decision-making to shape PHNsg practice. Part of the challenge with bridging multiple sectors in healthcare is the competing priorities (e.g., individuals versus a population focus), shifting mandates, and differences in targets (Levesque et al., 2013). PHNs are also challenged by the cultural dominance of the curative approach, and public expectations that influence greater investment in curative as opposed to preventative services (Falk-Rafael, 2005; Levesque et al., 2013). Nurses' wellbeing is at risk when they are constrained in providing adequate quality care, and witness needs going unmet.

Organizational Change and PHNs' Wellbeing

The effect of healthcare reform on the physical and psychological wellbeing of PHNs remains poorly explored, particularly in comparison to the body of research conducted within the hospital setting. However, in the research discussed above, Falk-Rafael and Betker (2012a) note the impact of organizational change on PHNs' wellbeing. PHNs in this study described the adverse effects on their role after the shift to a programmatic focus, severing nurses' connections with colleagues and in the community (Falk-Rafael & Betker, 2012a). Nurses in this study often expressed feelings of distress when organizational policy, funding, and public health structures hindered them from providing adequate care and services in their communities (Falk-Rafael & Betker, 2012a).

In a descriptive study by Reutter and Ford (1996), PHNs reported on the negative effects of cutbacks that reduced the number of PHNs. These researchers collected interview and focus group data from 28 PHNs across Alberta, and found that the greatest stressor reported by PHNs was insufficient time to carry out their day-to-day activities after the number of PHNs was reduced. PHNs in this study described that, when they had inadequate time to do what they perceived to be important parts of their role, they found work less enjoyable and satisfying, leading to feelings of frustration and guilt (Reutter & Ford, 1996). Nurse participants explained how they derived satisfaction in their role from the feeling that they made a difference in their communities, which included being autonomous in their role and being available and present with clients and families in the client's environment (Reutter & Ford, 1996). Canadian nurses are not alone in the difficulties of maintaining satisfaction in their role in the current healthcare milieu. PHNs in Ireland have also reported feeling disempowered and dissatisfied as a result of

organizational influences hindering their role, notably a lack of funding and lack of management will to advocate for PHN service provision (Cawley & McNamara, 2011).

Little research has been done to explore the satisfaction of the PHNsg workforce, which is an important facet to examine, given the link between job satisfaction and positive client outcomes (Graham et al., 2011). Two Canadian research teams studied PHN job satisfaction and found that PHN autonomy was a significant predictor of PHN satisfaction (Best & Thurston, 2006; Graham et al., 2011). Graham and colleagues (2011) conducted a secondary data analysis on data retrieved from the 2005 National Survey of the Work and Health of Nurses, consisting of a sample of 271 PHNs. These researchers examined the relationship between three work environment factors (autonomy, control over practice, and workload) and found that autonomy and workload were a significant predictor of PHNs' job satisfaction. There was an inverse association between workload and satisfaction, indicating that when workload increased, PHN job satisfaction decreased (Graham et al., 2011). Likewise, as PHN control over their practice increased, so too did PHN job satisfaction. However, despite the strengths of this dataset of a large national sample of PHNs, these researchers indicated that the single-item measure of job satisfaction that was dichotomized during analysis was a potential limitation of the study (Graham et al., 2011).

In their efforts to test the psychometric properties of a job satisfaction questionnaire with PHNs, Best and Thurston (2006) found that autonomy, followed by pay, were the most important factors influencing PHN job satisfaction. These researchers tested the applicability of a standardized questionnaire with 87 PHNs employed within one Canadian regional HA. Best and Thurston (2006) suggested that PHN job satisfaction, and its relationship with client outcomes,

such as vaccination coverage and breastfeeding rates, should be regularly measured to initiate and monitor work changes.

Researchers in the US discussed the importance of participative decision-making to PHN job satisfaction (Campbell et al., 2004). Despite the low survey response rate (55%), and the educational differences of PHNs in the US (registered nurses and licensed practical nurses) compared to Canadian PHNs (baccalaureate prepared registered nurses), PHNs (n=192) in this descriptive study reported that the more vertical participation, the degree to which supervisors and nurses consult together concerning job tasks and decisions, and the more horizontal participation, the degree to which nurses are involved in peer decision-making and task definition, the higher the PHN job satisfaction (Campbell et al., 2004). As vertical and horizontal decision-making opportunities increased, so did PHNs' job satisfaction (Campbell et al., 2004).

Currently, we have little understanding of how healthcare restructuring initiatives have affected the physical and psychological wellbeing of PHNs, but some PHNs have described feeling devalued in their role (Falk Rafael, 1999; Falk-Rafael & Betker, 2012a). With autonomy positively associated with job satisfaction, there is cause for concern about PHN satisfaction, given the reported decline in PHN autonomy as a result of certain healthcare changes, such as the hiring of managers without public health knowledge and experience (Aston et al., 2009; Cohen, 2006; Falk-Rafael & Betker, 2012a). Once again, there appears to be shared experience across nursing settings. As Choiniere (2011) points out, nurses were dissatisfied after recent hospital reforms because organizational changes, such as the adoption of managed care models and increased numbers of non-nurse managers, jeopardized nurses' ability to provide competent care and limited the use of their professional knowledge and expertise in providing care.

Organizational change hindering nurses' use of professional judgement and reducing their autonomy seems to transcend settings, and is applicable to PHNs.

Organizational Change and Client Outcomes

There is a paucity of research exploring an association between healthcare change, PHNsg practice, and client outcomes. Falk-Rafael and Betker (2012a) explained, however, that the distress of PHNs in their study reflected not only nurses' concern about adverse changes undermining their role, but even more so, PHN participants' concern for the impact on clients' wellbeing. Nurses overwhelmingly expressed concern regarding how changes in their practice could be detrimental to their communities, particularly to vulnerable and marginalized populations (Cohen, 2006; Falk-Rafael et al., 2005; Falk-Rafael & Betker, 2012a).

The main impetus for Falk-Rafael et al.'s (2005) study was to collect baseline data to monitor changes occurring to PHNsg services because no provincial PHN data existed. After discussing how several changes to PHN practice went against the best available evidence, Falk-Rafael et al. (2005) argued for policy decisions related to the provision of PHNsg programs and services to be based on systematic program evaluation and outcomes research (Falk-Rafael et al., 2005). However, when current documentation systems are insufficient, failing to capture the range of PHN activities, such as high priority family caseload, we are missing important data needed to track PHNsg services, and to examine the impact on health outcomes. Examining the impact of reorganization on nursing practice and patient outcomes in the hospital seems to be less of a challenge for researchers. For example, Aiken and colleagues (2001) studied changing nurse to patient ratios and patient mortality. Nursing researchers have also examined the effects of particular changes, such as nursing shortages and minimum patient-to-nurse ratio legislation,

on client outcomes (Aiken et al., 2002; Spence Laschinger & Leiter, 2006). Currently, we have little insight into how public health reform initiatives have affected health outcomes.

PHNs have been described as the backbone of public health agencies in the US, in part because they are the largest group of public health professionals, but recent budget cuts to public health departments, with the greatest cut to PHNsg, have negatively affected PHNs in their efforts to impact population health effectively (Hassmiller, 2014; Kub et al., 2017; Swinder et al., 2014; Swinder et al., 2017). The detrimental effect of budget cuts to PHN services was also evident after reviewing the Canadian literature. The chronic underfunding in public health units hinders PHNs in providing adequate care in their communities (Beaudet et al., 2011; Falk-Rafael & Betker, 2012b; Schofield et al., 2010). This retrenchment comes at a time when it has been made clear that effective Canadian health human resource planning necessitates ensuring that PHNs are used to their full potential (Meagher-Stewart et al., 2009).

The public health sector, including PHNsg, requires sufficient funding to promote health and prevent disease and injury in communities. Authors outside of nursing share in this concern and have called for increased funding to public health and for public health professionals to advocate more forcefully for their services (Rutty & Sullivan, 2010). Reductions in public health spending do not reflect the current evidence, in which researchers have demonstrated a large return on investment of public health interventions (Masters et al., 2017). Thus, investments in public health are actually cost saving.

Despite the financial cuts to PHNsg in the US, there appears to be momentum, with several organizations looking to enhance support for PHNsg education, practice, and research to attain health system reform (American Academy of Nursing, National Advisory Council on Nurse Education and Practice, Robert Wood Johnson Foundation, Quad Council of Public Health

Nursing Organizations). Hassmiller (2014) suggests that the potential of PHNs needs to be leveraged to contribute to better population-based health outcomes and achieve the promise of health reform. What is needed is a health system that works to prevent disease and promote health instead of one that focuses on treating illness and disease. PHNs could be central to this promise.

PHN effectiveness in promoting health and preventing disease and injury is grounded in their ability to develop relationships (Falk-Rafael & Betker, 2012a). PHNs require adequate time to build trusting relationships to go beyond a superficial understanding of others' circumstances (Aston et al., 2009). They face obstacles accessing their client population when organizational and policy changes impede their ability to establish connections with individuals and families in their community. During my time volunteering at a health unit, one nurse shared an experience with me regarding the effectiveness of a home visit, a PHN intervention she explained was being limited based on shifting organizational priorities. This nurse explained the critical role of PHNs being in their communities, and maintaining care at all levels. She stated to me that, over the phone a new mom reported to the PHN that breastfeeding was going well and had no concerns, which was in contrast to what the nurse found on the home visit. Upon arrival at the home, the nurse found a sleepy baby who was jaundiced and dehydrated. The PHN sent the mom and baby back to the hospital for the baby to receive treatment, while the mother received continued breastfeeding support in hospital and ongoing support from the nurse upon returning home. This home visit intervention helped to prevent potential brain damage to the baby from hyperbilirubinemia, and continued to improve the health and prevent disease of both mother and infant by maintaining breastfeeding.

By providing adequate care in the perinatal role, PHNs work to prevent health problems such as hyperbilirubinemia, but also support breastfeeding, and empower the mother in managing and coping with postpartum changes, and the transition into motherhood. We have little understanding how public health renewal initiatives have influenced PHNs in the provision of care, particularly in BC, and even less evidence detailing how these changes have affected community and population health. Thus, in this dissertation study I aim to provide insight into how public health reform has influenced PHNs providing services in three HAs in BC.

Summary

The purpose of this chapter was to review the literature to understand better how healthcare reform has affected nurses delivering care. Of particular interest, is to discern how organizational and policy changes have influenced PHNs practice. I began by exploring the impact of healthcare reform initiatives on nurses broadly, to learn about nurses in other, predominantly hospital settings before narrowing my purview to PHNs. Researchers have conducted comprehensive and rigorous research to examine the effects of hospital restructuring, such as budget cuts and patient ratios, on nurses' practice, nurses' wellbeing, and patient outcomes. Healthcare reform, such as shifting policies and changes in management that negatively influence PHNs' practice, PHNs' wellbeing, and client outcomes, have received less attention. Nursing researchers suggest that supporting PHNs to work more effectively, could lead to more efficient use of funds, improved program outcomes, and more prevention of illness and injuries (Underwood et al., 2009)

From the literature reviewed pertaining to organizational change and nursing practice, there are significant commonalities in the effects of organizational change on nurses across practice settings. The context in which nurses practice has a significant influence on determining

the nature and quality of their work, and, in turn, on PHN satisfaction with their work. One of the main themes that surfaced from this review of literature is nurses' concerns regarding organizational change that hindered their ability to provide adequate nursing care and limited their professional autonomy. This sentiment held true across healthcare settings. Nurses in many studies voiced their resentment and opposition towards changes that undermined their ability to provide adequate, professional, high quality care. PHNs, in particular, expressed their concern regarding changes in PHNsg practice that altered the fundamental nature of their role. By understanding how reform has affected their role, as well as what enables and hinders PHNs in managing and responding to organizational change, we could improve our understanding of what factors influence PHNs in promoting and protecting health. This might also provide evidence to inform better ways to structure and organize the public health system, and the services and programs provided by PHNs.

Researchers have demonstrated the effectiveness of numerous PHN interventions, such as PHN involvement in home visitation, breastfeeding, and immunizations. Each of these three areas of practice has been demonstrated to be important to the health and wellbeing of individuals, families, and populations. Minimal attention, however, has been paid to the impact of reform on PHNs delivering such interventions and whether those impacts might negatively influence health outcomes. After reviewing the literature, we have a better sense that contextual factors have an important role in shaping the delivery of PHN services. For example, PHNs in Ontario explained that the shift to program-focussed services and the loss of nursing leadership positions negatively affected their role, weakening nursing's voice in the organization and nurses' connections in their communities (Falk-Rafael et al., 2005). More work is required to decipher how organizational change unfolds in the day-to-day realities of PHN practice.

Therefore, in this study I explore how public health reform affected PHNsg practice in three regional HAs in BC.

Public health renewal in BC, intended to strengthen public health systems and services, commenced in 2005. The effect of public health renewal on PHNsg practice and health outcomes has received minimal inquiry, leaving us with a poor sense of whether public health reform has moved towards the intended health aims. The Ministry of Health (2005) initiated public health renewal with the release the Core Functions Framework to guide public health delivery across the province. Then in 2013, the Ministry implemented BC's Guiding Framework for Public Health, a 10 year directional document encompassing the Core Functions Framework, that was later revised in 2017. In 2012, the BC Ministry of Health launched the NFP research program, based on promising, rigorous research noted above. However, this program was implemented with no additional funding, leaving health units to absorb the extra workload within existing resources. As a result, there were fewer nurses and resources to provide perinatal support to those who did not qualify for the intensive support from the NFP Program, potentially affecting universal home visiting services. The province also launched a new electronic public health information and documentation system in 2011, once again changing the context in which PHNs deliver care. In addition to policy and program changes, PHNs were also required to navigate HA restructuring. For example, in 2002-2003 Interior Health amalgamated six public health units into a single regional public health department, intended to consolidate services and administrative functions, and improve clinical efficiencies. As one can see, PHNs in BC have been faced with numerous organizational and policy changes.

Unfortunately, little is known about how recent healthcare renewal processes across the province of BC have influenced PHNs and PHNsg practice, how PHNs have managed this

evolving landscape, and how the public has been affected. We currently have a poor understanding of how these efforts to strengthen public health across the province have played out for PHNs, the largest group of public health professionals in the province. We have a preliminary sense of organizational factors significant to PHNs in practice, but minimal understanding of how health reform in the province has affected their role. The purpose of this dissertation is to address this gap. I also address the call for researchers to conduct qualitative research to surface the complex and often invisible aspects of PHNs practice, as well as to attend to the issue of limited resources and organizational factors hindering their role (Aston et al., 2009). To that end, in the next chapter of this dissertation, I outline the qualitative research methodology I used to explore how significant organizational and policy changes have influenced PHNs practice in BC.

Chapter 3 – Methodology

In this chapter, I review the philosophical, theoretical, and methodological foundations of this dissertation research, as well as the research process for the study. To begin, I explain the philosophical and theoretical lens that I applied to this study of PHNsg practice to help guide the analytic process and in interpreting the findings. I discuss how a philosophical/methodological combination was useful in exploring underlying factors shaping the PHN role. I detail the grounded theory research methodology and methods to describe the research process, including data collection and analysis. Lastly, I discuss the safeguards used to protect study participants, as well as study rigour for this research project.

Philosophical Perspective

In preparation for discussing the methodology of this research project, it is important first to consider the philosophical underpinnings supporting this approach. I drew on the work of Roy Bhaskar and critical realism (1978). Bhaskar developed the ontologically-based philosophy of science, critical realism, in the 1970's with the publication of his book, *A Realist Theory of Science* (1978). As with many philosophers, Bhaskar's work has shifted over the last few decades, with a more recent spiritual turn towards Eastern philosophies (Oliver, 2012). To inform my study I drew on his earlier work, which I find aligns with my philosophical view.

Ontology of Critical Realism

In his original text, Bhaskar (1978) presents the question, "What must reality be like to make science possible?" He invites readers to consider this ontological question about reality and what is real, and provides his view of a stratified reality. He attempts to answer this question by outlining his view that reality consists of three layers or domains, referred to as the real, the actual, and the empirical.

The real layer consists of the underlying structures, generative mechanisms, and tendencies beneath the surface that exert power to produce phenomena and events in the actual domain. These underlying mechanisms and structures exist and act independently of our experience and understanding of them, yet generate certain events that we may or may not observe and experience (Clark et al., 2008). These mechanisms, or underlying factors at play in the real domain, interact with people and lead to events or outcomes in the actual, that we may witness or experience in the empirical. The actual domain is responsible for the phenomena and events that occur in the world that we may observe in the empirical domain (Bhaskar, 1978). Events in the actual layer take place regardless of whether we are there to observe or experience them (Eastwood et al., 2014).

The empirical layer only constitutes our experiences, that is, our perceptions of what we observe and sense, either directly or indirectly (Clark et al., 2008; Eastwood et al., 2014; McEvoy & Richards, 2006). The empirical is the position from which we study the events in the actual, in an attempt to draw insights about the real (Eastwood et al., 2014). Data collected in this dissertation research represent PHN experiences of the empirical domain. PHN descriptions of their experiences in the empirical domain reflect PHN interactions with phenomena and events in the actual domain, which are shaped by mechanisms in the real domain. A central aim of research informed by critical realism is to search for the causes of events and phenomena in context while looking for a deeper understanding and explanation (McEvoy & Richards, 2006).

Epistemology of Critical Realism

Although Bhaskar emphasized ontology in his framing of critical realism, epistemology, or how we come to know in science, is often joined to a discussion of ontology. Some have labelled Bhaskar's position as ontologically realist and epistemologically relativist (Lee, 2012;

Oliver, 2012). From this point of view, reality exists but knowledge of it and scientific inquiry about it are socially embedded, historically contingent, and change over time. Our views and experiences of reality are mediated through our own situatedness and, as a result, knowledge is always socially produced and thus provisional (Oliver, 2012). Knowledge we generate can reflect different layers of reality, but remains fallible, in that there are no eternal “truths.” We can never close the distance between the real and our knowledge of it, but we can capture better or worse accounts or assessments of reality (Oliver, 2012).

Bhaskar (1978) also calls attention to the epistemic fallacy, in which we conflate that which exists with the knowledge we have of it. He suggests we need to avoid coupling ontology and epistemology, because this leads us to believe that our experience is all that goes on in the world. Thus, there is a critical distinction between the underlying causal mechanisms (real) and the occurrence of events (actual) that are apart from our experiences or knowledge of them (empirical) (Oliver, 2012). As researchers, therefore, our attempts should not be limited to identifying the regularities of events but should move beyond to uncover the underlying structures and mechanisms responsible for such events. This helps the researcher move from description in identifying regularities to explanation by uncovering underlying mechanisms.

Applying Critical Realism in Nursing Research

Critical realism is not new in the nursing literature. For example, an entire issue of *Nursing Inquiry* (2012) was dedicated to the use of this philosophical perspective in nursing research. Researchers have found the stratified reality of critical realism useful to help explain complex issues evident in the actual by exploring generative factors in the real. For instance, Oladele et al. (2013) found critical realism valuable when examining the complexities of smoking and tobacco control across different global settings by pushing the analysis into the

underlying multifactorial nature of policies, interventions, and outcomes. In their study of complex influences on smoking, these authors report that what has typically taken place within public health is linear logic, assuming that what works in one location will be generalizable to other contexts, without considering particularities that make each context unique (Oladele et al., 2013).

One key ingredient that critical realism has to offer nursing researchers is the explicit attempt to take into consideration the underlying mechanisms of causation. Drawing on this perspective, researchers are supported to consider the numerous factors and influences that come together in complex ways, which are not linear, and give rise to new events (Clark et al., 2008). I see critical realism as a useful perspective because it enables the researcher to take the middle ground between a positivist objectivist viewpoint of universal order and the social dimensions of science in which the influence of human perspective in knowledge generation is embraced (Clark et al., 2008). In other words, researchers are pushed to acknowledge the role of both structure and agency when exploring phenomena of interest in nursing research.

Applying Critical Realism in my Dissertation Research

Critical realism is a useful philosophical perspective for this study because it helps to address the underlying social and structural mechanisms influencing PHNs and PHNsg practice (Oladele et al., 2013; Oliver, 2012). In fact, two nurses, Hill (2017) and Musto (2018), recently delineated critical realism as the philosophical underpinnings of their dissertation research. Hill employed a case study to explore PHNsg practice, and Musto conducted a grounded theory study to investigate moral distress in healthcare providers working in mental health settings. Both Hill and Musto used critical realism as a philosophical perspective to examine healthcare providers,

including nurses and nursing practice in context. This aligns with my dissertation research exploring the impact of healthcare reform on PHNsg practice.

A researcher using a critical realist perspective believes that individuals hold and enact agency, but broader structural factors always shape their actions (Bhaskar, 1998). PHNs have the capacity to act, albeit by navigating through the structural dynamics external to them. By seriously considering the role of broader structural factors on PHNsg practice, the grounded theory I constructed is an attempt to explain this vertical relationship between those stratified layers of reality. To me, context plays out in all three layers of reality. For instance, nurses navigate contextual factors they experience in the empirical layer. Nurses encounter events taking place in the actual, shaping the context in which they work. Nurses also experience various contextual elements playing out in the real as underlying mechanisms. Thus, researchers holding this perspective consider context as an essential object of inquiry, and value examining how context interacts with individual and program characteristics by asking the key question of what works, for whom, why, and in what situation (Clark & Thompson, 2010; Kempster & Perry, 2011; Lee, 2012; Oladele et al., 2013; Oliver, 2012; Poland et al., 2008). It becomes evident from this discussion that the critical realist consideration of the mutual interplay between context and people coincides with the tenets of a socio-ecological framework and the symbolic interactionist foundations of the grounded theory method (MacDonald, 2001), both outlined below. Together, critical realism, a socio-ecological framework, and grounded theory analytical strategies helped me to maintain my theoretical sensitivity around the mutual interdependence of PHNsg practice and context, because PHN agency can only take place in context. Theoretical sensitivity assists researchers in their “ability to recognize and extract from the data elements that have relevance for the emerging theory” (Birks & Mills, 2011, p. 176).

Applying Critical Realism to Grounded Theory.

The use of critical realism in grounded theory has been applied by researchers from several different disciplines, including economics (Lee, 2012), leadership (Kempster & Parry, 2011), social work (Bunt, 2018; Oliver, 2012), and nursing (Musto, 2018). These authors agree on the usefulness and congruence of a critical realist philosophy and the grounded theory method. They found grounded theory techniques to be useful to examine the structures and causal mechanisms required within the analysis when informed by the critical realism of Bhaskar (Bunt, 2018; Kempster & Perry, 2011; Lee, 2012; Musto, 2018; Oliver, 2012).

A researcher using grounded theory informed by critical realism aims to connect social phenomena with underlying generative mechanisms, producing a contextualized understanding and explanation of participant meaning and action (Kempster & Perry, 2011). Researchers found analytic devices developed by the originators of grounded theory, Barney Glaser and Anselm Strauss, useful to help delineate such connections in the data. For instance, Kempster and Perry found Glaser's (1978) six Cs – cause, consequence, contingency, condition, covariance, and context – useful to detect relationships between the variables identified as important during their analysis. Similarly, Oliver (2012) found Strauss' conditional matrix a useful tool to situate individual action within broader structures and context (Strauss & Corbin, 1990). Such grounded theory methodological tools are fitting, and support researchers to explain vertical relationships between the layers of reality when using critical realism as a philosophical frame in their study. These methodological tools help the researcher to connect events and experiences to underlying generative mechanisms by contextualizing action in the data (Oliver, 2012). Oliver recommends asking the data, “What must be true for this to be the case?” and “What makes this possible?” (p. 380) in an attempt to explain the underlying generative mechanisms of individual action. In

addition to a philosophical perspective guiding research, researchers also use theories to inform their perspective throughout the research process (Creswell, 2013). I outline my theoretical perspective below, as well as position myself within the contentious terrain of *a priori* theory use in grounded theory research.

Theoretical Perspective

I draw on social ecological theory as a theoretical framework to situate my study. Stokols (1992) describes social ecology as a conceptual framework that depicts humans in mutual interdependence and in reciprocal relationship with their socio-cultural contexts. MacDonald (2001) defined social ecology as the “social, institutional, and cultural contexts of people-environment relations” (p. 116). This framework supports me to make the positioning of PHNs located within context explicit in my thinking, in which organizational and system level forces shape their practice and, in turn, PHNs constitute and shape the organization.

Social ecology has evolved from ecology into a general framework for understanding human action and interaction in society (MacDonald, 2001), often depicted as a series of nested concentric circles representing micro, meso, and exo levels of influence (McLaren & Hawe, 2005). There are multiple levels of contextual influence on human action and interaction, and in reciprocal fashion, human action influences these broad contextual conditions. Thus, the nature of the relationship or interaction is considered mutually influential, or transactional. This transactional view of human interaction within a larger system helps me to consider the reciprocal influence of the social and structural location of PHNs and their actions. As I outlined above, researchers conducting inquiries within the realm of critical realism consider context as central within their analysis, alongside examining the action/interaction between individuals and groups in that context. Thus, by drawing from both critical realist philosophy and socio-

ecological theory I am guided in my analysis to consider explicitly the mutual interplay between context and PHN action and process.

Social Ecological Theory and Grounded Theory

A social ecological theory is not only congruent with my own understanding and conceptualization of humans interacting in the world, but it is also congruent with grounded theory (MacDonald, 2001), the methodological approach in my study. For instance, a researcher using grounded theory sets out to understand the lives of people in their everyday worlds (MacDonald & Schreiber, 2001), thus, explicitly acknowledging that human action is situated in context. Grounded theory, founded on symbolic interactionism (Blumer, 1969) and rooted in pragmatism (Dewey, 1922; Mead, 1934), is concerned with the dynamic relationship between human action/interaction and society (MacDonald & Schreiber, 2001). As a result, a central focus of researchers while conducting a grounded theory study is to learn how people understand and act, and the meaning of such action within certain settings, or around the phenomenon of interest. Grounded theory has even been referred to as a transactional system in which an array of broad environmental conditions and micro level influences are integrated to shape individual meaning and action (Strauss, 1987; Strauss & Corbin, 1990). Even the development of certain analytic tools, namely the conditional matrix, reflects a leveled ecological approach and transactional view of data within grounded theory. The conditional matrix is used within grounded theory to help the analyst be theoretically sensitive to the array of contextual factors potentially important to the phenomenon of interest (Strauss & Corbin, 1990).

Researchers bring their own theoretical perspective to a grounded theory analysis, shaping the analytic process and findings (MacDonald & Schreiber, 2001). MacDonald and Schreiber (2001) clarified that grounded theorists take an atheoretical stance, in that they begin

collecting data without a sense of what the findings will entail, and need to remain open to various possible theoretical ideas fitting the data. However, researchers do not have empty heads (Schreiber, 2001); they bring their experiences and interests with them as they explore their data. Constant comparison of data, concepts, and categories is one method to ensure that study findings continue to reflect participants' understanding and experience, while acknowledging the integral role of the qualitative researcher in the analytic process (MacDonald & Schreiber, 2001). Another theoretical perspective central in this research is symbolic interactionism, a classic theoretical root in grounded theory (Blumer, 1969).

Symbolic Interactionism and Grounded Theory

Symbolic interactionism is a theoretical perspective foundational to grounded theory that enables the researcher to address and understand communication and construction of meaning among individuals in society (Milliken & Schreiber, 2001). It is our own internal dialogue and interaction with others that shape the meaning things have and how we act toward them (Milliken & Schreiber, 2001). Blumer (1969) explains how humans actively construct the world around them through making meaning of their world, and act based on this meaning, shaping subsequent action and meaning making. A central focus of a grounded theory study is to understand participant meaning and the meaning of actions and interactions within certain settings or in relation to a phenomenon of interest (MacDonald & Schreiber, 2001). By drawing on the symbolic interactionist roots of grounded theory, a researcher focusses on understanding participant action and language within context. In my study, I listened closely to the meaning and understanding PHN participants gave to their action and interaction in the context of organizational change. Thus, the researcher aims to go beyond describing behavior to explain the meaning that motivates behavior. Through the use of constant comparison, a key analytic

technique in grounded theory, we begin to conceptualize and understand meaning in grounded theory data.

Symbolic interactionism attends to the meaning people give to objects, experiences, and events, which relates to notions from my philosophical positioning of critical realism. Both symbolic interactionism and critical realism address the perceptions and meaning people attribute to phenomena and events, and view humans as social agents who act based on their views and experiences. We can see the fit between these perspectives when we acknowledge that a researcher from either position would advance the idea that participants' experiences are socially contingent, and thus our knowledge and understanding of the world is socially produced. Clark and colleagues (2008) explain how critical realism helps researchers to understand the social aspects of humans in science, in that the human perspective is central in generating knowledge.

By locating this study within the theoretical perspectives of social ecology and symbolic interaction, demonstrating the interconnectedness of meaning and action in a social setting, I examine how recent organizational and policy changes in BC's health system shaped PHNsg practice, and how PHNs navigated this change. Informed by my theoretical and philosophical positioning, my theoretical sensitivity is enhanced regarding the role context plays in influencing the actions and interactions of PHNs around the basic social problem. Theoretical sensitivity has to do with "the researcher's level of insight into the research area, how attuned they are to the nuances and complexity of the participant's words and actions, and their ability to reconstruct meaning from the data generated with the participant" (Mills et al., 2006, p.4). By using this theoretical and philosophical mix, I am well positioned to explore PHNsg practice in the context of organizational change, using the grounded theory method.

Applying a Theoretical and Philosophical Perspective in Grounded Theory Research

Researchers have used grounded theory and incorporated varying theoretical and philosophical perspectives to allow for new ways of looking at the data (e.g., Clarke, 2005; MacDonald, 2001; Musto, 2018). As researchers, we bring certain perspectives, theories, or paradigms that guide our action and decision-making (Creswell, 2013). The choice of a methodological approach reflects particular ontological assumptions about reality, and epistemological assumptions regarding knowledge generation (Crotty, 1998). Even the originators of grounded theory, Anselm Strauss and Barney Glaser, ultimately had different views as to the grounding of the method and the analytic techniques that ought to be employed in generating a grounded theory (Stern, 1994). Some view grounded theory as adaptable to a range of theoretical and philosophical perspectives (Charmaz, 2014; Oliver, 2012), whereas others, including Glaser (2002), perceive the evolution of the method to have eroded the analytical power of grounded theory. Although Glaser (1998) rejects the use of an *a priori* theoretical perspective in grounded theory research, he does not argue against using a theoretical perspective in interpreting the findings. Based on this, I used social ecological theory (Stokols, 1992) in my grounded theory research to aid in conceptualizing and thinking through the layers of influence in the data, not to preconceptualize the problem or categories in the theory. This helped me maintain rigour in the research approach.

The flexibility of grounded theory has been observed in the work of Kathy Charmaz (2006; 2014) in her use of a constructivist philosophy within grounded theory research, and in the recent work of Adele Clarke (2005) with situational analysis. Clarke claims she aimed to bring grounded theory “around the postmodern turn” (p. 5) by incorporating diverse theoretical and philosophical perspectives, such as actor network theory, and post-structuralism, in addition

to the classic roots of grounded theory in symbolic interactionism and Chicago ecological theory. Reiger (2019) also discussed developments in, and extensions of grounded theory, and provided examples of feminist grounded theory (Wuest, 1995), and situational analysis (Clarke, 2005; 2009). Despite these developments, Musto (2018) explains how, “there are strategies common to conducting all grounded theory research that reflect its focus on processes, regardless of the ontological position of the researcher” (p. 136). Despite the apparent diversity within grounded theory, most approaches share some core characteristics, such as concurrent data collection and analysis, theoretical sampling based on emerging concepts, constant comparison, memoing of ideas and relationships between categories, and diagramming (Charmaz, 2014; Musto, 2018; Oliver, 2012). Reiger (2019), however, urges researchers to be mindful of similarities and differences between variations of grounded theory to ensure methodological transparency and congruency in one’s research, enhancing the rigour of the research project.

Grounded theory informed by critical realism does not seem such a stretch for an adaptable methodology because it maintains the focus on action and meaning in context, which aligns with the theoretical views of predominant grounded theory methodologists, for instance, Anselm Strauss and Kathy Charmaz. Even though Charmaz (2006) places her use of constructivist grounded theory squarely within the interpretivist tradition, she explicitly outlines how her approach is congenial with other perspectives and research approaches, one of which she mentions is critical realism, along with feminist theory, narrative analysis, cultural studies, and critical inquiry. Unfortunately, she does not elaborate as to how her approach might be useful to, or fit for researchers subscribing to these other philosophical and theoretical camps. However, where critical realism pulls away from constructivism is with the view that there is only one stratified reality, rather than the multiple realities. Nonetheless, in critical realism there

are multiple interpretations and understandings of reality in the empirical layer, constructed based on one's location in the world. What we know about this reality is fallible and partial, but diverse, given our individual locations. Regardless of our different ontological philosophical positions, Charmaz and I agree that knowledge generated from a research endeavor is a construction. The theory I constructed reflects this viewpoint: historically contingent and socially constructed, yet grounded in the data. This, however, to me, does not negate the existence of an external reality. This relates back to Bhaskar's standpoint on the epistemic fallacy, in which he warns against conflating one's epistemological and ontological stance. Informed by critical realist philosophy as well as the theoretical perspectives of social ecology theory and symbolic interactionism, I developed a theory that captured a range of PHN practice experiences and the influences of healthcare reform.

Grounded Theory Method

As mentioned above, grounded theory was developed by two sociologists, Barney Glaser and Anselm Strauss, and became popular with the publication of their ground-breaking text, *The Discovery of Grounded Theory* (1967). Glaser and Strauss wrote this text in reaction to the dominant deductive approach to research commonplace during that time. Researchers often use grounded theory to uncover basic issues for people within a setting or situation, as well as to explain what is going on in the situation around the issue at hand. The aim of grounded theory is to develop an understanding or an explanation of a phenomenon within context, from the ground up, thus producing a theory that remains grounded in the data (Glaser & Strauss, 1967). It is this fit with the data and experiences of participants that allows a grounded theory to be readily available to inform practice (MacDonald & Schreiber, 2001), and makes it an appropriate

research methodology for my study. Constant comparison is the central analytic tool used within grounded theory research to help the researcher understand meaning and action in the data.

Constant Comparison in Grounded Theory

Constant comparison takes place through a process of inductive and deductive reasoning, as well as concurrent data collection and analysis (Milliken & Schreiber, 2001). Constant comparison supports the researcher in theoretical conceptualization by moving back and forth between data and theory, comparing the data with newly emerging concepts while moving to higher levels of abstraction, and testing out emerging categories to ensure fit with the data (MacDonald & Schreiber, 2001). Ongoing analysis and the development of theoretical insights guide subsequent data collection, often called theoretical sampling. Once a core category is distilled and a theory begins to take shape, the researcher purposefully samples for contrary cases to ensure the range of experiences are captured as people deal with the basic social problem (Milliken & Schreiber, 2001). In my dissertation research, through the process of constant comparison, a basic social process or core category emerged, titled *managing the eroding PHN role*, reflecting how participants managed the basic social problem, *when it is no longer your call*.

Grounded Theory Method in my Dissertation Research

The justification for the choice of a research methodology is linked with the original purpose of inquiry (Crotty, 1998). Schreiber and Stern (2001) describe grounded theory as an exploratory method of research, but it is also explanatory; that is, the method helps researchers move beyond understanding to explaining meaning and action. This broad-based approach to research fits well with the intent of my study aimed at understanding how PHNs navigated the

shifting grounds in the context of organizational and policy changes. The grounded theory method allowed me to delve into the shared concerns of PHN participants, and develop a conceptualization of how PHNs managed their role. With a focus on meaning and action, I drew on grounded theory to explain the meaning, causes, and consequences of PHN responses to healthcare change.

I used Kathy Charmaz' newest text, *Constructing Grounded Theory* (2014), as a guide to conduct my own grounded theory study because I found her explanations clear and her examples useful. However, I drew from other supporting grounded theory texts as necessary, such as Strauss and Corbin's (1990) explanation of the conditional matrix analytic tool, to make a clear connection with critical realism. I also drew from their explanation of coding. I largely used Strauss and Corbin's (1990) edition of the text because in later versions, Corbin replaced *action* with *individual* at the center of the conditional matrix. Replacing *action* with *individual* shifts the focus of the analysis. Action is central in a grounded theory analysis and belongs in the center of the conditional matrix, true to its original conceptualization (Strauss, 1987). Thus, I drew largely on their first text.

In her 2006 text, Kathy Charmaz explains how her use of grounded theory draws on the Glaser and Strauss approach, but she applies a constructivist view to interpreting research findings. I discussed our philosophical tensions above, and drew on her text at the level of method. I found particularly useful the insights she offered readers into the *how to* of grounded theory research, and her explanations of traditional grounded theory analytic techniques in practice. True to the original foundations of the method, she draws out the pragmatist underpinnings of traditional grounded theory to highlight language, meaning, and action within

the analysis. Regardless of our philosophical grounds, Charmaz (2014) provides a clear pathway for students to follow in learning the grounded theory method.

In her text, Charmaz (2014) offers students advice in using basic grounded theory guidelines, and provides exemplar cases on gathering rich data, conducting interviews, coding data, memo-writing, theoretical sampling and sorting, and even how to go about writing up findings in a manuscript. She describes such methods as “neutral” in her first edition of the text (Charmaz, 2006, p. 9) and explains that they are “transportable across epistemological and ontological gulfs” in her second edition (Charmaz, 2014, p. 12). Thus, she also believes that researchers subscribing to various philosophical and theoretical viewpoints on grounded theory can use these methods towards theorizing. Charmaz (2006) states that the main contribution of grounded theory methods is that they offer a guide to theorizing, not a blueprint for theoretical development.

Grounded Theory Method Informed by Critical Realism in my Dissertation Research.

As previously noted, the grounded theory toolkit offers techniques that help researchers to explore underlying structures and mechanisms central to theory generation founded on a critical realist philosophy. I found the work of several researchers useful in providing methodological guidance for conducting grounded theory from a critical realist perspective (e.g., Bunt, 2018; Kempster & Parry, 2011; Lee, 2012; Oliver, 2012). These researchers reported how traditional grounded theory techniques, such as Glaser’s six Cs and Strauss’s conditional matrix, were useful in theory generation to help contextualize understanding and explanation, and link action/interaction to underlying generative mechanisms (Bunt, 2018; Kempster & Parry, 2011; Oliver, 2012).

Charmaz (2006) also advocates for placing the data within relevant social contexts to aid in the conceptual complexity of theorizing, because concern with context is common in an interpretive stance. Charmaz (2006; 2014) explains how, in conducting a grounded theory study, the researcher often returns to the field to test out hunches and clarify or elaborate theoretical categories surfacing in the data. Through means of theoretical sampling to define properties and relationships between or among emerging categories, researchers enhance the conceptual complexity of their data (Charmaz, 2006; Glaser & Strauss, 1967; Strauss, 1987). Charmaz (2006), in explaining grounded theory à la Glaser and Strauss, outlines how a researcher strives to construct a grounded theory that explains the properties of identified categories and describes the precursors and outcomes of the studied process, leading to a new theoretical understanding.

The application of critical realism to grounded theory in the study of PHNsg practice is a relatively novel approach. Even though grounded theory is a frequently used research methodology in nursing, the use of critical realism as a philosophical perspective within such a methodological mix is relatively new. I hope to add this discussion to the nursing literature and beyond. I will now outline the data collection methods and the key analytic tools I employed in conducting this grounded theory study.

Conducting my Grounded Theory Study

In this section, I describe the progression of my grounded theory study exploring PHNsg practice in the context of healthcare reform in BC. I begin by outlining the ethics approval process, then describe the study participants, the sampling strategy and recruitment efforts employed. Following this, I discuss the data analysis and analytical tools I used to enhance my theorizing. Lastly, I outline the evaluation criteria used in grounded theory research, and apply these concepts to my dissertation study.

Ethics Application

I obtained ethical approval for this study through the harmonized ethics review process in BC. The study commenced once I obtained ethics approval (see Appendix A) and operational approval for the regions. As the Principal Investigator on this study, I completed the Tri-Council Policy Statement, Second Edition, online tutorial. Once I received ethics approval, I began participant recruitment.

Data Collection Methods.

Recruitment Process.

At the outset of this study, I envisioned collecting data from all five regional HAs in BC, but after facing time constraints and unexpected barriers receiving operational approval in two HAs, I collected data in three HAs. I had not worked in any of these HAs, and therefore had no formal employment connections within any of them. My PhD supervisor and I anticipated that I would achieve theoretical saturation by collecting data in three authorities, and believed that the sample would capture diverse experiences and practice settings representative of PHNs in BC. I learned that a clear organizational structure, as well as a having someone to spearhead the project, were important to gain entrée in HAs.

I began the recruitment process for this study in health authority (HA)1. After receiving approval from the director of public health in HA1, she connected me with an administrative assistant who acted as a neutral third party and distributed my recruitment letter (see Appendix B) via email to all PHNs in the region. The recruitment letter was distributed across HA1 first because it was the first region to approve my study. In the study recruitment letter, I explained the background and purpose of the study, eligibility criteria for participants, data collection details, and what was required of potential participants. I included my contact information on the

recruitment letter for potential participants to contact me via email if they were interested in participating in the study. After participants contacted me via email, I screened them for eligibility before arranging a date and time for the interview.

I then collected data in HA2 and HA3. Due to differences in ethics protocols among the three HAs, I had to rely on individual PHNsg managers for HA2 and HA3 to access PHNs for data collection. To gain access to PHNs in these health regions, I required both manager and director signatures, which took considerable time. In HA2, my dissertation supervisor had a personal connection with a PHN manager who was instrumental in gaining access to PHNs. The PHN manager emailed other managers and discussed my study at a manager meeting to improve buy-in and participation. Again, having a key contact or champion of the research within an organization was vital to facilitate the recruitment process. I had access to three health unit offices in HA2, and seven health units in HA3. A recruitment email was sent out twice in each HA. Following the distribution of two recruitment letters in each HA, I achieved theoretical saturation of the core category and sub-categories. Saturation is achieved when the core category and sub-categories capture the full variation in participant action and meaning in response to the basic social problem.

In arranging the recruitment process for this study, I took measures to avoid undue pressure on staff to participate in the study. For example, in HA1 I sent the recruitment email via a neutral third party. Unfortunately, this was not the case in HA2 and HA3, where I had to rely on PHNsg managers to send out the recruitment emails to PHNs. There was no neutral participant recruitment process available in these HAs. A statement was included, however, in the recruitment email to mitigate the potential perception by participants that they were being pressured into participating. The statement was, "Please note, the person who sent you this email

has nothing to do with this research and you should not see this email as something that may influence your professional relationship with your health authority.” PHNs had to meet certain criteria to participate.

Inclusion and Exclusion Criteria.

To be included in the study, participants had to be employed in PHNsg, or were managers knowledgeable about the PHN role in one of the three regional HAs being studied. These participants had to be able to communicate in English, and to have been employed in PHNsg for at least three years. I initially made this cut-off point because I was interested in exploring the impact of organizational and policy change on PHNsg practice, and at that point, the most recent provincial policy shift to the Guiding Framework had taken place in 2013, hence three years’ experience. All PHNs interested in participating spoke English and had at least three years of experience. Thus, I did not exclude any participants from the study, and each participant provided consent.

Informed Consent.

For each participant who contacted me with an interest in participating in the study, I emailed them a consent form (see Appendix D) for their review prior to participating. I also sent them study information if they requested additional study details (see Appendix C). I provided prospective participants with these documents pertaining to the study to enable them to make an informed decision regarding participation. Prior to beginning the interview, I asked participants whether they had read and understood the information on the consent form, and if they had any questions. Whether they were interviewed in person or over the phone, participants consented by providing a signed copy of the consent form, or verbal consent that was audio recorded. I

reassured participants that I would keep all information confidential, that participation was voluntary, and that they could stop the interview and withdraw at any time.

Participant Sample.

This study consisted of 29 PHNs and 3 PHNsg managers from three HAs in BC, who were currently providing PHNsg programs and services to their communities. All participants expressed an interest in discussing the nature of PHNsg practice and role. I recruited a diverse sample of PHNs from varied settings, ranging in experience from three years to several decades. These PHNs represented both urban and rural practice settings, both single nurse offices and larger multi-nurse offices, and both generalist and specialist PHN roles. I had a few early-career participants who were in their late 20s or early 30s, more participants who were mid-career in their 40s, and the largest number of participants were in the later stages of their career, with several eligible for retirement. I also interviewed three PHN managers, two from HA2 and one from HA3, who wished to participate, who had knowledge of the current nature of PHNsg practice in the province. Each manager had a PHNsg background and had oversight of PHNsg programs. These managers provided insight into the realities of management positions, the nature of leadership, and how organizational change was managed while mentoring PHNs throughout such change. See Table 2 for a summary of the participant population.

Table 2
Demographic Characteristics of Study Sample

<i>Participant Characteristics</i>	<i>HA1</i>	<i>HA2</i>	<i>HA3</i>
Years of PHN experience			
3-10	1	4	2
11-20	6	2	3
21-	2	6	6
Setting			
Urban	8	10	2
Rural	1	2	9
Work Environment			
Team Practice	9	10	5
Solo Practice^a	0	0	5
Generalist	5	0	10
Specialist	4	10	0

Note. Manager/Team Leader participants were not included in work environment category.

^aSolo practice is a one nurse office.

Sampling.

For participant recruitment, I strove to capture a range of PHN perspectives, sampling PHNs from three HAs who had different PHN roles and worked in different settings, with varying levels of experience, outlined in Table 1. I used purposive sampling, which is a type of non-probability sampling in which the researcher predetermines and recruits participants based on certain characteristics. In this study, I purposefully sampled PHNs who were employed prior to the last provincial public health policy shift in BC, with the implementation of the *Guiding Framework for Public Health* in 2013, to learn about their experience with policy change and the influence it had on their practice. I was able to capture a range of diverse perspectives and experiences within my interview data, which is important in a fully developed grounded theory (Milliken & Schreiber, 2001).

I anticipated recruiting a sample of 20-30 participants, as recommended by Oliver (2012), but was aware that I might have needed to adjust the sample size depending on the length and diversity of participant experiences. I had no challenge in recruiting participants. In fact, I had

several PHNs contact me to participate within 24 hours of distributing the first recruitment letter. At times, it was a challenge to schedule all the interviews, given the number of PHNs interested in participating. It seemed the time was ripe for this study. Multiple participants expressed to me their eagerness to participate because they were concerned about recent changes to PHNsg practice. In the end, I interviewed a total of 32 participants.

Additional Data Sources.

I also drew from a variety of additional data sources in this study. Ultimately, I aimed to capture a range of experiences within participants' interviews, and included other data sources if they added to the conceptual density of my work. As Glaser (1978) suggests, "all is data" in grounded theory. Data sources for this study included individual interviews, organizational documents (e.g., HA vision statements and strategic planning documents), government documents (e.g., Ministry of Health provincial policy frameworks related to public health), auditor general reports (e.g., review of Panorama, an electronic health database), and PHNsg guiding practice documents (e.g., national standards of practice). See Table 3 for a list of additional data sources. Charmaz (2014) added a section in her new text explaining how one can go about including documents as text within their analysis. I drew on these documents during memo writing, while mapping data to support my understanding of contextual factors shaping PHN practice, and throughout coding to understand practice expectations for PHNs in their role.

Table 3
Additional Data Sources

1. Auditor General of British Columbia (2015). An Audit of the Panorama Public Health
2. British Columbia Ministry of Health (2014). Module 1: What is public health?
3. British Columbia Ministry of Health (2014). Module 2: Population health and the determinants of health.

4. British Columbia Ministry of Health (2014). Module 3: How does public health work?
5. British Columbia Ministry of Health (2014). Module 4: How is the public health system organized in Canada?
6. British Columbia Ministry of Health (2014). Module 5: Public health renewal in Canada.
7. British Columbia Ministry of Health (2014). Module 6: Public health renewal in BC.
8. British Columbia Ministry of Health (2014). Module 7: Core functions in public health.
9. Canadian Foundation for Healthcare Improvement (2016). Towards the triple aim of better health, better care, and better value for Canadians.
10. British Columbia Ministry of Health Services (2005). A framework for core functions in public health.
11. British Columbia Ministry of Health Services (2013). Promote, protect, prevent: Our health begins here.
12. British Columbia Ministry of Health Services (2014). Setting priorities for the B.C. health system.
13. Canadian Institute for Health Information (2016). Improving health system efficiency in Canada: Perspectives of decision-makers.
14. Perinatal Services BC (2014). Population and public health prenatal care pathway.
15. Government of British Columbia (2014). Taxpayer accountability principles: Strengthening public sector governance and accountability.
16. Health Authority Service Plans (2016/17-2018/19).
17. Health Authority Performance Based Pay (2016/17).

Interview Design and Questions.

I interviewed PHNs over a nine-month period in 2016. All interviews were digitally recorded, and ranged between 45 and 75 minutes in length. I conducted one face-to-face interview in a private location at a convenient time for the participant. The remaining interviews were done over the telephone, which was preferred by most participants, given privacy, flexibility, and convenience. Participants selected a time and gave me a phone number where I

could reach them. I transcribed each interview verbatim, and then listened to the interviews again while reviewing the transcripts to ensure accuracy.

I used semi-structured interviews in this study, guided by an initial list of open-ended interview questions (see Appendix E). Semi-structured interviews provided guidance in the conversation but also created space and flexibility for participants to express their perspectives, and shape the nature of the conversation. I opened each interview in the same manner by introducing myself and allowing some time for questions and conversation. This helped to establish rapport with the participant and built trust between myself as the interviewer and the nurse. Once they found out I was a nurse, it allowed them to open up about their experiences, eliminating some of the potential power differential. A few PHNs made explicit comments regarding the fact that they were relieved that I was not from another discipline or management background. They were more comfortable discussing their thoughts, ideas, and experiences, given that I was a nurse. Many stated that they appreciated the opportunity to discuss the changing nature of PHNsg practice, as well as my research interests in this work. In fact, the majority of participants thanked me at the end of the interview for the opportunity to be heard. I closed in the same fashion by asking if there was anything else they would like to discuss, or if there was anything I had overlooked asking them.

Given the flexibility of semi-structured interviews and the emergent nature of grounded theory research, the initial list of open-ended interview questions evolved over the course of concurrent data collection and analysis. I included questions designed to elicit what was happening and had happened in their practice, as well as precursors, conditions, and consequences of organizational and practice change. This line of questioning stemmed from Glaser's six Cs, in which I attempted to surface some of the meaning, as well as the mechanisms

guiding participant action. I also aimed to draw out their thoughts and ideas about organizational decision-making processes and practice change that affected PHNs, as well as their views about what should or would support PHNsg practice.

During the initial interviews, I asked questions specifically about policy change, and provided participants with examples of policy changes, such as the Core Functions Framework and the Guiding Framework documents, and how they affected PHN practice. However, by about the fifth interview, my line of questioning moved away from focusing on policy implementation after I was told by multiple participants that Core Functions and other policy documents were not the primary factors in the changing nature of their practice, and that they had more pressing concerns they wished to discuss. These participants agreed with many of the ideas in the Core Functions Framework, but they felt there was not adequate time or financial resources to implement the programs.

The focus of the interview questions shifted away from examining how high level policy had shaped PHNsg practice, to a broader focus on what they perceived to be key factors at play that shaped their practice, aligning with the emerging basic social problem. The line of questioning became less about facilitators and barriers to the implementation of Core Functions, and more about how contextual factors had shaped the PHN role, and how participants were navigating this change. A more pressing concern to participants in my study was the frequency of organizational restructuring, the changing nature of PHNsg leadership and decision-making, and the cuts to the PHNsg budget. Thus, my line of questioning in interviews evolved as I analyzed data and as themes emerged. I asked more explicitly about how PHNs managed their role in light of practice changes. I followed up on theoretical ideas, such as how PHNs came together to advocate for parts of the PHN role being reduced, and probed more into the process

of PHN thinking and decision-making about managing change. Nearing the end of one interview, the PHN said that, based on the nature of the interview and the intent of this research project, she felt that I had been listening to PHNs, and had heard their concerns. This reaffirmed for me that I was delving into an area of importance and of use to PHNs in practice.

As I explained in Chapter 1, I used my knowledge and insights from the Renewal of Public Health Systems (RePHs) data, and my volunteer experience as sensitizing concepts, both of which shaped the conceptualization of the research problem and the initial design of the interview questions for this study. Charmaz (2014, p. 30) explains how sensitizing concepts can be used to guide research, however, they are “points of departure” to further develop conceptualizing. Extant theories, literature searches, and research questions also help to enhance research theoretical sensitivity (Charmaz, 2014). Once I began interviewing participants, the focus of my interviews and theorizing shifted. Thus, I used knowledge of RePHs data and insights from my volunteer experience as points of departure. I reminded myself that qualitative designs are emergent, meaning that one’s ongoing analysis and development of theoretical insights guide data collection to support theorizing.

Confidentiality and Privacy Steps.

To maintain the confidentiality of participants, I de-identified the interview transcripts, and labelled each with a code. No identifying information was used in reporting quotations in the study findings. Names of locations and services have been eliminated to avoid the risk of identification. By collecting data in more than one HA, the findings of my research are not only transferable across health regions, but provide distance between PHNs and organizational criticism in any one region.

As the Principal Investigator, I was the sole person to have access to the study code list, a master list linking coded transcripts to participant information. I kept the study code list to respect the wishes of any participant who might have wanted to withdraw from the study and have their data removed. To ensure this list containing participant information was kept secure, it was stored on a University of Victoria (UVic) password protected and locked computer that was connected to the University's server. This list will be kept for 5 years post data collection only on a University of Victoria computer connected to the UVic server. The study code list is kept in a separate file folder from the data.

Data Analysis Process

Grounded Theory Analytical Process.

Even though I separated data collection and analysis into different sections for ease of explanation, the practice of concurrent data collection, coding, memoing (i.e., recording analytical thoughts and methodological decisions), and conceptual analysis is central within grounded theory because it helps to guide the researcher in subsequent data collection and analysis based on developing analytic insights (Glaser, 1978; Glaser & Strauss, 1967). Reflective of the inductive logic in grounded theory, issues that were important to participants emerged through data collection and analysis, leading to the definition of the basic social problem (Rieger, 2019). I managed and analysed my data using QSR International NVIVO 10, a qualitative software program. NVIVO facilitated creating and organizing nodes at all stages of coding, as well as linking memos to nodes to capture meaning.

Data Coding.

I drew insights from Strauss and Corbin's (1990) three levels of coding, as well as other sources to guide my coding process. In her text, Charmaz (2014) also outlines three types of

coding that draw on and closely mirror the stages advanced by Strauss and Corbin (1990), however she finds some of their analytic strategies somewhat cumbersome, as did others (e.g., MacDonald, 2001). MacDonald (2001) explains how some of the tools presented by Strauss and Corbin (1990) are a bit unwieldy and not useful to all. Charmaz suggests emergent coding, which is a well-established notion in grounded theory (Strauss & Corbin, 1990; Glaser & Strauss, 1967), and refers to three types of coding: initial coding characterized by line-by-line coding using *in vivo* codes, comparing incident with incident; focused coding; and theoretical coding. These levels of coding were not linear for me, and I found I worked my way up to theoretical coding as categories were saturated, properties explained, and relationships clarified. Throughout coding, the researcher engages in constant comparison, an analytical method in which the researcher gradually moves the findings to higher levels of theoretical abstraction, by comparing incident to incident in the data, code to code, category to category, as well as categories and codes to incidents, and vice versa, deriving theoretical import from the data (Glaser, 1978).

During the initial stages of my analysis, soon after the first interview was recorded and transcribed, I began to analyze the data by reading and coding line-by-line using NVIVO. Line-by-line coding is intended to “break open the data to consider all possible meanings” (Corbin & Strauss, 2008, p. 59), which is useful to enhance one’s familiarity with the data. Milliken and Schreiber (2001) suggest that researchers begin coding by creating codes that closely match the language used by participants, referred to as *in vivo* codes. I had many initial codes that reflected the language used by study participants. For instance, “being cut out of the equation,” “putting our practices into boxes,” and “using band-aid solutions” are examples of *in vivo* codes from my data.

These first few interviews provided an initial set of codes as I broke apart the data into many codes. This initial breaking down or opening up the data in open coding allowed me to examine and compare incidents in the data, leading to preliminary conceptualizations of what was going on, and the formation of initial substantive codes. I found some of the questions presented by Glaser (1978) helpful during open coding, as well as throughout the remainder of the analysis. These questions were: What is this a study of? What property of what category does this incident indicate? What is actually happening in the data? What is the main concern being faced by participants? These questions were helpful in my initial theorizing of the basic social problem, a shared concern among participants.

To me, coding became a process of multiple rounds of expansion and contraction. After open coding the first five interviews, I had well over 150 initial codes. At this point, I started to see patterns and overlaps between codes, and I began to collapse related codes together at a higher level of abstraction, comparing incident to incident, incident to concept, and concept to concept. At times, I could see how higher level codes were more similar than different, and merged codes. After subsuming codes under a higher level code, I produced memos about the similarities between the ideas captured in the new code. In the beginning stages of analysis, I developed a new set of initial codes after each interview when these concepts and ideas were not yet represented by a code in my code book. Then I would, once again, draw on Glaser's (1978) list of neutral questions to think through the meaning and action in the data, and how they fit with other emerging concepts. As the study progressed, however, the rate of development of new codes diminished, with very few new codes created later in my analysis. I attempted to title codes using gerunds, or words that ended in -ing, to indicate action and process in the data when applicable.

Gradually, codes began to shift to reflect higher-level categories mirroring my conceptual understanding of the data. These categories were developed iteratively, comparing meaning within and between categories to understand the dimensions of each category in different conditions (Glaser & Strauss, 1967). The constant comparison process led to the development of a core category or basic social process. The core category accounts for much of the variation in the data and explains how participants continually work to resolve the basic social problem. Some codes were eventually dropped, or set aside if they did not help to explain the basic social process that was related to the basic social problem. In the end, this process led me to see that participants in my study engaged in five strategies to manage the basic social problem, *when it is no longer your call*.

Once I began to collapse data and look for how concepts were related, I also drew on some of the coding schemes used in axial coding, Strauss and Corbin's (1990) second level of coding, as a means of forging links between categories and sub-categories. Strauss and Corbin (1990) explain how, in axial coding, the researcher puts the data back together, but in new ways. They suggest that by coding the data using their "coding paradigm", the researcher begins to develop higher conceptual categories and theoretical linkages between the categories. The coding paradigm includes coding categories such as causal conditions, the phenomenon under study, context, intervening conditions, action/interactional strategies, and consequences, which aligns closely with Glaser's Six Cs: "cause, consequence, contingency, condition, covariance, and context" (1978, p. 74). In order to explain the linkages between categories, I examined the relationships between codes and emerging categories and returned to the data to test out hunches regarding these relationships (MacDonald, 2001).

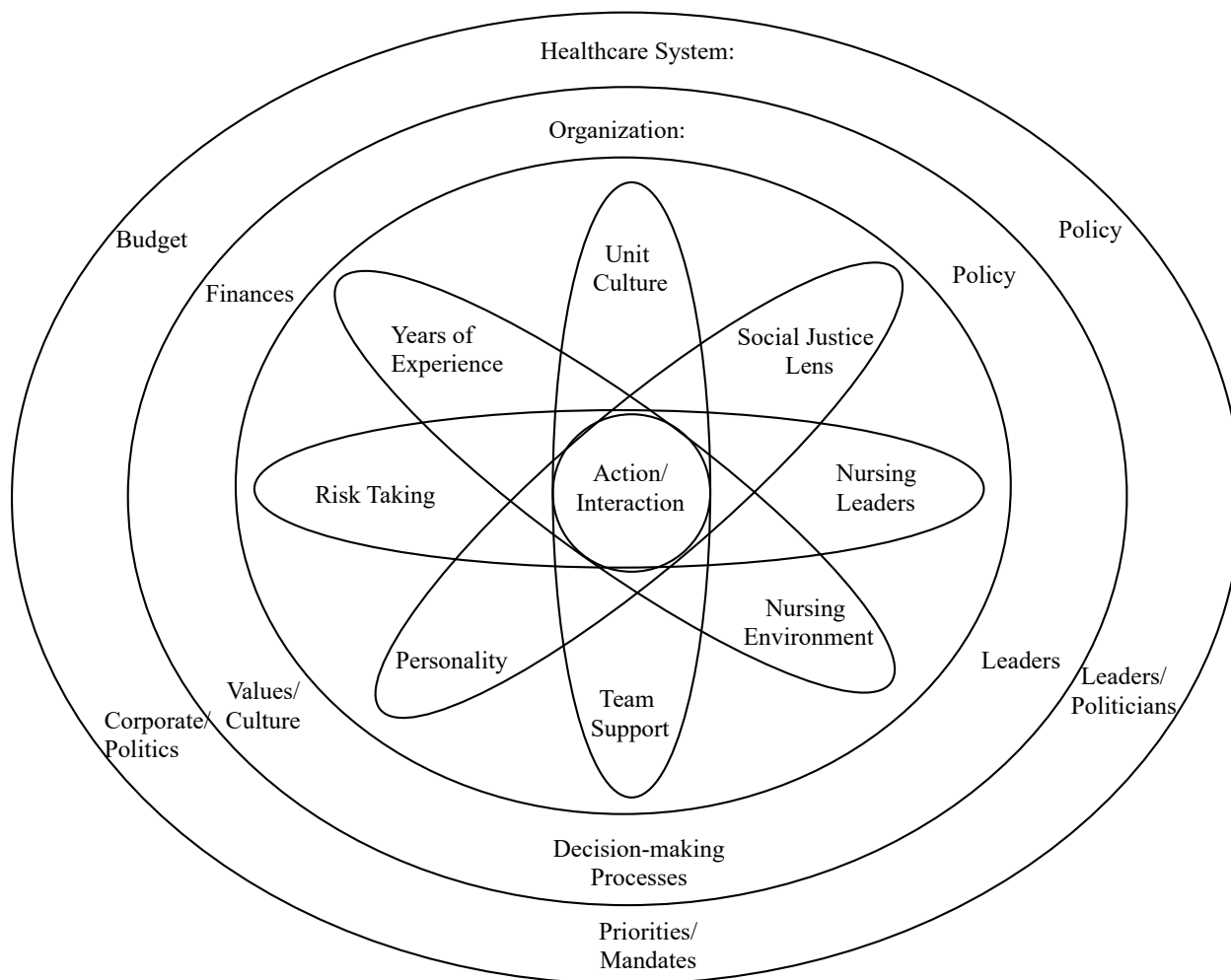
I began to focus on mapping the process I observed emerging in my data. I grappled with and categorized the broad contextual factors that PHNs reported had led to changes in their practice. After describing those changes, I examined how PHNs managed this phenomenon across varying situations and contexts. For instance, I began to see how PHNs, with the implementation of a new directive undermining their practice, navigated between the strategies of *standing tall* and *getting by*. Based on such factors as the nature and frequency of organizational change and leaders, team morale, and available resources, PHNs decided how and when to advocate for their role, or to keep their heads down. I looked for the variance in strategies that PHNs employed to manage changes in their practice, and the implications they perceived from such change.

I found axial coding particularly useful to help move beyond describing the data, and to progress towards developing a contextualized understanding and explanation of the phenomena. For example, the coding category of covariance from Glaser's six Cs pushed me to consider the relationship between two or more concepts or categories, and was also useful when conceptualizing conditional factors shaping PHN action in my theory. For example, I observed how PHN participants who engaged in the strategy of *standing tall*, were also likely to go *underground*. Certain personal conditional factors also corresponded with PHNs who engaged in these strategies. Experienced PHNs operating from a social justice perspective often engaged in *standing tall* and *going underground* to navigate the basic social problem.

I also found the conditional matrix (Strauss & Corbin, 1990) a useful tool to support my conceptualization in using Strauss and Corbin's coding paradigm to think purposefully about and characterize the various contextual levels shaping PHN action and interaction around the basic social problem. Kearney (2009) believes that to construct stronger grounded theory, nurses need

to include the context within their analyses to understand how it shapes individual action and interaction. MacDonald (2001) also suggested that Strauss' conditional matrix is a useful analytic tool to consider the range of conditions related to the phenomenon of interest. By using this model, I was able to portray nested circles to think through the dynamic interplay between the healthcare system, organization, and individual (both interpersonal and intrapersonal) level factors (see Figure 1). You can see in the center of Figure 1 that there are several micro level factors that overlap to inform PHN action and interaction. I found the conditional matrix helpful in understanding PHN action also within the broad healthcare setting to contextualize action, and identify conditions that activated PHN action, and the consequences of such actions. The influence of this analytical tool on my conceptualization of the data is apparent when viewing the conceptual model I developed in this study. I found diagramming and written memos helpful at this stage to assist me to visualize and think through the connections and meaning in the emerging codes and categories. External frameworks such as Glaser's six Cs and the conditional matrix can be useful, but the insights that emerge must "earn their way" into the analysis (Charmaz, 2014, p. 153).

Figure 1
Conditional Matrix of Study Phenomenon



The final stage of coding outlined by Strauss and Corbin (1990) is selective coding, whereby the researcher focuses in on one (core) category and integrates the categories at a higher level of abstraction. The researcher spends time delineating the relationships around the core category and fitting it with other categories to explain what is going on in the data. Strauss and Corbin (1990) offer five steps to support researchers in selective coding, which helped me to integrate codes. These steps are: a) explicating the story line; b) relating subsidiary categories around the core category (or basic social process) via the coding paradigm; c) relating categories at the dimensional level; d) validating relationships against the data; and e) filling in categories

that need refinement by, for instance, saturating categories (p. 117). I found the first step, explicating how PHNs managed the undermining of their role a useful exercise and presented this conceptualization at Grounded Theory Club, a group of researchers and graduate students interested in grounded theory. I initiated the second step during axial coding, and the coding paradigm and the conditional matrix helped me to conceptualize relationships to the core category. The third step helped to establish dimensions and properties within the core category. The last two steps began around the mid-point of my interviews, when I delved further into how PHNs managed the basic social problem, as well as when I continued to test hunches against the data.

Memoing.

Throughout the coding process, I created memos capturing my substantive or methodological insights, as well as salient features of individual interviews and nodes. For example, creating a memo was a useful tool when I was thinking about the similarities and differences between two PHN strategies, and wondering whether to merge the concepts under a higher level category, or to keep them separate. I also produced memos on the linkages and relationships within and between concepts, and the theoretical import of categories. I used memos to capture the meaning and underlying characteristics of the data contained in nodes. After each interview, I took time to reflect and write a memo about the content of the interview, and the similarities and differences of the PHN's perspective with other participant points of view.

Oliver (2012) explains how memoing is part of the analysis that helps to capture a researcher's internal dialogue during the analytic process. It provides opportunity for reflexivity, and is also a source of data to be potentially integrated into the write up of the findings.

Memoing helped me to process what I was seeing and thinking about in the data, and helped in delineating the basic social problem for my theory. Memoing is a key step in the analytic process of grounded theory, taking the researcher from initial coding to higher levels of abstraction, leading to theory generation (Milliken & Schreiber, 2001). For instance, I started with memos about loss and identity, and moved towards identifying and recording ideas about losing meaning and purpose in PHN practice, before reaching the concept of the erosion of the PHN role.

In actuality, the researcher constructs the theory through the recording of memos or theoretical ideas about the phenomenon under study (Milliken & Schreiber, 2001). I found Charmaz's (2014) guidance and examples on how to write and use memos particularly helpful as a means of developing and raising the conceptualization of codes to conceptual categories. I generated memos throughout the analytic phase, and they became increasingly complex as the theory developed (Milliken & Schreiber, 2001).

Establishing Rigour in a Grounded Theory

Reiger (2019) discusses several ways that researchers evaluate grounded theory studies, and references criteria outlined by Glaser (1978), Strauss and Corbin (1990), and Charmaz (2014). I gravitate towards the evaluation criteria discussed by Glaser and Strauss (1967), later added to by Glaser (1978), because these criteria are parsimonious and clear. Originally, Glaser and Strauss indicated that a grounded theory should have fit, work, and grab. That is, categories must fit or reflect the data collected by the researcher, the theory must work to explain the behaviour and meaning in the data, and must "grab" or capture the attention of anyone who has experience with the phenomenon under study because findings ring true in a powerful way (Glaser & Strauss, 1967). To Glaser, a good grounded theory is also relevant and modifiable in

light of new data (1978). I aimed to construct a grounded theory that fits, works, has grab, is relevant to PHN practice, and is modifiable in light of new data (Glaser, 1978).

The inductive and deductive processes of constant comparison, guiding the analytic process, is a rigorous process in itself, ensuring the emerging theory incorporates a full range of variation (Glaser, 1992). To ensure the rigour of my findings, I used a variety of thoroughly developed analytic devices to aid in the construction of a grounded theory examining the impact of organizational and policy change on PHNsg practice and PHN response to such change. For instance, I began analyzing the data after conducting and transcribing my first interview, commonly referred to as concurrent data collection and analysis. By initiating analysis during data collection, I was able to explore emerging concepts in subsequent interviews. I used constant comparison throughout the analysis to develop theoretical insights and examine similarities and differences between and among pieces of data, with codes and categories at all levels of abstraction. I recorded my initial thoughts, theoretical conceptualizations, and methodological decision-making in memos, which I returned to throughout the analysis. I dated all memos and drawings so I could track the evolution of my thinking and theorizing.

Over the course of data collection and analysis, I presented preliminary findings in both formal and informal settings to obtain feedback and to determine whether my emerging categories fit the data and resonated with PHNs. I talked to several PHNs that I know personally throughout my analysis to glean their insight into my theoretical rendering of the data. As well, I discussed my evolving theory and model at Grounded Theory Club. I also had routine meetings with my supervisor and committee member, both experts in the grounded theory method, with whom I shared my emerging findings. They asked questions that pushed me to develop higher

levels of abstraction, identified thin areas that required more explanation, and indicated instances when I was too wedded to a concept, or when I had overlooked my assumptions.

I used these opportunities, as well as memos, to engage in reflexivity. That is, I took the time to think critically about how I might have influenced the research process and the study findings. Charmaz (2014) refers to the importance of researcher reflexivity to enhance study rigour, by considering the assumptions one brings to the research process. In the end, a grounded theory is complete when the researcher has developed a symbolic representation that explains actions and interactions of participants, and illustrates the relationships between concepts (Milliken & Schreiber, 2001). Others speak to the end of the analytic process as the point at which theoretical saturation has been reached, that is, when no new dimensions and properties emerge, and categories are well developed (Charmaz, 2014; Oliver, 2012).

Summary

Rieger (2019) suggests researchers consider the study purpose, their philosophical positioning, and pragmatics in determining methodological fit for a study, promoting methodological transparency and philosophical/methodological congruence, and ensuring rigorous research. Throughout this chapter I have detailed my philosophical and theoretical orientation in this study. I outlined the philosophical fit of grounded theory and critical realism that informed this research. I hope that my account of the research process in this chapter enhances the rigour of this dissertation study.

The focus of my research evolved, as I collected and analyzed the data, to reflect the concerns of participants in the study. My conceptual understanding of issues arising for PHNs, given both historical and recent organizational and policy changes and the changing nature of their practice, informed my line of questioning to elaborate and explore emerging categories in

the data. By implementing a variety of analytical tools and levels of coding, while using constant comparison and memoing, I portrayed how PHNs managed in the face of organizational change eroding the PHN role. In the next chapter, I describe the results of this process in the findings chapter, which follows.

Chapter 4 – Findings

In this chapter, I consolidate the data gathered from PHN interviews into a theory entitled *managing the eroding PHN role*. The theory is an explanation of how PHNs have navigated the weakening of their role in the context of health system restructuring and financial constraint in three HAs in BC. I begin with a depiction of the basic social problem at the core of this theory, conveying the significance of the problem and its importance to the day-to-day practice of PHNs. I then move on to explain the basic social process of the theory, represented by five PHN strategies, defining and describing the categories and subcategories, illustrating each with quotes from participants, and demonstrating the relationship between the categories. It is from the words and experiences of PHNs that the basic social problem and process emerged. Before examining the details of how PHNs have managed organizational and policy change undermining their role, I begin with a description of shared participant concerns in the basic social problem.

Basic Social Problem

The basic social problem is a shared concern among participants that they are working to resolve, manage, or respond to. In this study, the basic social problem, *when it is no longer your call*, reflects the experience of many PHNs in my study in which nurses have witnessed weakening authority in their role such that they no longer can make decisions that have traditionally fallen within their scope of practice. The basic social problem consists of three overlapping, yet distinct components. PHN participants described a loss of support, autonomy, and flexibility in practice, eroding PHN control and professionalism in their role. Nurses in this study explained how a number of provincial and organizational changes in the planning, funding, and delivery of PHNsg services have reduced and, at times, eliminated PHNsg programs and narrowed the PHN role. These changes constrained their ability to anticipate and respond to local

health issues and promote health at a population level. As discussed in Chapter 1, the scope and depth of the PHN role is clearly articulated in several Canadian practice documents, most notably in the Community Health Nurses of Canada (CHNC) Standards of Practice (2011, 2019).

Nurses in this study discussed several examples of PHNsg services no longer offered in their communities, such as prenatal classes, universal postpartum home visitation programs, mother-child programs, early childhood development programs, health education in schools, as well as a reduction in immunization clinics and community development and advocacy work. There was, however, variation across regions. Many participants described the contracting out of traditional PHNsg services to other agencies and paraprofessionals, as well as the hands-off approach of their role in some community settings, such as schools. In some regions, leaders no longer supported PHNs' direct involvement with educational activities in schools, and only permitted PHNs to share educational resources with teachers. Several nurses also discussed the narrowing scope of their role, limiting their activities to individually-focussed tasks within the health unit, often at the expense of community-based work. They explained how several contextual changes, such as budget cutbacks and changing leadership, have restricted PHN involvement and reach in the community, compromising the nature of their role. Many nurses were demoralized by the state of continuous healthcare reorganization within the region, alleged to improve services and outcomes, when most participants believed it resulted in weakened, inadequate, and poorly coordinated care. There was consensus among PHN participants that multiple changes over time have diminished their ability to work across levels of practice, the quality of their relationships, and compromised their effectiveness in the role.

In the past, PHNs were supported by their managers to use their professional judgement, applying their knowledge and skill, and taking initiative to identify local health issues and work

with their community partners to engage in a range of health promotion and disease prevention activities. Many participants explained that organizational changes have compromised the PHN role because nurses were restricted in initiating and maintaining connections that were key to promoting and maintaining health in their communities. PHNs were constrained in drawing on their professional knowledge to guide their activities, and limited in their day to day work beyond provincially mandated programs. When confronted with a punitive organizational culture, nurses often feared retribution if they went against organizational priorities, and were left feeling disrespected and devalued in their role and concerned about health and wellbeing in their communities. Throughout the interviews, PHN participants spoke about three aspects of the basic social problem (i.e., loss of support, loss of autonomy, loss of flexibility), giving examples of organizational and policy changes and the negative impact on PHNs' authority in their practice, reducing PHN control over their work and undermining their ability to collaborate with their communities to improve health.

Loss of Support

Several PHN participants explained how healthcare restructuring has resulted in weakened support for the PHN role. A number of experienced nurses in this study indicated that the wave of change eroding the infrastructure supporting the PHN role began with the regionalization of the provincial healthcare system throughout the 1990s. They stated that by amalgamating public health with the larger healthcare system, public health leaders lost authority in decision-making and struggled to compete for healthcare dollars against the dominant medical paradigm, namely acute care.

It seems that public health and PHN leaders experienced less control and decision-making authority in HAs than they had when PHNsg programs were directly linked to the

Ministry of Health in Victoria, or the local municipal health department. As one PHN noted, even though public health leaders, such as medical health officers, brought public health knowledge to decision-making tables, they seemed to have little power with regard to funding decisions. PHNs were used to working independently, but were then integrated into a system that was inherently autocratic. With regionalization of health services and the reconfiguration of reporting structures came top-down decision-making that took place across the province. A few participants explained that regionalization also seemed to open the door for subsequent organizational change, such as hiring managers who lacked public health or PHNsg knowledge and experience to oversee PHNs. This has eroded the PHN role. No longer were all higher-level public health managers steeped in goals of prevention, health promotion, and social justice.

A number of PHNs in this study discussed how restructuring has continued within HA structures since regionalization, negatively influencing PHNsg practice. After regionalization, when HA administrators became responsible for the organization and delivery of public health services within a region, including PHNsg, several PHNs noted how variations in organizational change between HAs resulted in regional differences in the PHN role. They discussed the importance of public health and PHNsg leadership within HA administration and how it influenced the level of support for the PHN role within the organization.

Many nurses in the study also discussed the effect of leadership on public health funding and the level of PHN staffing within regions. When public health and PHNsg leaders were no longer seated at decision-making tables, or had limited power at those tables, they lost their ability to advocate for prevention and health promotion initiatives. This contributed to reduced PHNsg budgets and staffing levels. For example, the presence of public health champions in HA3 administration, in part, created a strong public health culture, and as a result, several

participants noted higher levels of PHNsg funding and staffing in that region as compared to the other two regions. A few PHNs in HA3 noted a shared public health vision and historical support for their role. However, a number of nurses in the region believed this level of support was in decline because administrators were changing the management structure and moving managers to different portfolios. These nurses were concerned that their new managers would lack public health knowledge and experience and undermine their role.

Several PHNs in HA2 discussed another form of organizational restructuring across their region, whereby the community portfolio, which included PHNsg, was integrated with the acute portfolio. As a result, PHNs were divided, and no longer all together under the same portfolio. These participants explained how the scattering of nurses across numerous portfolios weakened PHNsg infrastructure, voice, and support within the team. Several PHNs in this study explained how nurses were no longer all together in a public health department, which had a detrimental effect on their community of practice and ability to come together to support each other. They indicated that program development now took place in a different portfolio than the department comprising PHNs who implement the program, disconnecting the processes of program development and implementation. These nurses were concerned that reorganizing in HA2 displaced public health, which they believed negatively affected PHNsg practice, as well as the communities they served. A manager in HA2 indicated that there was minimal understanding of public health in the administration prior to this round of reorganizing, and that since integrating acute and community portfolios, there was even less.

Some participants in HA2 also noted that changes in the location of public health in the community had a significant effect on their role. A few nurses discussed how they did not have the appropriate spaces to provide services. For instance, one nurse expressed concern regarding

having to provide care in a hospital clinic room that was not appropriate for the range of PHN activities, whether that was supporting a young mother who was seeking breastfeeding assistance, an individual requesting a sexual health service, or a distraught teen who thought she was pregnant. Nurses were also concerned about plans to move public health offices to locations away from community centers, decreasing visibility and accessibility of PHNsg programs and services. Several nurses discussed the importance of a health unit being convenient and prominent to the community. After it was announced that PHNs were being moved, one participant expressed concern about no longer being co-located with other child and family services. This nurse explained how these other services offered free food and supplements, such as prenatal vitamins and vitamin D, drawing in clients who might benefit from PHN involvement. She stated that when leaders viewed PHNs as portable, they overlooked the importance of continuity of relationships and accessibility of PHNs in their community. These nurses emphasized the significance of being co-located and working in collaboration with partners in partnerships that take time to develop. When decision makers moved PHNs away from other community-based services and community centers, weakening their ability to connect and provide adequate care, they believed they were less effective in their role.

A number of participants also noted how a round of reorganizing in another HA, not included in this study, affected the PHN role in that region. They raised concerns about how the amalgamation of the PHN role with the home care nurse role took place within one HA in BC. These nurses noted how their own leadership were watching this change with interest. These participants stated that they were worried that this may be implemented in their region. They explained that if this took place, they believed the individual clinical focus of home care would

be prioritized over the broader community and population focussed aspects of the PHN role, further reducing their role in community health promotion and prevention.

Across all three study regions, PHNs reported a number of recent cuts to the public health budget, which they felt were disproportionately directed at the PHNsg budget. These nurses attributed cuts to the PHNsg budget, such as decreasing the number of PHNs in many regions and narrowing PHNsg programs and services, to be a reflection of the dwindling influence of public health within healthcare, financial pressures of escalating hospital costs, shifting government priorities, and a devaluing of the PHN role. With fewer PHN positions, nurses commented that the remaining PHNs had higher workloads, more often focussed on priority populations and less universal support.

Many PHN participants believed that decisions to eliminate meaningful and effective PHN programs and services were largely based on budget because they did not fit with organizational priorities and mandates, regardless of the benefits to communities. One PHN captured the experience of many nurses in this study when she stated:

What has been hard is that those cuts and the changes were not discussed with input from people who actually do the work. So, I think we would have been a little bit more on board if we'd really felt like our voices had been heard, but they weren't.

Many participants acknowledged that change is inevitable and can be an improvement in promoting health, but noted that they have had little input and control over how a change is implemented. Several nurses explained that a number of program changes weakened nurses' ability to anticipate and address health issues. For example, the provincial decision to discontinue universal postpartum home visitation impeded their ability to identify and mediate potential health issues, such as infant jaundice or maternal postpartum depression. Currently,

however, there is no means of tracking the level of investment, or divestment, in public health and PHNsg services across HAs to substantiate these PHN participant claims of budget cuts (Guyon & Perreault, 2016).

Nurses from all study regions also discussed the decline in professional development opportunities in their role. Many nurses explained how they were no longer provided with financial support to attend conferences, and to advance their knowledge by completing educational programs or certificates. They described the lack of investment in updating and refreshing services provided by PHNs, such as prenatal education, to ensure the credibility and usefulness of information distributed in their communities. Many nurses also noted the decline of educational presentations for PHNs by key speakers once brought in by HAs. PHNs were concerned about maintaining professionalism in their role and ensuring that what they offered to the community was current and best practice. Once again, PHNs were often told that there was no funding for these educational pursuits to support their practice.

It was changes in leadership, however, that were the most frequently reported organizational change that reduced support for PHNs in their role. Most nurses in this study stated that they no longer had a manager who had PHNsg experience, but instead had a manager from an acute care setting or with a business background. A few participants noted that the amalgamation of public health with the larger health system created the opportunity for changes in the type of managers overseeing PHNsg. Several nurses also noted that these managers were likely hired or reallocated based on the premise that they were skilled at accounting and measuring outputs, as well as their seniority within the organization. It seems that PHNs were not alone in being treated as interchangeable, because managers were too.

This shift in management affected support for PHN practice in several ways. Changes in leadership weakened advocacy for PHNsg within the organization because their managers lacked understanding of public health, population health, and the PHN role. Nurses also reported that they were no longer able to draw on the professional expertise of their managers to problem solve and to help them to think through complex practice issues, and were often questioned about what they were doing and why. A few nurses characterized this questioning as patronizing. Several PHNs explained that their managers did not value the foundational parts of their role, such as community advocacy. Due to their managers' poor understanding of public health aims, PHNs witnessed management decision-making that led to the narrowing of the PHN role and an increased clinical focus. For the few PHNs who had managers with PHNsg experience, changes in manager portfolios meant that managers were less accessible to PHNs. Expanding the scope of management portfolios meant that managers were no longer solely covering public health, but a number of other practice areas too, such as mental health and ambulatory clinics, multiplying the workload of managers. These managers were not often available to the nursing team to provide mentorship and guidance to support nurses providing care, and predominantly played an administrative role.

The changing of leadership reflected not only changes in the background and expertise of leaders, but also the rate of leader turnover. Many participants discussed that their managers were often only in their roles for short timeframes. One PHN reported having five managers in the last six years. The increasing frequency of leader turnover in health units was unsettling for nurses in this study. This not only created a sense of instability in the team, but also diminished PHN trust in their managers because these nurses believed that some leaders used their position as a means to attain higher-powered positions in the organization, and were strategic in their

decision-making in alignment with their career goals. Several nurses also attributed the turnover in leaders to the frequency of structural change in management within HAs, often altering who was responsible for each program. Participants explained that manager turnover, and the lack of trust, negatively influenced team culture and the ability to create a longer-term vision, important in addressing the broad determinants of health in PHNsg practice. Several PHNs stated that many leaders were driven by financial incentives, accolades, and self-interest, and much less so by the health and interests of the community. These PHNs noted that this was in contrast to how managers in the past were predominantly PHNs who worked their way from practice into leadership positions. PHN managers often remained in the same community, bringing with them not only professional knowledge but community knowledge and relationships to mentor other nurses, and as a guide to decision-making. The level of investment in the community was noted to be different among current managers who did not appear to share the same values or the inclusive and participatory nature of decision-making of prior managers who were supportive of community development and the PHN role.

Participants were concerned about their disconnection from leaders and the organization, but they also described several ways in which healthcare reorganizing had restricted their ability to connect with their community and with PHN colleagues. When PHNs were divided into different portfolios in HA2, several participants noted how they spent less time as a team supporting each other and reported feeling disconnected from other PHNs. In HA3, one PHN discussed how a new Chief Executive Officer (CEO) reorganized the administrative structure, shuffling and hiring new leaders, and cancelled all PHNsg practice meetings. PHNs were disconcerted that many new leaders no longer supported opportunities for PHNs to come together, to share practice issues and ideas, thereby weakening the connection among nurses.

Losing professional mentorship from both leaders and peers weakened support for PHNs, leaving some nurses feeling isolated in their role.

Several nurses also discussed the demise of province-wide PHNsg meetings and indicated that PHN leaders were no longer supported to gather in-person to discuss practice issues and programs, collaborate with Ministry partners, and influence the direction of practice. A few nurses framed the administrative decision to discontinue PHN meetings across the province or within regions on work time as a demonstration of power and authority, indicating that decision-making was to take place at the HA executive level. As a result, PHNs stated they lost connections with fellow nurses, as well as with Ministry partners, important in directing their activities. Many PHNs believed that their role was poorly understood and not valued or supported within the organization, and at times, they felt invisible. A confluence of organizational factors, initiated with the regionalization of the health system, have eroded the infrastructure supporting PHNs in their role, contributing to the basic social problem, *when it is no longer your call*. The series of organizational changes have also constrained PHNs' autonomy in practice, reducing their ability to address health inequities and improve the health of the population.

Loss of Autonomy

Many participants were concerned about the impact of organizational restructuring on PHN autonomy, and in particular, the negative effect on PHNs' ability to initiate and maintain relationships foundational to their role. Several nurses in this study explained how contextual changes have reduced PHN control in organizing their practice, hindering the continuity of relationships with individuals, families, and partners, such as schools. These nurses explained how they used to have more control over prioritizing their activities and authority in developing

community-based programs reflective of the community context. That is, they drew on their professional knowledge and skill, often in partnership with individuals, groups, and organizations in the community, to guide their activities and program development. Participants discussed several ways in which healthcare changes have eroded PHN autonomy and decision-making authority in their role, contributing to the basic social problem, *when it is no longer your call*.

Particularly concerning to nurses in this study was the number and frequency of organizational and policy changes, and the effect of these changes on the PHN role. A few participants indicated that, despite the fact that the responsibility of organizing and delivering most health services was devolved to HAs, funding came from the Ministry of Health. Thus, HAs were largely steered by provincial goals and mandates. Several participants stated that funding was often tied to targets, which they described as poorly defined and unmeasurable, directing leader decision-making and their practice. Even though responsibility for health services was devolved to the regional level, authority appeared to remain at the provincial level, and provincial-level decisions did not always fit with the local context. This did not reflect the purported intention of regionalization, which was to shift health services decision-making closer to home.

This balance of power was reflected in PHN accounts from all three HAs, when nurses discussed the increasing number of provincially-mandated programs and the impact on their role. Several nurses in this study explained that with the rise in mandated programs, combined with inadequate PHN staffing, there was less consideration and space for locally generated programs based on specific needs, demographics, and resources in the community. PHNs, however, pointed to the limitations of PHNsg programs and services that were conceptualized and

developed separate from PHNs delivering the programs, with little to no PHN input. A number of nurses in the study discussed that administrators often failed to consider fully issues such as the appropriateness, feasibility, and fit of new programs with what PHNs were already doing in the community. PHNs in this study believed that provincially-mandated programs were often too prescriptive, predetermining the focus of PHNsg practice irrelevant to context, and with little consideration of how such changes would influence the effectiveness of the PHN role in the community. For example, during my volunteer experience, a PHN explained that their team of nurses developed and implemented a smoking prevention program in local schools, but it was later eliminated with the implementation of the provincially mandated Comprehensive School Health program.

Several nurses in this study also discussed how the adoption of standardized processes within provincially-mandated programs undermined their autonomy. PHN judgement was undermined because standardized processes and assessment tools were privileged over other forms of knowledge in practice. Most nurses did not find these tools provided support and structure, and thus did not find them useful as a guide to practice. Instead, they interfered with practice. Some participants explained that these standardized processes directed how and when PHNs connected with individuals and families in their communities, not allowing for professional PHN judgement. Although PHNs embraced some components of mandated programs that worked well in their community, more often than not they believed that outside forces exerted too much control over, and created barriers in their role. For example, some nurses discussed that after the implementation of a provincial perinatal initiative, they were no longer allowed to connect with and support prenatal and postnatal women in their community unless the client had been screened through the central prenatal registry and was eligible for PHNsg

service. Many PHNs were concerned that these mandated processes, far removed from practice, created barriers to nurses connecting with a priority population in their community. The provincial shift to provide prenatal and postnatal home visit support solely to the most socially and economically disadvantaged women conflicted with nurses' view of their role in providing accessible care across the social gradient in their communities. Thus, organizational standardized processes used to determine who got care moved away from PHNs' professional judgment to determine appropriate and effective care for women and infants. Many of these changes coincided with changing of leadership.

As with a loss of support, discussed earlier, the changing of leadership also affected PHN autonomy. PHN participants stated that leadership changes within HAs constrained their professional autonomy. In all three HAs, participants described how the hiring of managers with acute care or business backgrounds had restricted their role in assessing, anticipating, and responding to health issues and promoting health in their communities. Many participants described how their "hands are tied" in the PHN role because their managers did not support many of their activities to prevent disease and support health at the population level because these managers appeared to be guided by the value of individualism.

Nurses across study regions were concerned about their ability to establish and maintain relationships with their clients and work across all levels, from individual through to population, due to such changes. Several PHNs discussed how these managers failed to understand the nature of PHNsg practice and activities, such as coalition building and improving population health, and thus directed nurses to abandon these activities. Participants believed that this was likely because they did not understand public health, population health, and the role and benefits of PHNsg practice. For example, one nurse in this study noted a conversation with a manager

that indicated to her this person struggled to understand the nature of PHNsg practice. The manager failed to understand the value of maintaining community connections and thus did not allow the nurse to participate in a specific community event, contrary to the nurse's professional judgement on the importance of community advocacy.

Many participants described how, with changes in leadership, they had experienced controlling management practices that restricted their professional judgement and decision making. Several nurses explained that they were instructed by their managers to request permission before taking initiative on activities squarely within their scope, and which they once did of their own accord. Many PHNs also indicated that these managers were more likely than managers who were PHNs to implement edicts from above uncritically, and limit the scope of PHNsg practice to organizational directives, with little consideration of the community context. A number of nurses characterized this behaviour as toeing-the-line, resulting in a top-down organization, which they reported to be commonplace across regions.

Participants indicated that leadership changes made it difficult for PHNs to practice autonomously because the punitive culture within the organization threatened PHNs and forced them to adopt organizational priorities and processes that were not congruent with their values or the Standards of Practice (CHNC, 2011, 2019) because they feared retribution. PHNs in this study believed management changes contributed to a narrowing of the PHN role and constrained PHNs' ability to empower their communities to better health. Restrictions on PHN autonomy contributed to poor PHN job satisfaction and low team morale. There was a growing sense of unease among participants that the PHN role was being eroded and they were uncertain of what was deemed PHN decision-making authority.

When managers failed to provide the opportunity and encouragement to connect with communities, PHNs reported a decline in relationships and partnerships in their local areas, which they deemed foundational to their role. Many participants discussed how leadership and program changes have limited PHNsg practice, and as a result, local community health issues went unaddressed. When this happened, PHNs felt powerless to help their communities to better health, and they saw worsening health outcomes, such as increased rates of mastitis, isolation, depression, and insufficient infant weight gain, that they believed could have been avoided. PHNs were concerned about the future of their practice because of their experiences of weakening trust, respect, and vision in public health within their organizations. Many nurses in this study recounted attempts to have their voices heard by leadership at a variety of levels within the HA, but they described how their concerns were often ignored, dismissed, and at times, silenced. Such constraints on PHN autonomy often affected their ability to be flexible in providing care for individuals and communities.

Loss of Flexibility

PHN participants described various provincial and organizational changes that resulted in a loss of flexibility within their day-to-day practice activities. Several contextual mechanisms that reduced PHN support and autonomy, also limited PHN flexibility in practice by controlling PHN time. Participants discussed the influence of contextual factors, such as reduced PHNsg budgets, more mandated programs, changing leadership, as well as an increasingly dominant organizational discourse of time and efficiency. For example, several nurses stated that PHNs were now scheduled into shift hours and breaks, reflective of nursing schedules in the acute care sector, limiting flexibility in their day. This change in scheduling was likely a reflection of the

unionized work environment, but it also could be the result of amalgamating healthcare sectors into one organization.

PHN participants across all three health regions referenced the increased use of the concept of time within administration, which was used as a tool to organize PHN day-to-day activities. Many nurses in this study described instances when they were told by leaders that their community-based activities were not a good use of nursing time, and that they were to withdraw from such activities. Several participants also discussed how PHN workdays had become tightly scheduled, such as immunization clinic time, with little open time to participate in their communities, as well as being required to request permission to work outside of scheduled hours. One PHN illustrated for her supervisor the need for schedule flexibility. The nurse pointed out that if a distraught woman comes into her office at 4:20 pm with a positive pregnancy test, she could not stop in the middle of the interaction to ask her supervisor for permission to stay late to support this woman.

Many nurses in this study were also concerned about the lack of organizational support for PHN initiatives in working proactively and problem solving in their communities. As one PHN indicated, "People [clients, families] have to come to us," because PHN time has been narrowed to programs and clinics offered in the health unit office, with much less time for outreach in the community. Many nurses were concerned about limited available time in their schedule to be active in their communities, building and maintaining partnerships, promoting health, responding to local issues, and working across levels of practice. Another nurse concerned about practice stated:

It's a hollow shell of what it was. We're not following through on anything. We're given some tasks to do and you have to do it...you have to fill in all the boxes and cross the

“t`s” and dot the “i`s,” that kind of thing, but we`re not actually doing care like we did before.

This nurse was frustrated because she used to have more independence in practice to engage in a range of activities, and was afforded the time to connect and follow-up with clients. Several nurses acknowledged that they respected the political climate of healthcare and the financial constraint within HAs, but the lack of understanding and the devaluing of prevention and population health by administration and leaders limited PHN investment in the health and wellbeing of their communities. PHNs were clear that they needed time to explore their community and establish relationships, and required freedom to innovate to be effective in their role. Nurses emphasized that community-based activities take time. The lack of organizational and manager support, however, resulted in PHNs engaging in community development and advocacy work, in what nurses referred to as “off the side of their desks.”

Many participants discussed having inadequate staffing to cover what they often labelled as the basics, resulting in minimal time to engage in activities beyond mandated functions. The basics referred to what they deemed as necessary components of their role, including mandated activities. For instance, several PHNs indicated that they had to complete postnatal contact within a certain time frame after a women and infant were discharged from hospital. However, they also noted that some activities that they considered part of the basics were not getting done, such as completion of the Edinburgh screening tool for postnatal depression. With inadequate staff, many nurses believed that they were failing to provide what they deemed essential components of their role. Several experienced PHNs mentioned how, when they had better staffing levels and more flexibility in their day, they were more effective because they had more time to anticipate and prevent health issues, while also engaging in health promotion, capacity

building, and advocacy for health enhancing policy and programs. Many nurses reported witnessing poorer health outcomes in their community, due in part, to the narrowing of PHN activities. For example, several PHNs reported reduced breastfeeding and immunization rates, a higher hospital readmission rate with breastfeeding problems and postpartum infections, and an increase in children's emergency room admissions. Nurses also discussed the potential for increases in problems such as teenage pregnancies, communicable diseases, high risk children being inadequately supported, and social isolation and depression.

Provincial level priorities, such as the implementation of Panorama, an electronic documentation system, have also influenced the flexibility of the PHN role. For example, many nurses in this study expressed concern about the introduction of Panorama because of the additional time it took to complete documentation, consuming time they once had for other activities. Several PHNs noted that expectations were clear from HA and provincial administration that PHNs were to use Panorama to complete documentation, and to access practice protocols and guidelines. Many nurses emphasized that capturing data was important, but the Panorama system was ineffective. Most participants described the computer program to be convoluted, poorly designed, and unreliable because the program frequently crashed or was often updating. Several nurses in the study also expressed concern that the computer directed their practice and interfered with their ability to connect with clients and families during appointments. They also noted that the program was inadequate because it failed to capture central parts of the PHN role, reducing their role to what could be denoted by a tick box. Many participants believed that management overlooked or failed to grasp the poor functioning and inadequacies of Panorama for practitioners. It is important to note, however, that at the time of data collection, Panorama had recently been implemented across all three HAs. Thus, this study

captured initial PHN experiences with the computer program and it is possible that, with time, their perspectives on Panorama could evolve.

Although not discussed as frequently as other changes, several experienced PHNs raised concern about the impact of the shift to specialist PHNsg practice from generalist PHNsg practice. These nurses noted this change because PHNs were divided between programs, and as a result, it decreased the breadth of PHNsg practice. This concerned some nurses because it meant that they were not involved in their community in a comprehensive way, and practice activities were often focussed on a segment of the population or a health topic. Some nurses also noted that in generalist practice, they felt they had a picture of the whole community, and as a result, were more dynamic. Not all PHNs were opposed to specialist PHNsg practice, however, because they explained that with specialist practice they were able to develop expertise in one area, compared to having some knowledge in many areas. In this study, urban practice was dominated by specialist practice, whereas rural practice remained largely generalist.

Nurses in this study were not alone in expressing their concern about healthcare changes that have eroded the PHN role. Public health leaders and advocates elsewhere in Canada have also sounded the alarm with regard to the weakening of public health locally, as well as on a broad scale (Guyon & Perreault, 2016; Potvin, 2014). PHN participants explained that healthcare changes undermined their effectiveness, professionalism, and authority in the role by weakening PHN support, autonomy, and flexibility in practice, detailed throughout the explanation of the basic social problem. Despite bleak descriptions from participants working within bureaucratic organizations in BC, nurses demonstrated agency in response to these changes, albeit buffeted by organizational forces. Through semi-structured interviews with PHNs working across three HAs

in BC, I developed a grounded theory to explain how nurses have managed the erosion of their role in health promotion and disease prevention.

The Basic Social Process: Managing the Eroding PHN Role

Participants were adept at managing provincial and organizational change that created the basic social problem and eroded the PHN role. PHNs described creative ways they, and their colleagues, responded to and worked through and around the challenges they faced. Nurses in this study demonstrated resilience and garnered energy to withstand, adapt to, and deal with change. They did so by leaning on colleagues, drawing on their collective strength as well as rewarding experiences with individuals and families. Nurses also remained steadfast in their role by holding onto their belief in the difference PHNs can make in their communities. Many PHNs were prepared to advocate for PHN services, founded on the belief in health and access to care for all, but they also knew when to retreat.

PHNs in this study managed the basic social problem, *when it is no longer your call*, by engaging in five strategies: *standing tall*, *getting by*, *going underground*, *contemplating getting out*, and *reaffirming commitment*. Participants used these strategies to navigate healthcare changes that undermined PHN support, reduced PHN autonomy, and restricted PHN flexibility, thereby weakening PHNs' practice. Nurses responded to, or managed system change that eroded their role to be able to provide continued care and support to their communities. However, at times, their actions became more about self-preservation.

Despite varying forms of organizational change, participant strategies remained consistent. PHN participants advocated for their practice in *standing tall*, worked within organizational constraints in *getting by*, subverted organizational barriers and harnessed their community connections in *going underground*, considered other possibilities in *contemplating*

getting out, and restored their dedication to the PHN role in *reaffirming commitment*. Each strategy was pivotal in explaining how participants responded to and managed provincial and organizational decisions and changes that they believed were counter to the values underpinning PHN work. Several personal factors shaped participant action within each of the five strategies, which are explored in the discussion of each strategy.

Nurses in this study explained that a number of external factors, detailed in the basic social problem, have altered the nature of the PHN role, impeding PHNs in practice. Thus, context is a central object of inquiry because this theory emerged from the experiences of PHNs operating within the healthcare system. Figure 2 is a depiction of the theoretical model and portrays multiple contextual factors that affected PHNs and PHNsg practice, and illustrates the strategies participants used to work through external changes shaping their role. It is important to note, however, that the model portrays a static picture, whereas PHNs in this study were clear that contextual forces influencing their role, as well as participants' action within and between strategies, were fluid and mutually influential across levels of the model.

Figure 2***A Theoretical Model of PHNs Managing the Eroding PHN Role in BC***

The outer area of the model represents provincial level factors that participants identified as influencing PHNs practice. Many of these factors were previously discussed in the section on the basic social problem, thus are noted only briefly here. For instance, PHN participants described the impact of an increasing number of provincially-mandated programs and provincial directives on their role. Several nurses in this study also indicated that healthcare restructuring, particularly regionalization of the health system in the 1990s, reconfigured the organization and delivery of healthcare across the province. They explained how the frequency of changing decision-making and management structures within HAs had affected the PHN role. Many participants noted the political climate of healthcare, with implications for health spending, and

in particular, the chronic underfunding of health and social services. The pressure on the healthcare budget was particularly evident with the decline in federal health transfers to provincial and territorial governments, leaving provinces to finance a larger proportion of healthcare (Fayerman, 2019; Times Colonist Editorial Board, 2019).

The Ministry of Health allocates funds to HAs and thus, provincial healthcare spending sets the stage for the funding climate in HAs. The Ministry provides stewardship to HAs, directing HA priorities and processes through provincial directives, such as mandates, targets, and priorities. Thus, HA administrations have authority to organize and distribute funds within the regions, however, HAs are accountable to the Ministry for spending and outcomes. Several participants explained how, with limited healthcare dollars and increasing acute care costs due in part to an aging population and expensive surgeries, other sectors, such as public health, have been sacrificed to fund what are often perceived as more urgent care demands. Many nurses in this study discussed the state of financial constraint within HAs, and the number of budget cuts directed squarely at PHNsg that has resulted in inadequate PHN staffing levels. These HA level factors, among others, are depicted in the outer ring of the model, and reflect the organizational changes that participants explained were significant in eroding the PHN role as discussed above in the basic social problem.

The adoption of organizational processes, such as standardization and centralization of programs and processes, and the hiring of leaders who were “toeing the line”, influenced the organizational culture that seemed to be established, in part, by the Ministry with a command-and-control style of leadership. Organizational values, however, particularly the value placed on public health by administrators and the presence of public health champions, also shaped organizational culture. Several nurses noted how they were once proud to be an employee in

their HA, but now they no longer felt that they were a valued member of the healthcare team. A number of participants characterized the organizational climate as toxic, in which they were devalued and marginalized. The sense of devaluing was partly due to the divisiveness created within the organization, whereby provincial organizational priorities and decisions that directly affected PHNsg practice were developed without input and insight from nurses who provided programs in the communities. Many participants explained how the silencing of nurses and their heightened fear of reprisal have weakened nurses' voices within the organization.

The confluence of provincial and organizational forces has negatively affected PHNs in practice, but nurses were often resilient and navigated their role in ways they believed were beneficial to the community, or necessary in difficult circumstances. Several personal conditional factors influenced how PHNs *managed the eroding role* and are represented in the second ring. PHN participants navigated the complex organizational terrain, based in part on these personal conditional factors that informed their decision-making and action. Participants were more likely to use certain strategies depending on their years of PHN experience, perceptions of the unit culture, appetite for risk, and explicit commitment to social justice, which included core PHNsg and public health values. In some strategies, personal conditional factors were woven throughout the explanation of the strategy, but other strategies required a more detailed description and were elaborated on in an additional section at the end of the strategy.

Provincial and organizational level factors, such as provincial mandates and changing leadership, depicted in the outer area and outer ring of the model, were also conditional factors that shaped participant action. For example, when leaders with PHN experience were still in place, they acted as a critical link between PHNs and the larger system. These PHN leaders advocated for practice, worked collaboratively with nurses to support community health, and

were considered integral to the team in guiding practice and fostering PHN autonomy, influencing PHNs' response to change. They also helped to protect PHN time, creating space for them to use their judgement (i.e., supporting PHN flexibility and autonomy) to address local needs and participate in community activities that nurses deemed important. Thus, provincial and HA level factors were responsible for eroding the PHN role, as well as shaping PHN action in response to changes in their role. In some strategies, these contextual conditional factors were woven throughout the explanation of the strategy, but other times they were elaborated on in a separate section at the end of the strategy, along with personal conditional factors.

In the center of the model, I depict the interconnected and overlapping strategies PHNs used in *managing the eroding PHN role*, the basic social process, to address the basic social problem, *when it is no longer your call*. I discuss each of these strategies in more detail below, beginning with the process of *standing tall*. I present these strategies in sequence but, as noted above, participant action was fluid within and among strategies depending on the nature of the change, as well as personal and organizational level factors.

Standing Tall

Participants used *standing tall* as one strategy in *managing the eroding PHN role*. *Standing tall* is about advocacy for the PHN role and adequate PHNsg programs and services to promote health and prevent disease and injury. For instance, PHNs addressed leaders about organizational changes negatively affecting practice and stood up for essential components of their role. Several PHNs were sure to note that many nurses were not against change, in fact, they embraced change when they could see how the change improved service and health outcomes. Participants voiced their concerns, however, when they believed an organizational or policy change undermined their practice by restricting their autonomy, weakening PHN support,

or reducing their flexibility. Nurses in this study stood tall to support and act on behalf of their communities, and worked to improve population health, guided by local knowledge and partnerships. Advocacy, in fact, is a core competency of both public health and PHNsg (CHNC, 2009; PHAC, 2007).

Participants stood tall with a range of approaches when changes occurred. Their actions included such things as seeking clarification and information regarding a change, informing leaders about current evidence and best practices, raising concern about the impact of an organizational change, and challenging and opposing a health service change. For example, one PHN explained how their team of specialized nurses collected and presented data to their leaders to demonstrate “look at what we [PHNs] do and look at the results” they were getting in the school setting. This participant indicated that if they did not show evidence of the difference that they made, “they would not be going into the schools and doing health promotion education or sexual health education or talking about relationships with the students” because they would not be supported by leaders. By providing evidence of their effectiveness in schools, these PHNs advocated for and maintained their role in the school. Several participants in other locations stated that nurses were no longer supported to provide health education in schools. At times, PHNs used a collegial approach to advocacy to share their knowledge and expertise to inform leader decision-making, while at other times, PHNs took an adversarial stance in opposition to leaders. In this way, *standing tall* was often an overt form of resistance. The underlying aim of this strategy was to have their voices heard and to work in support of community health and wellbeing.

Some PHNs engaged in *standing tall* to gain insight into the vision of a planned change and to understand the implications for PHNsg programs and services, as well as for the

community. Nurses often posed questions to leaders and sought the opportunity to problem solve together to clarify decisions and mandates. They did so in an effort to think through how the change would work in their day-to-day activities. For instance, over the course of several interviews, nurses discussed their efforts to understand the aim of new programs, to determine what was feasible within their context, how it fit with what they were already doing in the community, and what was possible within available resources. One participant explained how, “We [nurses] talk, we look at what we can do, try to get together and bring information forward that we think is inappropriate to our managers.” When they did not believe a change fit in their context, PHNs often requested additional information or insight to clarify or seek understanding and guidance in interpreting or problem solving a change. Nurses made initial inquiries to inform their viewpoint or seek mutual understanding of changes in practice and did not jump immediately to opposition.

Participants also used this strategy to bring information forward to leaders to address gaps in local service because of practice changes, with the intention of strengthening community support. Many nurses promoted components of their role and advocated for additional services when they believed community needs were going unaddressed. PHNs used knowledge from numerous sources to inform their advocacy work, such as community knowledge and partnerships, experiential knowing, and evidence from other programs and contexts. For instance, one PHN in this study identified the need for additional prenatal care in the community and discussed how she had been exploring with her manager the feasibility of implementing a prenatal program that she had delivered while working at another health unit. The nurse reiterated her conversation with her manager and stated, “Okay, what can we take from that [the prenatal program], that we could deliver here in [city] to improve our outcomes?” The nurse

presented to her manager the impact the program had on birthing outcomes in the other community. She indicated that together, they were exploring the availability of resources to deliver the prenatal program. The nurse felt respected and heard by her manager in thinking through the community issue and said, “And the fact [is] that my manager supported me in thinking that was a great idea; let’s see what we can do.” The program had yet to be implemented, but the nurse felt encouraged in being able to address gaps in services in her local community. This nurse engaged in *standing tall* in advocating to her manager for additional prenatal care based on her observation of inadequate services in the community, and was successful in her advocacy efforts. Universal prenatal care is a traditional component of PHNs practice that has more recently been discontinued in many regions of the province.

Participants also brought forward issues to their manager to defend their role when they believed a change would have negative health implications for their community. Many PHNs raised questions and requested further explanation from their managers with the intention to discuss the implications of a change. At times, nurses voiced their concern about a change, outlining the limitations of the proposed change, and shared insights about what was appropriate and applicable to the local context. For example, one nurse in this study overheard talk about a proposed change to how and what immunization records were being stored at daycare centers in her community, a population of focus within her specialized practice. She addressed the documentation changes with her manager, requesting further information regarding the change, and shared how certain aspects of the change may not work based on the nature of the population. The daycare centers in the community had large proportions of children from different countries, and the nurse was concerned about considerations for immunizing this population. She posed questions, urging her manager to consider the broader implications of the

record change, to no avail. The manager told the PHN that they were going ahead with the change. The nurse, unsuccessful in her advocacy attempt, was frustrated because the proposed change was developed without PHN input, and her attempts to share community-based knowledge were dismissed. This nurse believed there was pressure from the top for managers to implement the change.

Sometimes participants voiced their opposition to a decision or change. When nurses believed a change jeopardized their ability to provide effective care, some were confrontational in standing up for what they deemed was right for clients, families, and the community. This was particularly the case with several experienced PHNs who were explicit about their commitment to social justice. These nurses challenged leader decision-making by presenting the implications of such change for PHNsg practice and the consequences for health in their communities. For example, one nurse recounted a teleconference when leaders announced another round of reorganizing in which PHNs were being relocated away from the city center and other family and child services. She exclaimed, “I couldn’t get my phone off mute fast enough to say, ‘What about our partners? What about these partnerships that we have built up here at the center for so many years?’” PHNs in this health unit disputed with their leader about the decision to relocate the health unit, and outlined how PHN services would become harder to access for many clients, including hard-to-reach target populations. Other community partners advocated alongside these nurses to keep the health unit in the community center, co-located with other family services and close to schools. The participant reported that they were unsuccessful in their advocacy efforts because their concerns were ignored and leaders were going forward with the planned move. Nurses, at times, *stood tall* by voicing their concerns and pushing back against changes that they

believed would be detrimental to clients and PHN service provision but at times their push back was not effective.

A few PHNs in this study described other situations when nurses stood in opposition to a particular change by voicing their objection. When there was a direct cut to PHNsg programs that nurses deemed essential, with direct implications for worsening health outcomes, nurses often stood their ground and advocated with more force. That was the case when a group of nurses went to the public with their concerns about the elimination of sexual health clinics that they believed were an essential PHNsg program in their community. These nurses voiced their concerns and opposition through community channels and were formally reprimanded for their actions. They were reacting to the loss of service to their community, concerned about the negative impact, such as teenage pregnancy rates and rates of sexually transmitted infections in the community. One participant explained how nurses were basically told that they are not allowed to disagree with organizational decisions and practice changes. They felt that to do so would be to risk losing their jobs. These clinics were shut down, but some of the nurses obtained other positions to provide this service in their community. These nurses remained within their PHN positions, but picked up additional part-time employment to support this need in their community. Most nurses were cautious and seemed reluctant to discuss this form of *standing tall* and requested that I was careful in my reporting of this approach.

A few participants noted that even PHN managers engaged in *standing tall*, advocating for PHN programs and services, but were also subject to disciplinary action. One nurse in the study recalled how her previous manager, a PHN, challenged decision-making at administrative tables, and was reprimanded for her behaviour. Similarly, another participant explained how her previous manager, also a PHN with a history of voicing her concerns, was moved into another

role, leaving many nurses in the unit speculating as to the rationale for her relocation.

Although several nurses in this study indicated that more PHNs were needed in leadership positions, they also noted the reluctance of PHNs to step into those positions, due to what they saw as a toxic organizational climate.

PHNs stood tall individually and in groups. On an individual basis, many participants described how they had approached their manager or team lead, expressing their concerns about how the change directly affected their practice, such as restricting nurses' time to collaborate with local organizations. In this way, PHNs sought opportunities to be heard, and to learn the rationale for the change. Nurses wanted to have their professional and community knowledge heard, acknowledged, respected, and used to inform decision-making. For example, one participant commented on her manager's opposition to nursing participation on a local community committee to address youth concerns, despite the value of relationships with community partners working to address health issues. By being aware of local youth issues in the community, such as drug use rates, communicable diseases, and mental health concerns, this nurse explained how this information helped to guide her in partnering with other organizations to address shared issues. By explaining to her manager the importance of attending these meetings, this PHN provided the rationale and potential outcomes of involvement. Despite the discussion, she was directed not to attend the meetings. By working in partnership, PHNs learn more about local issues, and are better positioned to ameliorate adverse social and health outcomes, but not if they are restricted from partnering.

PHNs also came together in groups presenting as a united front when they shared concerns about a change. One participant explained how PHNs "found strength in numbers," when they presented their viewpoints to their manager in a meeting. As a collective, they drew

on nurse expertise, and felt more assertive and protected from reprisal. For example, several rural nurses came together to form a group to share local knowledge and experiences and to support each other. In one instance, this rural nurses' group addressed the implementation of the standardized Nurse Family Partnership (NFP) program, a provincial prenatal and postnatal program for high priority women with strict inclusion criteria that several nurses claimed did not fit with their rural context and practice. These nurses were concerned about how one nurse covered a vast region to offer the program, travelling great distances, and leaving PHNs locally feeling disconnected from high priority women in their communities. In this case, PHNs felt that decision-making was dictated by the characteristics of urban practice settings, with little consideration of how the program worked in other settings in the province. They also discussed the effect of the NFP program on local office coverage, leaving the non-NFP nurses with an increased workload. Non-NFP nurses had to pick up the workload from NFP nurses no longer engaged in other components of the PHN role. Nurses in the rural group explained how each context was different, and they required support and flexibility in provincial mandates to address unique community issues and deliver programs in a way that worked in their setting. Nurses often came together to present as a collective voice to have a more effective means of being heard and standing against imposed practice changes that undermined their role.

Conditional Factors.

A PHN's approach in advocacy was influenced by both personal and contextual conditional factors, which are depicted in Figure 2. There were four personal factors that shaped one's approach in *standing tall*. I present these personal factors as if they are distinct, but they often overlap. For example, some participants at later stages of their careers, operating from a social justice lens, with an appetite for taking risk, and in a strong health unit culture, were more

likely to engage in *standing tall*. Early career PHNs with a less developed social justice perspective, limited appetite for risk, working in non-supportive health unit cultures were less likely to *stand tall*, and more likely to focus on *getting by*. Nurses in this study also discussed how organizational level factors influenced their action in *standing tall*, in particular the presence of PHN leaders. They talked about the effect of changing leadership, financial constraint, and organizational culture on their use of *standing tall*.

Years of PHN Experience.

PHN participants with substantial knowledge and experience in public health, particularly nurses nearing retirement, were more likely than junior and mid-career nurses to take an oppositional stance in standing tall because they were more comfortable taking risks, were confident in their PHN role, and had a vision for the pursuit of prevention. As one participant noted:

I think in [city] they [nurses] are very good at advocating for their practice. I know that there are some very experienced nurses and I think that's probably also a very large part of it because they've been advocating for their practice and for their clients for a long, long time.

Several nurses explained how their years of service gave them a historical perspective and insights into changes unfolding within healthcare that junior nurses and those with minimal PHNsg experience would not have. They indicated that they had a firm grounding in the nature of the PHN role, and recognized important aspects of the role imperative for PHN effectiveness.

PHNs' depth of knowledge and long-standing community relationships also strengthened their advocacy efforts. The positive feedback from the community, and observing the difference they were able to make through PHN involvement reassured them in their activities. A number of

PHNs in this study discussed how nurses who were hired into public health from an acute care setting may have years of nursing experience, but often struggled with the shift from an individual to a population orientation. One PHN manager explained this well when she stated, “It really is often a challenge for some nurses, especially ones that may have come from acute where your work is task driven and you’re following orders.” Some less experienced PHNs had difficulty grasping the broad components of the PHN role, such as community development and advocacy, rooted in values of social justice, and were less likely to take an oppositional approach in advocacy.

Social Justice Lens.

Several nurses were candid about the social justice foundations of their practice. When nurses viewed the PHN role as founded explicitly on social justice and equity, they were clear about their role and responsibility to promote health, through means such as community participation. Guided by a moral compass, many nurses looked to work in partnership with other organizations to tackle community issues effectively, and took a stand against changes that weakened the social safety net, such as reducing access to PHN services. It was evident that these nurses believed in universalism, and felt compelled to provide adequate and effective care to all, with a focus on, but not exclusive to, those with higher levels of need.

One mid-career PHN demonstrated her social justice orientation when she pushed back against decisions that weakened her harm reduction role. She described how she worked with her community partners to address the high levels of substance use in a rural community, and explained that she was no longer supported to participate because the emergency department was taking over the service. In advocating for her role, this PHN explained to her manager how emergency department providers did not have time to offer harm reduction, and were not able to

do outreach to these clients in the community. This nurse explained how she had developed relationships with such clients in her community, was working with partners using a harm reduction approach, and together, they were making progress. Her attempts to justify her involvement and to explain the limitations of the service change proved futile, and as a result, she engaged in alternate strategies, such as *going underground* in her activities. How PHNs responded to feeling ignored and undermined in their role, was also influenced by a nurse's willingness to take risk.

Appetite for Risk.

Nurses' appetites for taking risk were largely influenced by their years of experience. Experienced nurses were more comfortable taking risks because they did not feel as threatened in losing their job. As one mid-career participant noted, she still, "had to put food on the table for her family." A few experienced nurses who witnessed the slow erosion of prenatal education and universal postnatal support to women and families pushed back against cuts to these programs and voiced their concerns with force because they anticipated that these changes would lead to worsening health outcomes. Nurses were also more willing to take risks, such as presenting an oppositional stance, when they presented as a group. A nurse's appetite for risk taking in *standing tall* was often associated with an explicit commitment to social justice, and a positive health unit culture, particularly with the presence of supportive nursing leadership.

Health Unit Culture.

When participants were employed in an organization with strong public health leadership, they were steadfast in their role in promoting health equity, in part, because they were supported in this way of thinking. HA3 in particular had a noticeably strong public health and PHNs heritage in advocacy throughout the organization. Multiple participants noted the longstanding

strength of nursing and public health leadership within HA3 and how it bolstered nurse momentum in taking a stand for public health aims.

One PHN in HA3 explained how, in her health unit, nurses were still offering universal postpartum home visitation to new mothers. She indicated that, despite provincial pressure to minimize home visitation, they continued to provide this follow-up service when they deemed it appropriate. This participant stated, “So seeing the push for less home visits and seeing in [HA3] how the nurses are pushing back because we still have the autonomy to be able to make that decision as to who gets a home visit.” This nurse explained how her PHN manager continued to protect time for, and champion this service in their communities. In this situation, these PHNs still felt empowered in this area of professional decision-making, despite the external pressure to cut services. This nurse, however, was concerned that current restructuring and reshuffling of management portfolios would compromise the strength and quality of nursing and public health leadership to which they were accustomed.

Changing Leadership.

Many participants discussed the critical role of leadership, in particular, the pivotal role of PHN leaders, and demonstrated how it shaped PHN action in *standing tall*. How leaders responded to nurses’ efforts in advocating for their role and providing adequate services in their communities had a significant influence on nurses’ experiences of organizational and policy change, as well as their subsequent action. For instance, when PHN requests for further clarification and discussion regarding a proposed program change were met by a leader willing to listen to PHN views, and engage in an open and inclusive conversation, nurses felt acknowledged and respected in the process, and remained empowered in their advocacy efforts in *standing tall*. When nurses’ attempts at *standing tall* were met with resistance, disregarded, or

reprimanded by leaders, nurses often became frustrated and felt disempowered, at which point many nurses shifted to other strategies, such as *going underground* in their activities.

Nurses were more likely to take an advocacy role by putting forward their views and concerns when they had strong nursing leadership because they trusted that their nurse leader supported and respected them in their role, and as a result, they were less likely to resort to other strategies because they were successful in their efforts at *standing tall*. This was often the case when nurses had managers with PHN experience, who valued PHN professional knowledge and judgement. For example, one PHN manager explained how, by working with her nurses and hearing their concerns about attending various community activities, she implemented a flexible schedule to support PHNs to work outside of regular health unit hours and into the evening. Similarly, another participant explained how she raised concerns about the need for time in her day to connect with priority families in her community, and in doing so, her coordinator created some space in the PHN's schedule for non-clinic activities. In these instances, PHNs were successful in voicing their concerns about limited time in their schedule to participate in community initiatives or address needs, maintaining a sense of autonomy, because their leaders found ways to support them to make it work.

When nurses and leaders shared a vision regarding prevention and population health for the community, even amid unfavourable organizational change, participants felt heard when they voiced a concern, and worked together to support community health. At times, however, some managers ignored, dismissed, or punished PHNs in their attempts at *standing tall*, leaving nurses feeling silenced and devalued. Many participants described the hiring of leaders who had no experience or knowledge in public health, but demanded control over PHN practice and instructed nurses as to what was a good use of nursing time. Several nurses in this study

perceived these managers to be preoccupied with balancing the budget, having no real investment in or commitment to supporting PHNs in practice. One PHN described her experience of writing a letter to management explaining an issue of importance. This PHN stated:

I'd be really afraid to write a letter because, I'm trying to think of what I did, I wrote a letter once about something. And I did get my hand slapped. I actually... whenever you write to upper management it immediately, it goes back to your manager.

Many new managers instilled a sense of fear in those who did not obey, thereby stripping PHNs of their ability to advocate within the organization. Another participant expressed concern over the muzzling of PHNs in their efforts to ensure adequate support and care, and stated that, "There's a tremendous sense of feeling that publicly speaking out, but definitely criticism, could be really detrimental to your job." As a result, a number of PHNs also explained that they were unsure of where to direct their voice to be heard, stunting their advocacy capabilities. Changing leadership, as well as financial constraint, influenced PHN advocacy efforts in *standing tall*.

Financial Constraint.

Every nurse I interviewed had experienced some level of frustration in the face of recent changing organizational contextual factors affecting the PHN role, particularly financial constraint, that resulted in nurses *standing tall*. Lack of public health funding within HAs was a key contributor to this frustration, leading participants to advocate for more resources. Every nurse in this study pointed to the lack of funding for PHNsg programs and services, as well as inadequate funding for adequate staffing levels across regions. Several nurses indicated that the state of financial constraint unfolded largely after 2005. However, PHNs in this study did note

some variation in PHNsg resources between HAs. Again, HA3 was perceived, not only to have stronger nursing leadership, but also to have better PHNsg funding.

Many nurses informed their leaders about the implications of inadequate services in the community and the consequences of their decisions to reallocate funding. For example, one PHN who specialized in sexual health attempted to bring attention to youth sexual health needs in her community and brought forward the issue to her manager. This PHN identified high teen pregnancy rates in the community. She realized that many teens did not have access to a primary care provider, and took steps to address youth sexual health needs in her community. She described multiple failed attempts to make headway on this project, organizing with partners, and they remained stalled without the approval to move forward due to lack of financial support. Financial constraint played a large role in shaping PHN practice and led many nurses to *stand tall* advocating for additional and sustained investment into community programs and services, along with organizational culture.

Organizational Culture.

With the turnover of leaders and the hiring of leaders with predominantly acute care and business backgrounds, many participants noted how it has contributed to an organizational culture characterized by top-down decision-making and toeing-the-line. The hiring of managers lacking public health or PHN expertise and experience, and their nature of decision-making and communication made it difficult for PHNs to *stand tall*. One participant exclaimed that, in her workplace, there is “a history of being told to shut up,” and a sense that PHNs are “always shut down.” Several nurses described a looming threat of disciplinary action, with stories about such actions etched into the minds of nurses. This resulted in some reluctance on their part to question and push back against decision-making, and eroded nurses’ trust in their leaders. As a result,

participants witnessed decisions that were not informed by the local knowledge and skill of PHNs, leaving many nurses demoralized by the state of their role, and turning to other strategies and avoiding interacting with administration.

Summary.

Participants described various ways in which they *stood tall* in their day-to-day practice. They talked about both the positive and negative effects of advocating for their role as PHNs, in an effort to support the health of their communities. PHNs who *stood tall* did so with a belief in the value of PHNs to connect with and support communities to better health. Many nurses in this study expressed the need to take a long-term view and to invest in communities to improve population health. PHNs felt strongly enough about their role, and ultimately, the health and wellbeing of their communities, that they were willing to stand up and voice their concerns in the name of health, often times at the expense of their own wellbeing.

Nurses in this study believed in the role of PHNs and the difference they can make by working across levels of practice. Many nurses made efforts to stand up for those values and beliefs. Several PHNs indicated, however, that there was only so far they would go to challenge their leaders because they feared negative repercussions. Many of these nurses also believed such efforts to be futile in changing the decision, which they say has resulted in low morale across many health units. When nurses' voices were overlooked, disregarded, or silenced within the organization, they adjusted and redirected their energy. Several nurses indicated that they continued to find ways to connect with and offer support to clients, often through involvement in other programs, by engaging in other strategies. When unsuccessful in *standing tall*, PHNs turned to other strategies, such as *getting by*, to *manage the eroding PHN role*.

Getting By

A second strategy in *managing the eroding PHN role* is *getting by*. *Getting by* refers to proceeding without attracting criticism or punishment; participants did what they could to maintain high quality PHNsg programs and services within the confines of organizational edicts that eroded their role. Part of the process of *getting by* was also about taking the time to figure out what one could and could not do within a policy or practice change. Participants often engaged in this strategy, in part, based on fear of retribution for *standing tall* within HAs. Within this strategy, nurses, at times, were passive in their action, while at other times, they were active.

Many nurses in this study adapted to organizational and policy changes shaping their practice, typically because they saw these changes as outside of their control because the decisions had already been made. For example, with the implementation of the NFP program and the pressure to discontinue universal postpartum follow-up, several PHNs did their best to adapt to reduced perinatal contact with high priority women in their communities, and to shift to telephone assessment and support. Many nurses explained that they worked to provide care within the limitations of their setting, and remained patient, looking and waiting for opportunities to collaborate with community partners to improve health.

Not all changes, however, conflicted with CHNC (2011; 2019) Standards of Practice and PHN values, nor did they require PHNs to *get by* in practice. When a proposed change fit well in PHNsg practice and PHNs could see how it improved service and health outcomes, they skillfully adjusted their practice to reflect such change. This was the case with the Back to Sleep campaign, and PHNs educated families to put their babies to sleep on their backs to reduce the risk of sudden infant death syndrome (SIDS). In another example, one nurse explained how her team accommodated a change in practice by integrating a new immunization schedule. They did

so seamlessly because they understood the rationale, had the necessary resources, and could see how the change improved health in the community. In these situations, there was no need to *stand tall* or *get by*. PHNs did not disagree with all HA-based decisions, but they often found the lack of consultation and inclusion of PHNs in the decision-making process, as well as limited resources, to be a significant barrier in bringing changes and programs to fruition.

Getting by is closely related to the category *standing tall*. Participants engaged in *getting by* when the threat of *standing tall* was perceived to be too great, or when PHNs became frustrated by *standing tall* and deemed such efforts as futile. Some nurses lost confidence that they could change or influence decisions that had been made when advocating for their role. When PHNs perceived *standing tall* as a perilous activity, they redirected their energy into other strategies, such as *getting by*.

Participants demonstrated how they moved from advocating for their role and activities, to doing what they could within the confines of their practice. For example, one nurse described how she went from *standing tall* to *getting by* in her activities. She stated:

I had a lot of uncomfortable conversations with the coordinator, saying I can't do all these programs and still see my families. She was trying to protect resources. Finally, I stopped having the conversations and I just decided to do whatever I can do.

After voicing her concerns about the inadequate time to follow-up with priority families in her community, this nurse recognized that she was not going to be supported to provide what she saw as essential to promoting health and preventing disease and injury. At this point, she redirected her efforts to figuring out how she was going to make time to support these families in her day. When nurses believed they were not going to be supported by leaders, they looked for other ways to provide care.

Getting by is composed of three subcategories: *adjusting to change*, *finding a way*, and *treading cautiously*, reflecting the ways in which PHNs adapted within change. These subcategories are presented as discrete, yet often overlap. Several conditional factors, such as years of PHN experience and changing leadership shaped how PHNs engaged in this strategy. In *adjusting to change*, conditional factors are discussed in a separate section at the end of the strategy because it required a more detailed description. Conditional factors in both *finding a way* and *treading cautiously* are woven throughout the strategy. I discuss each of the subcategories further, showing the types of activities involved, and demonstrating how they relate to the basic social problem.

Adjusting to Change.

One way participants described *getting by* was by *adjusting to change* in their role. In *adjusting to change*, participants used their professional judgement, to the extent possible, to adapt their practice in light of an organizational change. Depending on their circumstances and the nature of the change, PHNs discussed how they used their professional judgement to decide how to incorporate organizational priorities into their day-to-day activities. After failed attempts in *standing tall*, and in an effort to avoid criticism, PHNs were sometimes passive in their response to adapting their practice activities.

In the context of several program changes, including inadequate PHN staffing, participants described how they had to adjust their activities, often letting go of some components of practice. As one participant explained, “Economically, we just don’t have as many positions and so we’ve had to shift how we do our practice because the financial backing isn’t there anymore.” Many participants described how their practice had become focussed on priority populations, and less on the general population because of limited resources. That is,

they were mainly involved in targeted programs, and less often in universal programs. A nurse described this scenario well when she stated:

I mean if we had a larger team, we could afford to take on more clients and just give them better support. But because, with every contract and with every budget cut that needs to be made, we have to adjust so that our normal, healthy folks don't get the kind of service that they used to get.

Many participants also explained how they had to adapt their activities with mandated programs, often at the expense of broader components of the PHN role, such as community development and advocacy. With fewer PHNs and less organizational support for nurses' involvement in community development work, a number of participants explained how many people in need were not receiving the support they required and deserved. A number of nurses in this study described how practice changes have often unfolded slowly and in pieces, and how, at times, it was not until much later that they realized the compounded effect of several organizational changes in compromising PHN care.

Many PHNs described how they had to let go of components of practice in their communities that they were no longer supported to provide. For example, with the implementation of Comprehensive School Health across the province, PHNs in some regions were no longer allowed to visit local schools because they were to assume a referral or information sharing role, or because another public health person took over the school liaison. One participant referred to the newly created local position, the public health school collaborator, who took over local school visits. PHNs in many regions were no longer supported by their leaders to visit local schools, forsaking partnerships that nurses had developed over many years. Another nurse described how she was no longer supported to offer universal home visitation to

connect face-to-face with new mothers. This nurse was not alone, and several PHNs discussed how the shifting focus on perinatal clients with higher needs was at the expense of universal support. This shift to a targeted approach, at the expense for universal follow-up, could result in PHNs missing other health concerns faced by those without such risk factors, such as intimate partner violence, postpartum depression, and rising bilirubin levels, which may not be connected to poverty, education, or other social and economic risk factors.

Participants also spoke about how PHNs had fewer opportunities to see people outside of the health unit, and activities became more focused on one-to-one care. For example, several participants explained how some group programs were eliminated at their offices in favour of one-to-one support on an as-needed basis. These nurses discussed how they were required to let go of activities, such as prenatal classes and breastfeeding support groups, and instead PHNs were instructed to offer support on an individual and *ad hoc* basis, but the number of clients receiving this support was reported to be dwindling. A small percentage of young, first time pregnant mothers who met specific criteria were eligible for one-to-one prenatal support through the NFP program. Several PHNs I interviewed discussed how they had witnessed group programming as helpful in connecting mothers and children to others in their community, building resilience in clients by developing their support systems. Nurses felt that the value of such benefits was often overlooked within the organization. They explained how these programs offered more than health education, guidance, and a relationship with the PHN. PHNs perceived that by bringing together people who were sharing a similar experience, connections developed between clients and families that continued after the end of the group program. Regardless of their belief in the value of group classes, PHNs initiated and maintained connections with

perinatal women on an individual basis whenever possible, and encouraged mothers to meet in the community to develop a support system.

Some PHNs explained how they had to let go of components of practice because of lack of resources. Many PHNs stated they were constrained in providing what they perceived to be adequate service. One PHN stated, “and because the other resources aren’t there, then often we go home at the end of the day realizing that there’s so much more we could have done but we just haven’t been able to anymore.” Another participant explained how she was struggling to meet the scheduled clinic time while also supporting priority families in her community, because there was no protected time in her day to do so. She discussed her dilemma of having to decide what she was going to let go of in her day. She explained the day-to-day problem solving of practice and working within the time constraints this way:

Every day you juggle. I think that’s true of most nurses, but being in Public Health for 20 years, the juggling now is so much more intense. Yet, it’s frustrating. The trend I’m seeing, because I work casual as well, so I go to all the health units. And when you’re constantly faced with the barrage of juggle, juggle, juggling, the ethical dilemmas. Do I do my program? Do I get somebody to cover for me? Will anybody cover for me? Because they [other PHNs] are pissed off at this point because they’re always covering for me because I’ve got some crisis with my family [client]...or do I let something slide? Do I let something slide? What am I going to let slide? Because I just can’t keep this up forever.

This nurse talked about having to accept that she would not be able to maintain the same contact she once had with families. At times, PHNs had to let go of providing the level of care in their communities they believed necessary. As a result, many of these PHNs believed that they were

providing inadequate care, and perceived people to be falling through the cracks in community services. In *adjusting to change*, many participants were upset because they felt they were losing relationships in their community that were central to PHN effectiveness.

In addition to letting go of parts of their role, many participants described the process of accommodating new programs or directives. When new programs were implemented, PHNs used their professional judgement to prioritize activities and determine what aspects of the program worked in their role, how the program fit with what they were already doing, the level of resources available to them, as well as what parts they felt they had to do, and what parts they could overlook if necessary. Many participants also discussed how nurses came together to problem solve how directives could work in their setting within the available resources. With less guidance and support from leaders, PHNs drew on their network of expert and experienced nurses.

Participants *adjusted to change* with varying degrees of reluctance, and at times, disregarded a change that they deemed poor practice or irrelevant. At other times, participants described adopting only some aspects of a program or directive when they perceived that certain parts did not fit for the client or that it was not the appropriate time for the intervention. Some nurses did not implement a component of a directive until they deemed it appropriate because it did not fit into what they believed was good care. For example, one nurse felt screening for intimate partner violence during an initial encounter was too intrusive and interfered in developing a trusting relationship with a client. She explained that, based on a woman-centered approach, such screening was thought to be harmful during a first meeting. This PHN drew on best practices from her time working in another institute that specialized in women's health. If the nurse, however, did not have another opportunity to connect with a client, the opportunity to

assess and support this client could be missed. PHNs' professional judgement often informed how and when they implemented aspects of a program. PHNs used their professional knowledge and experience to *adjust to change* in delivering programs and services, as well as in accommodating new activities.

A number of participants also noted how PHNs have had to accommodate additional administrative activities because of changes in managers. One participant discussed how, with the high rates of manager turnover and increase in manager portfolio sizes, experienced PHNs were taking on management tasks, such as scheduling and organizing within the team, because their manager was not around. Some nurses took on more responsibility to support the functioning of their team, but they were clear that the lack of leadership was disruptive to planning and supporting day-to-day operations in the health unit offices. When managers were not available or when nurses were without a manager, they came together to problem solve local issues and to support each other the best that they could.

Participants often felt devalued in the process of *adjusting to change*. Not only did PHNs witness reductions to many of their services; several PHNs also discussed the inadequate opportunities for professional development, and far less support to engage in continuing education. Once again, they turned to each other for support in clinical decision-making, and looked for outside opportunities for education to enhance their programs. They felt the dwindling opportunities for professional development reflected not only inadequate resources, but also a devaluing of PHN programs and services in the organization. Participants often grieved the weakening connection with clients, families, and partners throughout their community in the process of *adjusting to change*.

Conditional Factors.

PHNs adapted their practice within the confines of the organizational constraints based, in part, on a number of conditional factors. Personal and contextual level factors outlined in the model, such as years of experience, changing leadership, and mandated programs shaped nurses' action in this process. It is important to note that these conditional factors often affected PHN action in each strategy in different ways.

Years of PHN Experience.

Several experienced PHNs commented on how less experienced PHNs, whether they were younger nurses or from another clinical background, were more willing to cooperate with, and uncritically adopt organizational edicts into their practice. For example, after outlining a recent discussion in her HA to incorporate home care nursing tasks, such as dressing changes, into the PHN role, one young participant stated that if an older PHN in her unit, "doesn't adapt to it, she's going to be out of a job."

For some nurses, meeting organizational standards and expectations was internalized as, and became a benchmark for, effective nursing practice. This level of assimilation left some participants, often experienced nurses with a strong social justice perspective, unsatisfied because they believed their professional responsibility included outreach and community development work. Some participants perceived these younger and less experienced nurses who did not have a strong theoretical or practice base in PHNsg, as more willing to adopt practice change, overlooking the processes undermining the PHN role.

Changing Leadership.

Several experienced PHNs also noted a trend in management hiring practices, with the increased hiring of nurses with little public health experience, and at times, young nurses. These

participants believed this to reflect leaders' desire for nurses who were more compliant and accommodating of organizational priorities and decision-making. Several PHNs also discussed how some nurses were praised for their efficiency in delivering service and completing electronic documentation, whereas some older nurses were criticized for being too slow with computer tasks and for not being obliging. These older nurses recognized the benefits of electronic documentation, but were concerned with the inefficiencies of the documentation system and the time it took away from providing care. Several participants noted competing priorities between efficiency and quality of care within their workplaces.

Mandated Programs.

Although nurses often agreed with the theory and evidence underpinning provincially-mandated programs, they raised concerns about how the program was implemented. A common thread across mandated programs was the PHN view that these policies often failed to consider the local context in which they were implemented. One example of a provincially-mandated program that had recently been reintroduced across the province was the Comprehensive School Health program. How this program was implemented between settings looked quite different. To some nurses, the implementation of this program led to less or no involvement in their school, while for other nurses, it led to more. PHNs in rural settings, who tended to have a generalist practice, described how some policies did not fit in their context. They argued that these policies were more appropriate for urban settings where there were more nurses and PHNs were often specialized. That is, some nurses discussed the difficulty implementing components of the Comprehensive School Health Program with only one rural nurse and limited resources, compared to a group of PHNs in an urban community dedicated to the school-aged population. This generic development of policy that did not take the local context into account, often failed

to consider what might have already been in place, or what the local school district felt about it, making it difficult for PHNs to *adjust to change*.

In another example, several nurses discussed the provincial implementation of the NFP program. In this program, backed by extensive longitudinal research in the US (Olds, 2006), PHNs provided intensive support to young, high priority, first time mothers prenatally and for two years postnatally. These PHNs indicated, however, that there were no new resources to implement the program, requiring non-NFP PHNs to absorb the previous workload of the NFP nurse. In several offices, a part or full time PHN was used to implement the program, but, given the strict research criteria of the program, this nurse was not permitted to help out other PHNs with postpartum services, even when the nurse had spare time. Nurses reported that this lack of flexibility in the program caused division within the team because the rest of the PHNs had to adjust their practice to take on additional responsibility, including supporting other high priority families in the community that did not meet NFP criteria.

Provincial Directives.

Nurses across the three HAs in this study spoke about the frequency of organizational and policy change. Several nurses characterized changes as “the flavour of the month”, suggesting a high rate of change within their organizations. A few PHNs noted recent changes in provincial guiding frameworks, and the implications for nurses and leadership. For example, one participant discussed how there were many useful program ideas within the provincial level Core Functions Framework and Model Core Program documents, introduced in 2005 to guide public health renewal across the province. However, she described how nothing really changed in their practice, and yet a great deal of meeting time was invested into planning and coordinating program change. This nurse perceived that there were no new resources and insufficient direction

to implement any real change from the policy. With subsequent shifts in policy, and the perceived lack of commitment from leadership to see any real change through, nurses began to disregard the hype and fanfare around such policy initiatives. Some nurses talked about tuning out, or not buying into the level of change or promises within organizational and provincial rhetoric.

Within a context of limited resources, PHNs *adjusted to change* by using their professional judgement to prioritize their practice activities. As a component of *getting by*, nurses did what they could to maintain high quality services while often letting go of parts of their role because of fear of reprisal in *standing tall*. Throughout *adjusting to change*, nurses described situations where they struggled to balance organizational directives and local community need. Within a landscape of shifting policies, many nurses adapted in their role, but they also focussed on *finding a way* to connect and maintain quality of care within organizational constraints.

Finding a Way.

At the same time as *adjusting to change*, another way many PHNs described *getting by* was by *finding a way* to maintain connection to and support in their community amidst organizational change eroding their role. These nurses worked towards *finding a way* to provide support to their communities by being creative within the limits placed on their role, as well as by going outside their role. Many participants, particularly experienced PHNs, were resourceful in their efforts to *find a way* to work within and around change that eroded their role to build relationships and support clients without upsetting administrators. At times, PHNs had to go outside of work hours to do so. These nurses tried to maintain their view of the bigger picture to work collaboratively to address health and social needs within their narrowing role. PHNs who

seemed to be defeated by recent changes were more likely to respond passively by *adjusting to change*. They did not engage in *finding a way* to the same extent as more resilient PHNs who had a firm sense of the PHN role, based on many years of experience in the community, and a stronger and more supportive team led by a PHN leader.

Many participants worked to find ways to establish and maintain relationships with people in the community to promote health, albeit with increasing difficulty. These PHNs recognized that organizational and leadership changes were restricting PHNs practice, yet many nurses remained focussed on what they could accomplish. They made the most out of each opportunity to connect and interact with clients and partners. For instance, one PHN explained how she directed her energy to connecting with clients and families during increasing clinic time, and made the most out of these opportunities to establish and maintain relationships. This participant said, “And just how I do my work in clinic. There`s a lot you could do in public health, it`s just how you do it, and you have to do it in the boxes you`re given.” She acknowledged the restrictions placed on PHNs in their practice, but highlighted how she capitalized on the opportunities to connect that she did have. Another PHN explained that, with the reduction in prenatal contact, she focussed on initiating relationships with mothers and families during childhood immunization clinics to assess whether families required additional support. With the implementation of new mandated programs, PHNs witnessed several of their perinatal programs eliminated or replaced with telephone assessment, leaving many PHNs *adjusting to change* and *finding a way* to maintain service in their communities.

When PHNs were presented with practice issues, they often worked together with PHN colleagues to generate solutions. They drew on the expertise and resources within the group of PHNs to think through how to address issues. For instance, one PHN explained how nurses in

her unit were upset with the decision to remove a telephone support line for families with newborns. The team of nurses brought forward the idea and initiated a one-hour daily phone line to support these clients. She stated:

Even with the removal of the [telephone support line for families with newborns], oh we still have our info nurse, our drop-in nurse, who do one hour a day. Our solution was one hour a day we'll have a nurse available for any questions. We'll do ECP [emergency contraceptive pills], or if they need a pregnancy test, any questions. By and large, it's mostly phone calls about babies, so I guess in our little way, we still brought back that [telephone support line for families with newborns], even if wasn't directly labelled as such.

This group of PHNs came together and worked creatively to address a practice issue, *finding a way* to make it work for their clients, and continued to serve the community after a program was eliminated.

A number of participants explained that they were committed to figuring out ways around changes that restricted their ability to connect, even if it meant they did so outside of work hours. These nurses worked diligently to explore possibilities in practice. For instance, several PHNs discussed connecting with other PHNs outside of work hours. These nurses were looking to reconnect because they used to come together in a number of ways that were no longer supported during work hours. One PHN discussed how she had been connecting with other PHNs outside of work hours to hear about what had been going on in their communities, to support each other, and to share practice ideas. She had been brainstorming ways to continue to meet face to face with more PHNs, believing that after meeting in person they were better able to maintain that

connection remotely. By working around restrictions disallowing PHNs to come together, these nurses found a way by going outside of work time to maintain support between nurses.

Another PHN demonstrated her commitment to support her community when she discussed going outside of work hours to provide sexual health services after the elimination of the sexual health clinic in the community. She explained how PHNs got together and found a way to continue to provide the needed service, but they did so outside of their job in public health. These nurses helped to establish a sexual health clinic in their city that was independent of public health. Once again, another PHN, identifying high teen pregnancy rates in the community, felt so strongly about providing sexual health support to teens that she took the initiative to expand her knowledge on her own time and at her own expense. This PHN personally paid for a contraceptive management course, funding for which was denied by management. These PHNs felt so committed to issues of social justice, prevention, and health promotion, that they would do this on their own time and at their own expense.

Several nurses were also committed to supporting and mentoring younger and less experienced PHNs, as well as others, such as community partners, in the pursuit of building capacity and addressing issues of health and wellbeing in their communities. One PHN described how she tried to do her work in an inspiring way, to lead by example in her health unit, in hopes that it would help others to hang onto broader aspects of the PHN role. She talked to other nurses in her office about how she worked with partners in the community to advance projects of mutual interest. Several other participants talked about needing to tell their [PHN] story, to share with people how PHNs' practice can make a difference in the community, to garner support for public health and the PHN role.

Individually and collectively, nurses continued to focus on ways they could lay the foundation for PHNsg programs. They did so to meet local issues and build connections to promote health in their community, often at their own expense. A few participants mentioned the aid of PHN leaders in supporting nurses to be creative to work within the constraints. When leaders and PHNs problem solved together and shared a common vision, participants *got by* with less resentment and were less likely to *go underground* in their activities.

In *finding a way*, some PHNs took the initiative to look for solutions to changes undermining their role. Several participants explained how nurses were creative in their efforts to maintain relationships and support within external limitations. These nurses showcased the resourcefulness of their colleagues and their commitment to come together to maintain a population focus within a narrowing role. However, many PHNs found maintaining relationships increasingly difficult with inadequate staffing levels, and with changing leadership exerting tighter control, and decreasing the flexibility in PHNsg practice. In light of tighter control over practice and an increasingly punitive culture, at times nurses were cautious in navigating their roles.

Treading Cautiously.

Within *getting by*, several PHNs discussed how nurses often felt insecure in their role, given what they saw as a punitive organizational culture. This sense was, in part, based on nurses' experiences in *standing tall*, and the sense that they could be replaced. *Treading cautiously* is to be careful about what one says or does in a difficult situation. Many PHNs in this study were hesitant in their role, as well as in voicing their perspectives because of experiences of feeling ignored or silenced by leaders, and the perceived threat of retribution and losing their

job. After negative experiences in *standing tall*, a number of participants stated that nurses were left *treading cautiously*. As a result, some nurses abided by the rules.

Many PHNs in this study were wary or reluctant to speak up, take action, or ask questions. These nurses attempted to avoid getting into trouble by asking permission and waiting for direction from leaders before engaging in PHN activities. Several nurses described how they often followed edicts and tried to keep their heads down in what they portrayed as times of organizational unrest. A number of PHNs in this study were mid-career nurses who indicated that they could not afford to lose their jobs because they were raising families. The autocratic style of leadership and decision-making undermining the PHN role left some nurses feeling uneasy about the organizational direction and the future of their role.

After several participants experienced what they described as “being shut down” by leaders, they withdrew, distancing themselves from these leaders and deliberately avoiding potential problems. One PHN described feeling shut down by leaders and stated, “I almost feel like I dare not ask a question because I’m likely to get in trouble. Or I’m told to go [to the internet], here’s the hyperlink for it.” The relationship between PHNs and leaders was often strained. This was the case when nurses sensed their leader was not a leader at all, that is, the leader was not mentoring and supporting PHNs in practice. Rather they were largely dictating PHNsg practice. A number of participants believed that their manager had no vested interest in, or commitment to, addressing issues in their communities. After being dismissed or silenced by leaders, nurses often had to *tread cautiously* in their roles because they feared retribution. As a result, several participants indicated that mutual respect and trust between nurses and leaders had diminished.

When leaders failed to build a relationship with PHNs, honouring their knowledge and experience, nurses negotiated and adjusted their practice with caution and compromise. Some participants were cautious in their day-to-day activities because components of their role were not supported by their leaders and many nurses explained the need to be careful, such as requesting permission before their activities. For example, one nurse commented on the top down nature of organizational processes, the punitive nature of leaders, and the implications of stepping out of line:

The information flows from the top to the bottom. It's a very top down organization. So if you go out of line, then your hand is going to get slapped, or you could even have a letter put on your file. So, you want to be very careful of what you do.

As a result, nurses requested permission for activities they once did based solely on their professional judgement. Another participant explained her experience of engaging in community development activities in her workplace, the requirement to request approval, and the need to be careful in one's activities:

You've got to think outside the box, and I think a lot of the time when you did something really crazy and creative, people [leaders] would be looking at you like, "What are you doing? It's too political. It's too community development type stuff. We don't want you doing that." So, every time you do something, you sort of get, the fishing line pulls you back, right? You've got to be very careful if you're going to do anything these days, that it is approved of.

PHNs were quick to learn what was supported as part of the PHN role through interactions with their leaders.

Many participants viewed activities such as surveillance of community issues, outreach, attending community meetings, and partnering to address broader factors impinging on health in their community, as central components of their role. Several PHNs stated that was just how they went about their work. When nurses were woven into the community fabric, that is, connected to clients, families, and partnering organizations, they skillfully navigated health promotion and prevention in their communities. Now, they had to wait for approval before engaging in activities that were actually core competencies and standards of PHNsg practice.

A number of participants explained that they were frustrated by the process of waiting for permission to move forward when they could see a pressing need being overlooked that they were equipped to address. Several nurses commented on how they were once supported to use their professional judgement to guide practice decision-making, but recently felt uncertain about what constituted part of their work and what should guide their practice. For instance, one PHN captured the frustration of many nurses when she exclaimed, “Can I not, as a professional, be trusted that I have the ability and professionalism and knowledge and skill to figure that one out on my own?” Another participant explained her frustration when administrative “red tape” impeded her involvement in developing and implementing a community-based program. She stated, “It doesn’t inspire you to do these things [develop community-based programs]” and she just “threw my hands up in the air” out of frustration due to the approval process. When PHN professional judgement was undermined, nurses felt stripped of their autonomy in their role and were cautious in their approach when led by autocratic leaders.

One manager with PHN experience noted how nurses in her office were still *treading cautiously* even after the previous manager left. She pointed to the low morale when she was first hired into the health unit and how she worked to support and empower PHNs, trusting their

knowledge and skill to re-engage in broader community activities, collaborating and working with partners in the community. She explained the negative impact of previous leaders and how she encouraged nurses in her office to collaborate across health sectors on joint issues. She explained:

You don't feel valued. You are scared to do anything. I still get staff asking me if they can do this or that, things I wouldn't think twice about. Like going to a committee meeting with postpartum, with the maternity floor to talk about postpartum issues. I wouldn't think twice. I think, yeah, that's an excellent thing to do. Whereas before, they were taken off all that kind of stuff. So, they're still treading quite cautiously because they don't know what's going to happen again. That's the thing, if I go, or they get new management, things could change again.

What she viewed as routine day-to-day activities in practice, PHNs in her office were still requesting permission for, based on experience with prior managers, proceeding with caution in their role. When nurses had managers with PHN experience, willing to work alongside them to determine whether they could accommodate their ideas and concerns in practice, they felt less constrained in taking initiative and moving forward.

Several participants also commented on *treading cautiously* in how they represented their organization. They were concerned about the state of their role, yet were cautious in speaking negatively about their employer, given the perceived backlash that could result from speaking out on such issues. For example, one participant discussed how a community partner questioned her absence at a meeting, recognizing the need for all partners to come together to discuss and address community issues. This nurse explained:

I think it's embarrassing and it takes away from our credibility when somebody says, "oh, why aren't you guys at the meeting?" It's like you've got marbles in your mouth because you don't want to be disrespectful to your employer, but the person is talking to you and you know damn well you should be at the table having those conversations.

Right?

In this case, the participant felt the leader's decision to remove nurses from community meetings served to undermine the PHN role and credibility more broadly throughout the community. PHNs were *treading cautiously* as they navigated their role between being an employee and being an advocate for health in their communities.

Summary.

Within the process of *getting by*, PHNs worked within the constraints of the organization. They did so to avoid retribution. Nurses in this study accommodated change while, to the extent possible, using their professional judgement in practice. PHNs also worked to find creative ways to connect with and continue to provide care for their community within their narrowing role. However, some nurses, marginalized and disciplined in advocating for their community, were careful in proceeding with their activities and obeyed the rules, for fear of retribution.

Many nurses in this study described the process of shifting between strategies, but a great deal of their time was spent in *getting by*. At times, however, nurses who were frustrated in the process of *getting by*, went underground in their role. Some nurses, when they could see a need being overlooked that they were equipped to address, bypassed permission and resorted to *going underground*.

Going Underground

Feeling a strong commitment to the values of prevention, health promotion, and social justice, and sometimes being unwilling to give up and conform to new directives, some nurses engaged in *going underground* to conduct activities unsupported by their leaders. *Going underground* is to do something in secret. Some participants, particularly experienced PHNs operating explicitly from a social justice lens, engaged in a quiet resistance and resorted to doing what they felt ethically compelled to do, while trying to remain undetected in their activities. These nurses knew they were taking a risk by engaging in covert activities, unsupported within the organization, but they did so anyway. Participants used phrases such as, “finding work-arounds” and “flying under the radar” to refer to instances of *going underground*.

Some participants went underground after they reached a point of frustration in, or were disciplined for, *standing tall* and were unsatisfied in *getting by*. Nurses often went underground in their activities when they were thwarted in their attempts to advocate for, and address community issues in their day-to-day practice. For example, one PHN working to develop a community-based program, shifted from *standing tall* to *going underground* in her activities after being stalled in the approval process. To move forward in the initiative, this PHN drew on her community partners to address the need, avoiding the administrative approval process. Another participant demonstrated nurses’ unsuccessful efforts in *standing tall* and their shift to *going underground* when she stated, “If management isn’t going to listen, they’ll [nurses] find a way to do it anyways.” She stressed that nurses would find a way meet client need if client safety and quality of care was in jeopardy.

Several nurses in this study drew on community partnerships to bring initiatives to fruition when they were limited by organizational restrictions and decision-making processes.

PHNs collaborated with partners on community issues of shared interest, and worked together to address concerns. They often pooled resources and each contributed by doing various parts of the work. For instance, one nurse partnered with several community agencies to help create a mothers' group in the community. She stated that PHNs were "sneaking around" to support such community initiatives because they were not supported by their leader. She indicated that the nurse, whose position she replaced, hid some of her activities too. This participant explained, "She [the other nurse] would write the article and pass it to her community partner who would put it into the paper under their agency, so to speak." Another participant also discussed drawing on community partners to avoid organizational processes in addressing needs and gaps in service in the community. She stated:

So for me, it was about, and for my colleagues, some of the people that I work with, we would identify the community agencies that we might be able to work with, and then very informally make a phone call to someone that you connect with so you always know someone, rather than going through all of the levels of "yip-yap". Um, you just connect and you figure it out.

To address a community issue, this nurse determined who she could partner with, while attempting to avoid approval processes in the organization. By drawing on community partners, nurses went around organizational constraints to get work done, which they perceived as important in the community.

Another participant, who was demoted from her role as clinical coordinator, in part for challenging decision-making within the organization, described how she went from *standing tall* to *going underground* after another experienced coordinator told her that the "[health authority] has never, and will never make decisions based on evidence." At that point, she felt that her

attempts to influence management decision-making were futile, and carried on in some of her day-to-day activities in secret. She explained how, “in that moment, I gave up. I thought, well, I will just do my thing; work with my clients, lie, cheat, steal, and do the best I can for the clients that I work with.” Participants explained that they did so because they felt ethically compelled, and it helped them maintain job satisfaction.

At times, participants engaged in components of their previously enacted role, such as outreach and community development work, discreetly, and without permission. Several nurses also reported on new restrictions on postnatal home visitation and how PHNs found ways, when they deemed it necessary, to do home visits even when the reason for the visit did not meet established criteria identified in the standardized postnatal screening tool used during a telephone assessment. One participant explained how she consulted team members to discuss the assessment and corroborate her clinical judgement. These nurses decided to alter responses on the assessment form to indicate the need for a home visit. These PHNs did so when they felt like something was not right with a new mom, and were concerned about the mother’s and/or baby’s wellbeing. Many nurses in this study indicated that their managers discouraged, if not stopped, universal home visitation because of a provincial directive. Home visits were only to be provided if the new mother met certain risk criteria; instead, PHNs were encouraged to provide telephone assessment and support. At the time of these interviews, it became apparent that universal home visitation was only taking place in a few locations in one HA, where PHN leadership was still intact.

PHNs usually went underground in their broader community development and capacity building activities, such as writing health promotion articles in a local newspaper, or networking and collaborating in their community to facilitate health and social initiatives. For example, one

PHN initiated various groups that worked together to support health promoting environments in her community. This nurse explained that she started this collaboration because she witnessed the changing demographics and an influx of young families in her community, and viewed such activities as central to the PHN role. She helped to establish free play spaces for children in a quickly-developing city. She explained:

But someone came to me in the community and said, “Do you realize that you were the pioneer to all these groups that are happening now in [city]. You saw that things were going to come to a real climax in [city].” It’s the fastest growing city in Canada. I saw those emerging and I said we’ve got to start making places for kids to play because all these apartments coming up, and we need free, accessible places for kids to play. And we started some groups. And I started advocating for people and spaces. But people don’t see that. It’s all done as I do my work, it’s not a case that I can show on our computer system. It’s nothing, it’s just people in the community seeing me as I have done that. I don’t even think my bosses know. So, a lot of our work and our success is invisible.

This PHN went about her work quietly in the community and under the radar of the organization. She stated:

So sometimes I go out in the community. A lot of my work is invisible, so I just do it anyway. And nobody can see it and I just don’t tell anybody. Not tell anybody, but nobody needs to know how I do my work.

She did what she believed important to promote health in the community. By being connected and knowledgeable about the changing community demographics, she brought people together to address surfacing issues. This participant commented that she found it challenging when other nurses, often with less public health experience, would question her about her activities. She

continued her efforts, and did so discreetly to avoid bringing attention to her health promotion practices.

Conditional Factors.

Some PHNs worked outside of the organizational limits and engaged in covert action. A number of conditional factors, both personal and organizational level depicted in Figure 2, shaped nurses' action with this strategy. These conditional factors were introduced in the description of the strategy, but are detailed further here. Similar to participants in *standing tall*, nurses at a later stage of career, operating from a social justice lens, with an appetite for taking risk were more likely to engage in *going underground*. Whereas, early career PHNs with a less developed social justice perspective and a limited appetite for risk were less likely to go underground, and more likely to focus on *getting by*.

Social Justice Lens, Years of PHN Experience, Appetite for Risk.

Nurses with an extensive career in public health who were explicit in their commitment to social justice were more likely to engage in covert activities. However, some mid-career nurses who demonstrated a social justice orientation also hid their activities at times. These nurses were more likely to circumvent organizational constraints because they deemed community development work to be imperative, given the social and health inequities pervasive in their communities, and what they understood as the social mandate of their role. One experienced PHN, who recounted multiple covert endeavours, was explicit about the social justice view informing her practice, when she stated, "Social justice is a really huge piece of my practice and has been for years." PHNs, firmly grounded in the belief that social circumstances shape health and wellbeing, were committed to reducing inequities, leading them to conceal their efforts when their autonomy was formally restricted. Operating with this lens, some participants

commented that citizens had a right to access care and made concerted efforts to address inequities regardless of organizational direction.

Experienced nurses also seemed more comfortable taking risks by *going underground* because they were nearing the end of their career and the threat of losing their job was not as great a concern. This was in contrast to some novice and mid-career participants who deemed the risk of *going underground* to be too great, or they were uncritical of change, and continued *getting by* within organizational constraints. Several PHNs explained that their experience of collaborating in the community and their long-term partnerships provided them leverage in their covert activities. They drew on their community networks to find alternate ways around organizational barriers constraining their practice. A few nurses reflected on how they once operated in the community and indicated that they looked to find ways to maintain these relationships to continue concealed efforts when needed.

Changing Leadership.

In addition to several personal factors, changing leadership, an organizational level conditional factor, also influenced PHN action in this strategy. When managers with public health or PHN experience were in place, participants were less likely to go underground in their activities, compared to nurses who had managers who lacked a shared background. PHN leaders understood the nature of PHNsg and collaborated with nurses to figure out how they could work towards organizational priorities. At the same time, they helped to maintain flexibility and allowed time for nurses to engage in community-based initiatives.

Some PHN leaders were also willing to *go underground* to support PHNs in their community. For instance, PHN leaders supporting nurses to maintain universal home visitation, despite changes in provincial direction, demonstrates the willingness of these leaders to work

outside directives along with their nurses. The fact that universal follow-up was still occurring in a few locations in HA3, is also likely indicative of higher PHNsg funding and staffing levels in that region, creating more space in practice to work outside mandated programs.

Summary.

Several PHNs, both late- and mid-career, tired of organizational change compromising their capacity and dissatisfied with the state of their practice, described engaging in covert activities to address issues. They did so based on the belief that it was unethical to overlook a need or withdraw support important to community health that they were educated to do. Participants went underground, in part, to maintain their job satisfaction within their narrowing role. However, several nurses were tired of the undermining of their role and considered other career opportunities, while some later career nurses stated it was time to take retirement.

Contemplating Getting Out

Several nurses, fed up with the bureaucracy within their organization and the eroding of the PHN role, were *contemplating getting out*. *Contemplating getting out* is to spend time considering leaving their PHN positions and exploring other career options because of their lack of job satisfaction. When PHNs lost a sense of control, meaning, and satisfaction in their work, commitment to the job weakened. Several nurses explained that they felt little power to change organizational factors influencing their role, particularly after feeling belittled in *standing tall*, and explored ways to regain satisfaction.

A number of nurses described having minimal job satisfaction with the narrowing of their role, restrictions on autonomy and flexibility, and diminishing support. One participant noted that she became a PHN specifically because of the broad community work that they used to be

supported to do in public health offices. Another PHN expressed dissatisfaction with changes she has witnessed in the PHN role, and stated, “A lot of nurses I know go, ‘I’ve got to get out of public health, I’m really not happy with it anymore.’” PHNs did not lose their commitment to providing good care; they lost their commitment to a role in which they felt devalued and unsupported to do what they believed they should be doing. One way PHNs felt that they were able to regain a sense of personal control, after feeling very little control on the job, was to consider leaving PHNs altogether.

The experience of PHNs in *contemplating getting out* was not an isolated event or confined to a particular location. In fact, nurses from every HA discussed a level of job dissatisfaction that led them and their colleagues to look for other job opportunities. Several nurses in this study expressed concern over the low morale across health units. These participants communicated their passion and belief in the difference PHNs made in their communities, but explained how current limits to their practice did not fit with their vision of PHNs or standards of practice. However, one factor that made a difference for nurses was when PHN leadership remained in place. Among the participants in this study, none with PHN leaders discussed leaving their role. These nurses still experienced some difficulties, such as limited resources, but PHN leaders buffered their staff from the system and created space for nurses to work creatively and to use their professional judgement in a range of activities. In this strategy, conditional factors are woven throughout the explanation of the strategy.

Both mid- and late-career nurses considered leaving their role. Younger nurses in this study did not talk about this. A few mid-career PHNs talked about exploring other types of nursing positions, and one discussed finding work outside of nursing. Several mid-career nurses discussed leaving PHNs in search of a more fulfilling nursing role. For example, a few nurses

explored whether to continue their education, and discussed nurse practitioner or midwifery programs because they believed they would regain some autonomy and satisfaction. One participant revealed that her colleagues had considered various avenues and explained:

Some of them [PHNs] have sought jobs elsewhere. I know some of the nurses are looking to do different things now. Like one of my colleagues is really bored and she's looking at maybe doing the nurse practitioner course or the midwifery course or something to get back to doing a full-scope practice again instead of just bits and pieces of things.

Some mid-career nurses found other nursing positions within their HA, some explored going back to school, while others considered teaching roles in an academic setting.

Several nurses nearing the end of their career considered taking early retirement. Some participants nearing retirement explained how they were relieved to be in a place where they could retire because of their discontent with the PHN role. One nurse captured the perspective of several experienced participants in stating, "A lot of nurses are saying, 'I'm going to retire early.'" Another experienced PHN shared in the frustration and commented that, "I got to an age when, you want to know what? My solution was, 'I can retire.'" When PHNs, both mid- and late-career, became dissatisfied with the state of their role, and felt little power to change it, they began to consider their career options.

PHNs were not alone in considering other opportunities; a number of PHN leaders did so as well. A few nurses noted that both PHNs and PHN leaders experienced dissatisfaction because of changes in their roles. One participant explained how her manager quit because she was expected to oversee an increasing number of portfolios. This PHN discussed how both managers and nurses are inadequately supported and stated that, "One of our managers just quit because she was expected to man post-partum and five other portfolios at the hospital... So a lot of

people, and I am being quite honest, are at the point of quitting.” It seems that both nurses and their leaders were wanting out.

Within the process of *contemplating getting out*, a few participants noted the reality that some nurses felt stuck because the job created stability in their life. One PHN discussed the difficulty for nurses, unsatisfied in their work, but acknowledged the pay and benefits of the job. She explained:

We are sort of stuck because it is a good job, and people were thinking, “If I could think of something else to do, I would do it.” When they say that, there is no place else they are going to get paid \$30 to \$35, or \$40, an hour, whatever it is, with all the benefits we get. You are not going to replace it. So, the health authority has us by the... in a velvet noose as they call it.

Even if PHNs were dissatisfied in their work, some nurses felt tied to the financial security of the job. Several PHNs in this study explored leaving because they were frustrated and dissatisfied with the state of their role, and demoralized with their practice within the current healthcare milieu, and yet, some nurses felt pulled to stay because of the security and the practicalities of the job.

Summary.

Some participants explained how dissatisfied they were with how organizational change had limited the ability of PHNs to use their professional judgement related to community work. These participants understood PHNs to be autonomous practitioners in promoting health in their communities. When organizational and practice changes left them feeling defeated in the PHN role, several nurses wanted out. These participants had not lost belief in the difference they could make in their communities, but they did not feel they had the power to change the direction of

organizational decision-making and its impact on the PHN role. As a result, several nurses expressed their weakening commitment to the PHN role and considered other options. While some participants continued to consider leaving public health, other nurses reaffirmed their commitment to the PHN role.

Reaffirming Commitment

Reaffirming commitment is to renew one's dedication to PHNsg. Reaffirming commitment occurs when participants were clear about their dedication to their role and their community, despite their dissatisfaction with organizational factors hampering PHNsg practice. Nurses remained in the PHN role based on their belief in the difference PHNs could make in promoting health and preventing disease in their community.

Several nurses indicated that they were not ready to leave PHNsg because of their belief in the need for PHN involvement in their communities. The conviction of one PHN was clear when she stated, "We were needed here." Some PHNs in this study reflected and focussed on the historic contribution of PHNs and their own past involvement in their communities as a source of inspiration to keep going. Many nurses conveyed their commitment to providing care to those in the community and exhibited great patience, capitalizing on opportunities to take action to advance health in their community.

Many nurses explained how they searched for places of satisfaction in their role, and held onto those moments where they felt meaning and fulfillment in their work. A number of participants recounted individual interactions with clients, where they supported women through difficult situations. These experiences acted as small reminders of why they do the work that they do and why their work is important. One PHN relayed the significance of when a client thanked her for the guidance and reassurance after the client brought her baby home. Another

nurse explained how nurses hold onto the feeling of making a difference, and stated, “And all of us have had clients who have come to us and said, ‘I don’t know how I would have made it through this without you.’” A number of nurses stated that it was not only clients’ expression of gratitude, but it was seeing confidence on the faces of clients they supported that was often the greatest reward in their work. PHNs in this study garnered energy from seeing the difference they made, despite a narrowing role.

Participants believed in the valuable contribution of PHNs, and had faith in the nurses who selected a career in public health and the values guiding their practice. For example, one nurse remained confident in the future of the PHN role despite her concerns with organizational shifts. She expressed her conviction by stating, “(I’m) still optimistic because I believe that the people who go into it [public health nursing] are people who really believe in what they do.” This participant believed in the faith and commitment of PHNs, regardless of the changing PHN role. Another nurse explained, “I’m super passionate about it [public health nursing]; just invest in your community. And I know it’s going to take long term and I just have to ride through some of these changes.” This nurse expressed her passion for PHNsg and recognized that public health takes time, requiring long-term vision. Despite their frustrations with limitations placed on PHN autonomy to initiate and build connections in their community, several participants expressed their passion and vision for promoting health, and carried forward committed in their role.

Reaffirming commitment is presented as a discrete strategy, yet participants engaged in some aspect of this process throughout almost every strategy of this theory. Throughout their efforts to *stand tall*, *get by*, and *go underground*, participants’ commitment to promoting health and reducing inequities was often implicit, and only became apparent by looking closely at their decision-making in their work. PHNs’ commitment to see it through and continue in their role

was evident in their descriptions of how they managed contextual changes that eroded their role. For example, one nurse remained dedicated in her role when she continued to provide sexual health services in her community despite confronting organizational barriers. She carried on doing what she could to educate teens, but was limited in some of her interventions, such as offering affordable birth control, without the sanction of her employer. This PHN *reaffirmed commitment* within the process of *getting by*, reflecting the overlap and fluid shifting of one strategy to another.

Several participants, who had reached the point of *contemplating getting out*, were more explicit in their process of *reaffirming commitment*. These nurses paused to reflect, and questioned what led them into PHNsg, and then considered whether they should continue on, given their frustrations. One participant asked herself, “I’ve done some soul searching, thinking ‘am I burning out?’” She identified the internal conflict she experienced and explained how she decided to stay. She stated:

Some days I get really down and I think of the demise of Public Health and we’re going the way of the dodo bird. You know? And other times, I get really inspired and think, no I believe and do love this, and I do believe in what I’m doing.

She realized that she was not ready to leave PHNsg, and restated her belief in her role. She explained:

And then I come full circle and think, No, I really do love what I do, and I just need to look at ways to make it so I still do love what I do. And being able to put my voice out there for your [research] project makes me feel like I’m contributing, I guess, and maintaining public health.

Several participants remained committed to the PHN role throughout the process of *managing the erosion of their role*. Based on their belief in the difference PHNs can make in their communities, many nurses decided to stay despite the limitations they faced in delivering public health services.

A number of participants discussed the need for PHNs to find a way to advocate for their role. These nurses aimed to help PHNs regain autonomy and meaning in their position to ensure intelligent and skilled nurses were not leaving public health. They urged nurses to make their voices heard. Two participants specifically referenced the importance of PHNs sharing their stories. One nurse explained how, when she was discouraged about the lack of understanding and support for her job, she found comfort in reading a book of nursing stories written by a retired PHN from BC. She explained, “I need to go and find it again myself and have a read of it. Because what she describes in her book is what I believe and feel public health nursing is.” This PHN felt revitalized and encouraged after reading stories of PHNsg practice, helping her to maintain her belief in and stay in her role. These PHN stories boosted her confidence because they corroborated her knowledge and understanding of PHN work.

Another participant indicated that she planned to write a book after her retirement to help share the important work of PHNs she witnessed throughout her career. She explained her reasoning, “But I think the really important stuff, I think, is not being documented. Because it’s hard to document. In my retirement I thought maybe I’ll write a book on stories of public health nursing in Canada”. These nurses believed in the important work of PHNs and found that documenting PHN stories was a great opportunity to share the tradition of PHN knowledge, skill, and vision, and help other PHNs to remain committed to the role throughout challenging times.

These participants recognized the difference PHNs make in their communities, and held onto the heritage of PHNsg practice as a way to reignite passion for their work.

Despite concerns over organizational change and the erosion of their role, the passion of PHNs was palpable, leading many participants to remain steadfast in their commitment to their role. One participant noted the work ethic and determination of PHNs, and stated, “Drive. I have yet to meet a PHN who wasn’t passionate about her work or his work.” The passion and drive of PHNs was evident through the cultivation of trusting relationships with clients, families, and partners in their community, and the ability to uncover and deal with local issues. Many PHNs were committed to addressing these issues, while tackling health inequities and improving population health.

It is through connections that PHNs perceived they were able to effect change in the health of clients. Their work starts with establishing relationships in their communities that informed their other activities. PHNs had a clear vision of the difference public health can make in communities, and were aware of the challenges of working within the healthcare system. One PHN discussed her view of public health by saying:

But I think you have to have the overall vision of all the good that can come from our work in the end through health promotion and community development. It’s not going to happen overnight; it takes time and in the current healthcare climate that’s not always well understood either. So, I really do see public health as a separate entity sometimes.

Several participants alluded to the diffuse nature of PHNsg practice that often contributed to the invisibility of their work, but also reflected the complexity of their role. Participants recognized how PHNsg did not fit well within the current healthcare milieu, with leaders fixated on short-term outcomes. The long-term investment in the community is a challenging pursuit within

healthcare now. Participants in this study had a clear vision of public health, the PHN role, and the difference they made to their communities, which they held onto in *reaffirming commitment*.

Summary

The healthcare climate in BC has been marked by system restructuring and fiscal constraint. A number of provincial and organizational level changes have affected the delivery of PHNsg programs and services. Many PHNs did not feel that adequate PHNsg services were being provided to prevent disease and injury, and promote health in their communities. PHNs in this study believed organizational and policy changes, which undermined PHN support, reduced PHN autonomy, and restricted PHN flexibility, eroded the PHN role and contributed to deteriorating health outcomes in their communities. Not only have these organizational changes narrowed PHNsg programs and outreach in the community, but the frequency of change has also negatively affected practice. Nurses described how organizational and policy changes undermined their ability to provide high quality public health care. To many participants, the moral aims of public health to promote population health and reduce inequities (Powers & Faden, 2006), were supported in theory by the organization, but were often given short shrift in practice, and in budget.

Participants used five strategies to manage contextual changes, such as changing leadership, mandated programs, and PHN staffing levels, which had the effect of eroding the PHN role. When nurses were confronted with organizational change undermining practice, many *stood tall* individually and collectively to advocate for the PHN role. When participants became frustrated and demoralized by the process of *standing tall*, they often engaged in *getting by*. In *getting by*, many PHNs let go of parts of their role, while also looking for ways to connect with

clients within organizational constraints. At the same time, nurses were often *treading cautiously* because they feared retribution, and sought permission or waited for direction before taking initiative. When dissatisfied in *getting by* or silenced in *standing tall*, several participants *went underground* in their activities to attend to local issues and promote health in their communities.

Several participants, disappointed with, and defeated by the state of PHNsg, and feeling like they had little power to change it, began losing commitment to the role and *contemplated getting out*, by taking early retirement, or by exploring other positions, both inside and outside of nursing. Throughout the process of *managing the eroding PHN role*, many nurses remained in their jobs by *reaffirming commitment*. Several participants, while *contemplating getting out*, reflected on what led them into PHNsg, helping them to reaffirm their commitment to the PHN role. How PHNs engaged in these strategies was shaped by a number of personal factors, such as where they were in their career. PHNs' actions were also influenced by several organizational level factors, with leadership playing a key role. How nurses engage in these strategies will likely shift at different times in their careers, influenced by a number of external factors unfolding around them.

One participant declared, "PHNs need a voice and they need to be shouting." Nurses in this study outlined particular means of resistance, some more overt than others, to handle the nature of organizational change eroding the PHN role. Participants engaged in strategies to manage the organizational challenges, but were often left feeling unheard, silenced, and at times muzzled by leaders. Nurses took strides to have their voices heard, drawing on the support and wisdom of their team. Often, PHNs focussed on doing as much as they could to initiate and maintain relationships in their community while, at other times, they did what they believed best

served the interests of the community. Unfortunately, much of the important work done by PHNs remains invisible because they often concealed these activities. PHNs were passionate about their role, and although they were often discouraged with the current state of practice, their commitment to their communities and belief in the difference PHNs could make, was a catalyst that spurred them into action.

Chapter 5 – Discussion and Conclusion

In this chapter, I discuss the implications of this dissertation research, or the *so what* of this research project. To start, I place key study findings within the context of current literature, to compare and contrast my study findings to the work of other researchers and scholars. Then, I examine the implications of the study for practice, education, policy, and further research. I end the chapter with a discussion of the strengths and limitations of this study, a brief note on the potential applicability of the study findings beyond BC and Canada, and concluding thoughts.

Key Study Findings

There are several key study findings from this dissertation research that I believe are particularly interesting and important. In this section, I place these key findings within the literature to examine how they relate to available research and scholarship. It is important to explore how my dissertation findings confirm or refute what is already known and how they contribute to our knowledge and understanding. First, I discuss the basic social problem identified by PHNs in this study in relation to the literature, and add to the recent dialogue on public health restructuring within the context of healthcare reform. Then, I explore whether the ways in which PHN participants managing the erosion of their role fit with how other nurses have responded to such change. Next, I examine the silencing of nurses' concerns regarding the quality of services delivered within healthcare organizations and client wellbeing. I finish this section with a discussion of the ethical foundation underlying PHN action in my findings and an exploration of the moral landscape of PHNsg practice amid healthcare reform.

The Basic Social Problem

At the outset of this project, I intended to examine how the public health renewal process in BC, initiated in 2005 to strengthen public health programs and services, improve population

health, and reduce health inequities, influenced PHNsg practice, and how PHNs navigated this changing landscape. As I began interviewing PHNs across three HAs in BC, it became evident that some nurses believed that public health renewal did not lead to the improvements in practice as planned, and in fact, public health has been weakened since these efforts began. These nurses noted that public health renewal efforts were unsuccessful because resources, guidance, and political will were inadequate to bring the vision to fruition amid competing priorities. What many PHNs in my study wanted to talk about was organizational and policy changes within broader healthcare reform initiatives that had both direct and indirect implications for public health in general, and specifically PHNsg, with the effect of compromising the PHN role. The title of the basic social problem, *when it is no longer your call*, reflects the experience of many PHNs in this dissertation study in which nurses have witnessed weakening authority in their role; that is, they are no longer supported or are required to request permission to engage in activities they once did based on their professional judgement.

PHNs in my dissertation study voiced concern about losing support, autonomy, and flexibility for PHNs in practice, and were generally in consensus about the weakening state of PHNsg programs and services. Nurses in my study described an eroding PHN role, a perspective that is shared by PHNs both nationally and internationally (e.g., Andrews & Waerness, 2011; Falk-Rafael et al., 2005; Falk-Rafael & Betker, 2012a; Hassmiller, 2014; Kub et al., 2017; Swinder et al., 2014). Andrews and Waerness (2011) described how PHNs in Norway have lost power, authority, and control over their activities, threatening the role. Some PHNs in my study used phrases such as “dismantling” and “decimating” in relation to changes in their practice. This choice of words conveys the extent of their concern regarding the impact of reform initiatives on the PHN role and scope of practice, leaving some nurses in my study feeling

uncertain about the future of the PHNsg specialty. Several authors have also raised concern about the future of PHNsg (e.g., Canales & Drevdahl, 2014; Hassmiller, 2014). Given this trajectory, we do not know what the future of PHNsg will be or what the PHN role will look like.

PHNs in my study made it clear that it has not been one event that has eroded their role, but a number of factors that have combined in different ways, at different times, and opened the door for other changes that slowly chipped away at the PHN role. Andrews and Waerness (2011) in Norway as well as Falk-Rafael et al. (2005) in Ontario also framed their examination of PHNsg practice by depicting a series of events unfolding over time that have eroded the PHN role. Andrews and Waerness (2011) contend that several changes since the mid-1980s have led to a process of deprofessionalizing the nursing specialty. For example, these authors describe how a number of healthcare reforms changed leadership structures and organizational frameworks, losing PHN leadership positions and distancing PHNs from their leaders. This account is consistent with my findings, as well as the findings from other Canadian PHNsg research (Falk-Rafael et al., 2005). Falk-Rafael et al. (2005) also talked about changes to funding structures and reorganization of the PHN role influencing PHNsg, which again, is consistent with my study. Thus, current PHNsg practice is not representative of any one external change but is reflective of a number of changes over several decades that have eroded the PHN role.

PHNs in my dissertation study were not alone in their concerns about losing ground in their practice amid healthcare reform initiatives. Nurses in several other settings, such as in the hospital and in long term care, have also experienced weakening involvement in decision making, along with reduced roles and autonomy, and increased workloads (Debesay et al., 2014; McMillan, 2016; Norrish & Rundall, 2001; Rankin, 2009). Norrish and Rundall (2001) explained

the importance of nurses' roles, workload, and control over practice, which affect the quality of care and the outcomes achieved.

Healthcare reform initiatives have also had negative implications for nurse and client outcomes in several settings (Aiken et al., 2001; Aiken et al., 2002; Duffield et al., 2007), and has led some to contend that the nursing profession itself is at risk (Choiniere, 2011). Some nursing researchers have even argued that years of reform have eroded the foundation for professional nursing practice (Varcoe & Rodney, 2009). It seems that nurses and nursing practice have not always fared well within ongoing government efforts to restructure the delivery of health services, and appear to be vulnerable during times of reform across settings.

Currently, we have limited understanding of the impact of health system change on PHNsg and population health outcomes because there has been little tracking of the outcomes for both PHNs and for clients. Researchers have suggested, however, that supporting PHNs to work to full scope of practice could lead to more effective use of funds, improved program outcomes, and better prevention of illness and injuries (Underwood et al., 2009). This, unfortunately, does not reflect the state of PHN practice in many health units because most PHNs in my study reported a narrowing of their role. We also have limited understanding of the impact of health system change on the capacity of public health to respond to emergencies, such as the current COVID-19 pandemic. Hence, the need for this, and future research examining the capacity and functioning of the public health system.

Many participants in my dissertation research were demoralized with the state of their role because PHNs have historically practiced with a great deal of autonomy, establishing relationships, addressing issues in their communities, and providing care proportionate to the level of need. In fact, PHNs were the first nursing speciality to require a baccalaureate degree to

practice (Duncan, 2016). Autonomy was a hallmark of PHNsg practice, and PHNs worked independently, usually outside of a clinical setting. Unfortunately, most nurses in my study stated that they were no longer supported by their managers to engage in community advocacy and outreach, and were largely told what to do in practice. This is a significant change to the nature of PHNsg practice, and is inconsistent with the expectations outlined in the Canadian Community Health Nursing Standards of Practice (CHNC, 2019) and the foundations of the PHN role (CPHA, 2010). Based on PHN interviews in my study, organizational and policy changes have hindered PHNs in providing adequate high quality care, and have altered the fundamental nature of their role.

Detrimental changes to the PHN role and scope of practice have led several authors to call for renewed efforts and investment to strengthen the public health workforce, including PHNsg (Bekemeier et al., 2016; Hassmiller, 2014; Kub et al., 2017; Swinder et al., 2014). These authors suggest that increased funding and educational opportunities for PHNs, and enhanced efforts to promote the effectiveness of PHNs would help to achieve the promise of health reform and to promote a culture of health. Many of the concerns expressed by PHN participants in my study reflect this broader discussion regarding reform initiatives that is taking place within public health both nationally and internationally.

Public Health Restructuring within Healthcare Reform.

Last year, in 2019, the Canadian Public Health Association (CPHA), the independent voice for public health in Canada, brought together an expert advisory panel to document their joint concerns regarding the reorganization of public health (CPHA, 2019a). CPHA released two companion documents titled *Public Health in the Context of Health System Renewal in Canada*. This group of public health leaders developed a background document to outline factors that

have shaped the current status of public health systems (CPHA, 2019a) and a position statement to offer recommendations in response to such changes (CPHA, 2019b).

The authors of these documents stated that, to address the current public health mandate and meet future health needs, we need to ensure the integrity of the public health system in our country. This statement rings true, particularly at this moment in history, because the capacity of public health systems is currently being tested provincially, nationally, and globally with the emerging spread of COVID-19, and the potential for dire health outcomes if our response is inadequate. In the background document (CPHA, 2019a), members of the expert panel also highlight the lack of evidence to refute or support claims regarding the impact of recent structural change and funding reallocations on public health integrity and capacity. My dissertation research is a preliminary step in filling that void. In the following section, I place my findings within the wider discussion of public health restructuring.

Public Health Restructuring in Canada.

Public health practitioners, leaders, and researchers from across Canada have shared their concerns about the state of public health. Many are sounding the alarm, arguing that the effectiveness of public health has been compromised with recent reforms, undermining the capacity of public health professionals to promote health and prevent disease and injury in their communities (Guyon & Perreault, 2016; Guyon et al., 2017; Potvin, 2014). Public health in Canada has recently been described as “weakened” (Guyon et al., 2017), “under attack” (Guyon & Perreault, 2016), and “under siege” (Potvin, 2014), sentiments echoed by many PHNs in my dissertation research. These authors point to health system reform and its negative effects on both the decision-making authority of public health leadership, and on practitioners who provide public health programs and services (Guyon et al., 2017; Guyon & Perreault, 2016). It is clear

that PHN participants in my study are not alone in their concerns about recent public health change undermining the effectiveness of public health efforts.

The authors of the CPHA background document (2019a) identified a discord between provincial government rhetoric and public health system change. Provincial governments claimed restructuring of health systems was a means to better align public health within the healthcare system to improve efficiency and services, as well as to save costs. Some who oppose this view, however, suggest restructuring has led to a loss of integrity and authority for public health, reducing public health capacity (CPHA, 2019a; Guyon et al., 2017; Guyon & Perreault, 2016). Findings from my dissertation research support those who raised concerns about the realignment of public health within the broader healthcare system. The population focus and long-term vision embedded in PHNsg practice did not fit well within an organization primarily focused on individuals, disease processes, treatment, and short-term indicators. Several PHNs in my study talked about the shift in organizational values after restructuring, whereby prevention and equity received short shrift. Data collected in my study help to substantiate claims that reorganization has led to reductions in PHN autonomy and authority in practice. Currently, however, we have little understanding of how these changes shaping the PHN role have affected public and population health.

Some of these concerns were echoed by participants in another recent BC research project, the Equity Lens in Public Health (ELPH) project. In the ELPH project, a 5-year program of research examining health equity in BC, researchers interviewed public health professionals throughout all levels of the organization, including PHNs. This team of researchers noted the tension between organizational and provincial Ministry priorities and what was supported in day-to-day public health practice, a finding congruent with my data. Practitioners interviewed for the

ELPH project stated that they felt constrained in responding to the needs of clients experiencing inequities (Pauly, Shahram, et al., 2017). They indicated that it was not so much what was valued by the practitioner, but what was valued within the organization and backed by resources that was supported in practice. This lack of support affected the ability of providers to take the initiative to tackle inequities in their communities. Factors external to public health professionals in the ELPH project, such as inadequate resources, as well as in my study, hindered their role in addressing broad social issues shaping health.

Many PHNs in my study spoke about how they used to develop community-based programs, but how that was reduced when PHN involvement in program decision-making was eliminated. These findings corroborate results from several studies in which the researchers also found that PHNsg leaders were being replaced with non-nurse administrators and that the role of nurses was being narrowed (Andrews & Waerness, 2011; Beaudet et al., 2011; Cohen, 2006; Schofield et al., 2010). Researchers also reported this finding in other nursing settings both inside and outside of Canada (Aiken et al., 2001; Choiniere, 2011). It seems that with the hiring of managers who lacked public health or PHNsg expertise and with the removal of public health leaders at decision-making tables, public health values and aims, such as improved population health and health equity, have been largely lost, while more dominant influences of biomedical and individually-focussed approaches to care have been further entrenched. The diminished understanding of public health and PHNsg across the organization has led to decisions and policies that often overlooked, or did not adequately consider the impact of the proposed change on population health or on PHNsg practice. Some believe that this is because public health and PHNsg are poorly understood and not valued by administrators (Schofield et al., 2010).

In a recent editorial, Butler-Jones (2020), who was Canada's first Chief Public Health Officer and Deputy Minister of the Public Health Agency of Canada, reported that many governments have diminished the resources, expertise, and capacity of public health to respond to public health threats as well as to carry out its mandate. Butler-Jones explained that decisions to divide public health services and expertise among different programs, to replace public health managers with generic public servants, and to move public health leaders away from organizational decision-making tables weakened public health, echoing several of the PHNs' concerns in my study. With the loss of a public health voice at decision-making tables, public health function and capacity may continue to be susceptible during times of reorganization as well as during times of emergency. Currently, however, it is unclear the extent to which these changes have affected public health and its ability to achieve its mandate.

A number of nurses in my study noted that the continuous and frequent nature of healthcare reorganizing within a regionalized healthcare system has had significant implications for PHNs, and is disruptive to the long-term vision and planning required in public health. Several participants were concerned, given the weakened authority of public health within HAs, that public health and PHNs were at risk of additional restructuring, further dismantling PHNs support and infrastructure, and hindering the ability of PHNs to actualize their potential. Health system restructuring appears to be ongoing in the country, suggesting that provincial governments are uncertain about what organization and governance structures best support the functioning of the healthcare system and, in particular, the public health system. For example, with the outcomes of regionalization being uncertain, some provinces have once again restructured their health systems, this time, consolidating numerous regionalized HAs into a single HA, a decision that Fierlbeck has called into question (Fierlbeck, 2016, 2019). In Nova

Scotia, recent restructuring, by amalgamating HAs, has not led to the intended reduction in administration costs or health system costs, but has strained relationships and diminished trust between healthcare professionals and leaders (Fierlbeck, 2019). Significant changes to any provincial health system affects the provision of public health programs and services (National Collaborating Centre for Healthy Public Policy, 2018). Reorganizing the health system often affects PHNsg service by disrupting long-term relationships and continuity of partnerships, which are essential to the effectiveness of many PHNsg programs to improve population health and reduce health inequity.

Other provincial governments, such as Alberta in 2009, Prince Edward Island in 2010, Quebec in 2015, and Saskatchewan in 2017, have abolished regional HAs and created one large HA, changing the organization and governance of health services across these provinces. The implications of these changes on delivering care across these provinces remains unclear, but could resemble outcomes similar to Nova Scotia. The government in Ontario did not regionalize the organization and delivery of public health services as did other provinces, leaving public health independent from the broader healthcare system. Recently, however, the newly elected government (in 2018) proposed to amalgamate the 35 health units into 10 regional agencies, with the goal of accruing cost savings (National Collaborating Centre for Healthy Public Policy, 2018). These are only some examples of recent and ongoing structural changes influencing public health in Canadian provinces. Currently, however, there is insufficient evidence to draw conclusions about the impact of these structural changes to guide government decision-making (CPHA, 2019a).

In the qualitative component of her mixed methods research, Hill (2017) interviewed PHNs in one BC HA and surfaced an array of organizational factors that affected PHNs in

practice, many of which were similar to the factors discussed by PHNs in my study. For example, many PHNs in Hill's study commented on the difficulty of engaging in health promotion activities in the face of shifting organizational priorities. Hill highlighted how the organizational context has a significant influence on PHNsg practice and the outcomes achieved. As a result, she extended a well-known PHNsg theory, Falk-Rafael's Critical Caring Model, by adding a new carative factor, *navigating organizational complexity*. Hill explained that PHNs have to navigate a complex changing organizational milieu, and talked about the importance of time and flexibility in their role, adequate staffing and professional education, as well as peer support and mentorship. A number of participants in my study, as well as PHNs in other research, also underscored the importance of flexibility, PHN autonomy, and the need for leaders to recognize the impact of context in the delivery of programs and services (Andrews, 2006; Oberle & Tenove, 2000). Hill's research, along with my dissertation study, help to demonstrate the negative impact of a range of organizational changes, such as the appointment of leaders without public health or PHNsg expertise, limited flexibility in the PHN role, and reduced opportunity for mentorship, on the delivery of adequate PHNsg programs and services in BC.

Public health restructuring has also been in the form of policy change, some of which has negatively affected PHNsg practice in the province. Several nurses in my study highlighted recent policy changes in the public health system that have resulted in a move away from universal programs, and an emphasis on targeted programs and populations. Many PHNs in my study explained that provincial mandates reducing universal programs in favour of targeted programs, narrowed their role and could have the potential to greatly increase, rather than decrease health inequities (Marmot, 2010). This is a troublesome change, given the fact that the two moral aims of public health, as well as PHNsg, are to improve population health and reduce

health inequities (Powers & Faden, 2006). This finding in my study reflects similar results reported in other recent research (Pauly, Shahram, et al., 2017).

In the ELPH project, outlined above, the team of researchers also reported that recent provincial policy has narrowed the approach to health equity in the province (Pauly, van Roode, et al., 2017). For example, the provincial government mandating targeted public health programs and discontinuing universal support, is an approach that will reach fewer people and is purported to be unsuccessful at improving outcomes across the whole population (Human Early Learning Partnership, 2015). There are risks with a targeted approach, such as addressing the consequences of inequities rather than the causes, and determining eligibility for programs can be problematic (National Collaborating Center for Determinants of Health, 2013). The shift toward a targeted public health approach adopted by the BC government may improve the health status of those with the lowest social position (i.e., socio-economic status), but will likely fail to improve the overall health of the population, the aim of public health. Focusing only on those most disadvantaged in our societies will not adequately reduce health inequities (Marmot, 2010).

PHNs in my dissertation study did not use the language of proportionate universalism, whereby universal programs and services are delivered at a scale and intensity in proportion to the level of need and disadvantage (Marmot, 2010), but they underscored the importance of delivering support and services based on that approach. They were clear that the narrowing of programs to targeted services was not the optimal public health approach to improve population health. A number of nurses in my dissertation research explained that people who fall outside of targeted programs may still be in need of support and could benefit from PHN involvement. In fact, a targeted approach can reach those most in need in an intensive way and improve outcomes for them, but can miss the largest number in need who are in the middle class, and does not

necessarily eliminate barriers (e.g., social stigma, transportation, language) (Human Early Learning Partnership 2015). With recent changes in mandated programs, PHNs were limited in their ability to meet the health and social needs of those who did not meet strict inclusion criteria for PHN programs. For example, the Nurse Family Partnership Program implemented in BC excludes teen mothers with a second (or more) child. Some nurses in my study talked about such limitations, and believed that women outside these criteria might well benefit from additional support. This change in approach could actually decrease overall population health.

PHNsg, as it has traditionally been delivered, is a good example of proportionate universalism where those who required greater levels of support received greater levels of care within the context of universal programs. This leveling of public health services across the health gradient can improve the overall health of the population as well as reduce health inequities (National Collaborating Center for Determinants of Health, 2013). PHNs in my study attempted to strike a balance between universal and targeted services and did what they could to provide services outside of targeted programs, but were often limited in their means. Creating a platform of universal support along with targeted approaches, while working to eliminate barriers to care, is an effective approach to resourcing and delivering services to improve the health of all (Human Early Learning Partnership, 2015). Yet, the erosion of the PHN role puts this at risk.

Taken together, the concerns expressed by a number of public health leaders in the country, along with evidence from PHNs in my dissertation research, paint a picture that should alarm citizens. Reported changes, such as the weakening authority of public health leadership, the fracturing of public health organizations, and cuts to public health budgets, reduce the capacity to meet performance expectations (CPHA, 2019a). The restructuring of public health within the broader realm of healthcare at local, regional, and provincial levels has affected the

roles, responsibilities, and functioning of public health, including PHNs, the largest component of the public health workforce. These changes undermine the integrity of public health and pose a threat to population health and health equity, as well as to the sustainability of our healthcare system (Guyon et al., 2017; Hancock & McLaren, 2019).

An International View of Public Health Restructuring within Healthcare Reform.

Researchers in England have reported that restructuring of health systems has had several disruptive effects on organizational outcomes, including the deteriorated performance of local health authorities (Andrews & Boyne, 2012). There have also been efforts internationally to examine how public health reform has influenced population health outcomes. For example, several researchers have reported that public health system reform has often had a negative effect on health equity (Bambra et al., 2014; Singh, 2014). Currently, there are efforts to monitor and strengthen the accountability of public health services in the United States (Bekemeier et al., 2016). This type of evaluation on the state of public health services and the impact of public health reform is lacking in Canada, and is important to demonstrate the difference these programs and services make in our communities.

Several researchers have noted cuts to public health funding in the United States, with the largest cuts made to the PHNsg budget, a finding congruent with PHN accounts in my dissertation study (Kub et al., 2017; Swinder et al., 2017). These budget cuts run contrary to the evidence, which suggests that cuts to the public health budget are a false economy (Allen, 2015). In the United States, researchers have found that increases in public health spending led to improved population health outcomes (Erwin et al., 2011; Erwin et al., 2012; Mays & Smith, 2011; Singh, 2014). Researchers have also demonstrated a positive return on investment of public health interventions, demonstrating that public health interventions are cost saving

(Masters et al., 2017). Cuts to the public health budget are not a consistent trend, however, because PHNs in Scotland have witnessed increased resources and enhanced PHNsg programs (Doi et al., 2017). Doi et al. (2017) found that enhanced home visiting resulted in increased monitoring, prevention, and identification of family concerns, and families were more open and willing to discuss sensitive issues and more engaged with wider services.

Many PHN participants in my study were frustrated as they witnessed changes to their programs, inadequate staffing, and budget reductions that they believed were not grounded in evidence. These participants believed that the eroding PHN role has led to worsening health outcomes in their communities. This is consistent with findings in the United States where researchers reported that funding cuts to maternal and child health programs provided by local health departments were linked to increased rates of low birth weight (Bekemeier et al., 2014). It is difficult to provide adequate public health services with inadequate resources and staff (Guyon et al., 2017). In fact, some argue that reductions in the public health workforce are associated with threats to the public's health (Bekemeier et al., 2016).

Part of the challenge in evaluating the impact of public health is the lack of accurate data on public health investments in Canada, which prevents governments from being accountable for reaching population health outcome targets (Guyon et al., 2017; Hill, 2017), and thus, the difficulty in making a case regarding the impact of this investment. A number of nurses in my study also highlighted this issue. They pointed to a lack of data to guide decision-making related to PHNsg programs and services. Public health requires infrastructure to be able to demonstrate the return on investment and the difference that programs and services make.

My dissertation research provides some preliminary insight into how public health restructuring has negatively affected PHNsg in parts of BC, with hints of its effects on the

population at large. Currently, however, there is little understanding about how this continually shifting landscape has influenced population health outcomes and health equity in Canada. When words such as *crisis*, *weakened*, *marginalized*, and *threatened* are used to depict the state of public health systems in Canada, it appears that the vision to strengthen public health systems and services, after several public health crises (Kirk et al., 2014; Naylor et al., 2003), has faded. It will be interesting to see how the current COVID-19 global pandemic influences leaders' decision-making in the ongoing restructuring of public health systems across the country and around the world. PHN participants in my study, however, were clear about several provincial and organizational factors that have compromised PHNsg practice, leaving them to manage the eroding PHN role.

Managing the Eroding PHN Role

Findings in my study corroborate the growing body of literature demonstrating the significance of provincial and organizational factors influencing the delivery of PHNsg programs and services, in particular, the importance of leaders' knowledge, values, and attributes (Ganann et al., 2010; Hill, 2017; Schofield et al., 2010; Underwood et al., 2009). The nurses that I interviewed, overwhelmingly, were upset with a variety of contextual changes that limited their ability to provide what they deemed high quality care because it resulted in worsening health outcomes. Nurses were frustrated because they believed they were equipped with the necessary knowledge and skill that could have helped to prevent and mediate such issues. As a result, participants engaged in a range of strategies to manage external factors eroding their role.

In many studies I have come across, a number of which I discussed in the literature review chapter of this dissertation, researchers described the barriers and facilitators to nursing practice, and at times, explained the nature of practice change (e.g., Schofield et al., 2010:

Underwood et al., 2009). Some researchers have provided a cursory view of nurses' actions in response to change. For example, after recent healthcare reforms, the level of distrust and resentment with administration, and professional dissatisfaction, led some nurses to leave the organization (Fierlbeck, 2019; Weinberg, 2006), and resulted in some nurses going part time (Choiniere, 2011). But there has been much less attention to the range of nurses' responses to significant change and the implications of these actions. My dissertation research provides insight into the range of PHNs' actions in response to recent external influences eroding their practice. It seems that nurses in a number of settings have engaged in similar strategies over the last several decades in response to organizational and policy change limiting their role (Rafael, 2000; Oberle & Tenove, 2000; Varcoe & Rodney, 2009).

In 1996, Rafael (2000) conducted a contemporary oral history of PHNs in southwestern Ontario, and presented findings that are particularly relevant to my dissertation. PHNs in both Falk-Rafael's study and mine experienced changes in practice, and reported less flexibility and autonomy in their role. At the beginning of the article, Falk-Rafael explained that there had been significant upheaval in public health in Ontario between the study period of 1980 to 1996, changing the scope and practice of PHNs. She interviewed 14 PHNs and reported on a number of ways that they adapted, and responded to change. Falk-Rafael stated that she sought to challenge the common notion that nurses are resistant to change. She used different language than I did to label PHNs' approaches to change, but there is significant overlap between our study findings.

Rafael (2000) described a "spectrum of orientations" to change. She acknowledged that change in the organization was often imposed in a top-down nature, sometimes forcefully with the threat of reprisal or promise of reward, while other times subtly, using rhetoric equating change with progress. Even the negative label of "resistant to change", she noted was a means of

control and undermined nurses' confidence, leading some to be complicit with change that they believed could lead to harm. Falk-Rafael delineated a number of personal factors that shaped PHNs' approach in the various orientations to change, such as personality, personal strength, belief in themselves and their contribution to health, and vision and experience in public health. This aligns with my dissertation study findings, wherein I described several organizational and personal conditional factors, such as years of experience and a social justice perspective that shaped PHN action in my theory. She also demonstrated the central role of leadership in shaping how PHNs responded to change. For example, when leaders supported nurses in enacting their professional autonomy, nurses were more likely to work together and problem solve with leaders. This finding closely aligns with the important role of PHN leaders in my dissertation data. In both studies, nurses drew from a number of sources, such as community knowledge, level of resources, and established programming, to interpret and respond to change.

Rafael (2000) used the phrases "visionary transformation" and "constructive opposition", which aligned with PHN action in *standing tall* in my dissertation study. She depicted how PHNs used various means to take initiative and advocate for their practice, similar to the range of PHNs' activities to advocate for their practice in my study. PHNs in Falk-Rafael's study were creative in problem solving issues and brought forward ideas to leaders in "visionary transformation." Nurses in her study also opposed decisions and voiced their concerns in "constructive opposition." These Ontario PHNs engaged in activities such as writing letters, collecting data, getting involved in a local association, and examining literature, to bring about change as well as to bring attention to issues of concern. "Constructive opposition" was an overt form of resistance whereby PHNs advocated for their role and community, aligning with *standing tall* in my dissertation study. How leaders communicate with nurses, include nurses in

decision-making processes, and respond to nurses' concerns seem to have important implications for, and is a reflection of, the organizational culture.

These Ontario PHNs also engaged in covert forms of resistance. Nurses who opposed changes, at times, worked to find ways around the change without the knowledge of their leaders. Thus, PHNs in my study were not alone in *going underground* to support clients and families and address needs that were being overlooked. Rafael (2000) used the language of “judiciously circumvented” to describe how nurses in her study searched for means around changes that controlled their practice and jeopardized the health of clients and families. This was often in response to a reduction in service. Nurses in several studies spoke of bending the rules, in which they decided to provide services that had been discontinued, based on their view of what was needed in a given situation (Rafael, 2000; Varcoe & Rodney, 2009).

Other nurses, both inside and outside of public health, have also engaged in both overt and covert strategies when external changes hinder their agency in providing what they deem adequate care (Crowe, 2019; Rafael, 2000; Oberle & Tenove, 2000; Varcoe & Rodney, 2009). Thus, it seems that nurses across settings and over several decades have also pushed back and worked around organizational constraints when faced with external factors undermining their role in an effort to maintain and provide high quality care. In fact, nurses working to provide care by subverting workplace constraints is not new, and was discussed in the literature 30 years ago (e.g., Hutchinson, 1990).

Despite the commonality of this strategy, there are instances, however, where *going underground* could be deemed poor practice that could lead to inconsistent and unjust treatment, and could raise a number of ethical issues, such as nursing practice according to one's own rules (Varcoe & Rodney, 2009). There could also be difficulties that arise in defining what is “good”

for the client (Oberle & Tenove, 2000). For example, a nurse once shared with me that she knew about nurses on a hospital maternity unit who sometimes fed babies formula during the night even though the mothers intended to breastfeed. These nurses may have done this with the best of intentions, to allow mothers to rest, but this action could hinder efforts to establish breastfeeding successfully and, in my view, is morally questionable.

Nurses' activities in *going underground* may not lead to the best outcomes. Varcoe and Rodney (2009) suggest that many of these activities are often directed at the individual level. *Going underground* to override the constraints in their practice could also further perpetuate the invisibility of parts of their role, such as community development, and this does not bring about the attention needed to address gaps in care. In fact, this strategy could perpetuate these gaps in service and jeopardize nurses' opportunities to enact their moral agency (Varcoe & Rodney, 2009).

Nurses in Falk-Rafael's (2000) study also recognized that they were often limited in their actions, and adapted their practice based on what they believed to be feasible, aligning with PHNs' working within organizational constraints in *getting by* in my dissertation study. Falk-Rafael depicted three orientations to change in which nurses adopted the change. These approaches consisted of approval of change through "critical approval", internalizing and accommodating dominant narratives through "insidious assimilation", and passive acceptance of change they believed detrimental to themselves or the health and wellbeing of their communities through "wounded acquiescence" (Rafael, 2000). In "insidious assimilation", some nurses abandoned parts of their practice that fell into disfavour with leaders, even when the change contradicted their professional judgment. To these nurses, they believed that those making the decision must know best, so they defaulted to those in higher authority positions.

Nurses in my study discussed all three of these orientations to change in which nurses integrated changes into practice, predominantly reflected in the strategy *getting by*, and, in particular, the sub-category *adjusting to change*. Within *adjusting to change*, PHN participants described a range of experiences. Nurses in my study acknowledged that a number of changes compromised the quality of PHNsg care. As a result, many nurses in my study focussed on doing what they could in their role to maintain quality of care while often also letting go of parts of their role, similar to “wounded acquiescence.” When changes strengthened services and PHN participants had the necessary guidance and resources, they implemented the practice change with ease, aligning with “critical approval.” Several experienced PHNs in my study recognized that inexperienced PHNs were often willing to give up components of the PHN role, in part, because they did not practice from a social justice perspective, and accommodated change similar to “insidious assimilation.” Nurses were often frustrated and experienced moral distress when they were required to let go of parts of their practice they deemed imperative to promote health and prevent disease in their communities, which led some to contemplate leaving their jobs.

In Falk-Rafael’s (2000) study, nurses described various ways that they used their professional judgement, got involved, and took responsibility for their practice. These values underpinned the actions of PHNs in my study, such as when they advocated for their practice and community issues in *standing tall*, worked to solve problematic organizational constraints and maintain high quality care in *getting by*, and believed it was a moral imperative to work towards meeting client needs in *going underground*. Nurses in Falk-Rafael’s study, however, did not discuss the last two processes, *contemplating getting out* and *reaffirming commitment*, found in

my dissertation research, suggesting that nurses in my research may have been experiencing greater levels of job dissatisfaction.

Nurses in several settings displayed this commitment to find a way to make things work and worked within the constraints of the organization in practice, such as donating their unpaid time to make up for shortfalls (Crowe, 2019; Rankin & Campbell, 2006; Varcoe & Rodney, 2009). Similarly, PHNs in my study described a number of ways they engaged in activities at their own expense in *finding a way*. Varcoe and Rodney explained that these nurses did this to reduce the moral distress they experienced in a workplace that limited their care. Nurses in different settings consistently came together and relied on each other and other members of their team to solve problems, and for support (Rafael, 2000; Varcoe & Rodney, 2009). They also found ways to navigate in between their responsibilities to the organization and to the client, often with limited resources (Andrews, 2006; Duncan, 1992; Misund Dahl et al., 2014).

In the study by Rafael (2000), many PHNs justified their circumvention or confrontation of imposed changes, such as directives and policies, to maintain relationships with individuals, families, schools, and communities. One nurse in the study described the time spent developing a trusting relationship, which sometimes takes years, as a critical first step to PHN effectiveness in practice, a sentiment that was also reflected in my data. The primacy of relationships in PHNsg practice has been established (Falk-Rafael & Betker, 2012a; Hill, 2017; Marcellus, 2005), but is important for nursing in other sectors too, such as in hospitals (Rankin & Campbell, 2006).

In her study of hospital nurses in Boston, Weinberg (2006) explained that nurses emphasize the importance of relationships, not because of the personal satisfaction from having close connections with individuals, but from the knowledge they gained from getting to know clients and families that allowed them to be more effective in practice. Nurses' relationships with

patients are a professional necessity and the focus of client encounters (Bergum, 2013; Weinberg, 2006). The quality of nurses' work, and their ability to provide professional nursing care and meet standards of practice, hinge on the quality of client interactions (Weinberg, 2006). Nursing researchers have described nurses' distress when they spent less time with clients because nurses believed they were providing inadequate care and failing to meet professional standards (Hill, 2017; Varcoe & Rodney, 2009).

Thus, nurses across sectors seem to agree on the centrality of relationships in nursing practice (Andrews, 2006; Bergum, 2013; Hill, 2017; Marcellus, 2005; Oberle & Tenove, 2000; Rankin & Campbell, 2009). Many nurses believe that building relationships is necessary for their professional responsibility and accountability (Weinberg, 2006), to create an environment that fosters respect, engagement, and authenticity (Marcellus, 2005). The importance of relationships in PHNsg practice plays a unique role in that PHNs actively seek out clients through community outreach, where these clients might not otherwise access the health system. Few other healthcare professionals do this sort of outreach. PHNs anticipate needs and health issues in their communities. The outreach component of the PHN role is clearly articulated in their standards of practice and guiding documents (CPHA, 2010; CHNC, 2019). In this way, PHNs connect and build relationships in their community as an access point to care, in addition to being a means of providing care. When PHNs are prevented from building relationships in their communities, local issues and needs can be overlooked.

In the final strategy, several PHNs in my study described the process of *reaffirming commitment* in their role, which was reflected in the accounts of other PHNs as well (e.g., Duncan, 1992; Misund Dahl et al., 2014). In her final paragraph, Duncan (1992) urged nurses to reaffirm their hope, by reflecting on and re-valuing their practice, and to continue to take strides

making a difference for health in their communities. Misund Dahl et al. (2014) found that value conflicts created an ethical awareness that mobilized nurses' courage and strength. In fact, these researchers stated that this conflict can be useful for professional identity and can improve the quality of PHNsg work (Misund Dahl et al., 2014). Rodney (2017) also explained that the negative feelings of moral distress, such as anger, frustration, and guilt, can be a catalyst for self-reflection, growth, and advocacy. This component of moral distress might help to explain why PHNs in my dissertation research moved from other strategies to *reaffirming commitment* or remained steadfast in their commitment to the PHN role.

Not all PHN participants in my study described the process of *reaffirming commitment*, and several PHNs in my dissertation research were *contemplating getting out*. These nurses were considering other employment possibilities or early retirement because of their discontent in the role. Several decades ago, researchers also found that PHNs discussed leaving public health because of the issues that they faced in their role (Clemen-Stone et al., 1995). The level of job dissatisfaction and low morale in health units reported by PHNs in my study is, however, a significant change for PHNs who have typically been an empowered and satisfied group of nurses (University of Michigan Center of Excellence in Public Health Workforce Studies, 2013). In 2005, 54% of Canadian PHNs reported being very satisfied in their jobs (Graham et al., 2011).

Some PHNs in my study were *contemplating getting out* and were making plans to leave their jobs because of organizational constraints undermining their ability to provide what they considered high quality care. PHN participants stated that organizational and policy change hindered nurses' use of professional judgment in practice and eroded their role, resulting in high levels of PHN frustration and dissatisfaction. Other researchers, nationally and internationally, have also found that PHNs reported feeling disempowered and distressed as a result of

organizational influences, such as policy changes, lack of funding, and lack of management will to advocate for PHNs, impeding them in providing adequate care and services in their communities (Cawley & McNamara, 2011; Curtis & Glacken, 2014; Falk-Rafael & Betker, 2012a). It seems that nurses outside of public health were also dissatisfied in their role because organizational and policy changes hindered their professional judgement and autonomy (e.g., Choiniere, 2011; Kuokkanen et al., 2007; Spence Laschinger & Leiter, 2006). Some PHN participants in my study nearing retirement talked about taking early retirement, a claim made by other Canadian nurses (O'Brien-Pallas et al., 2003). Older nurses in England talked about the importance of feeling valued and being consulted in change processes in their workplace, both of which influenced their willingness to stay (Storey et al., 2009). Nurses leaving because of dissatisfaction in their role has an economic impact. A team of nursing researchers highlighted the negative impact of nurse turnover on patient satisfaction and safety, nurse satisfaction, health and safety, and system outcomes (turnover costs) (O'Brien-Pallas et al., 2006).

Curtis and Glacken (2014) found professional status, interaction (relationships), and autonomy made the largest contribution to PHN job satisfaction (Curtis & Glacken, 2014). PHN job satisfaction has been positively associated with autonomy (Best & Thurston, 2006; Curtis & Glacken, 2014; Graham et al., 2011). In the University of Michigan study, PHNs reported high levels of satisfaction as well as autonomy (University of Michigan Center of Excellence in Public Health Workforce Studies, 2013). Graham et al. (2011) explained that PHN satisfaction was positively associated with PHN control over practice. Thus, it makes sense that as PHN participants' autonomy decreased, so too did their job satisfaction.

The level of job dissatisfaction among PHNs in my dissertation study is concerning because educated and skilled nurses are leaving the PHN role; this has implications for the

stability and competency of the public health workforce. This finding is also troublesome because job satisfaction is positively associated with client outcomes (Graham et al., 2011). Researchers have demonstrated that nursing practice environments are significant to nurse wellbeing, as well as to patient outcomes (Aiken et al., 2001; Aiken et al., 2002; Aiken et al., 2008; Aiken et al., 2014). There is evidence to suggest that PHN participation in decision-making, that is, being consulted by supervisors as well as being supported to engage in peer-to-peer discussion, are important factors in PHN job satisfaction (Campbell et al., 2004). Aiken and colleagues have recently started a large international initiative to improve hospital work environments to enhance mental health and well-being of health professionals and to increase patient safety (Penn Nursing, 2020).

Many of the nurses' strategies to navigate change discussed in this section and in my dissertation research reflect the difficulty nurses have had in managing their role and in maintaining the quality of their services in the face of organizational change within the healthcare milieu. The level of PHN job dissatisfaction in my study is one indicator of the state of their work environments. There are several important workplace factors, such as decision-making processes and leaders' knowledge and values that are important to consider in supporting the wellbeing of PHNs, and nurses in general. After conducting this research, I suggest one of those is for nursing knowledge and experience to be more valued and respected within the organization, and to be used to inform organizational and policy decision-making by including nursing leaders at decision-making tables. It might also be useful to consider the nature of decision making, such as, unanimous decisions as opposed to majority rule, providing more opportunity for all to be heard to address issue of power and voice at the table.

Silencing Nurses

When PHNs were dissatisfied with constraints in their role, they engaged in strategies, such as *going underground*, often because they felt their concerns were ignored by leaders; at times they were silenced. PHNs in this dissertation research frequently claimed that their concerns fell on deaf ears, they were muzzled and were marginalized when *standing tall*. Nurses have been silent for a reason. Several participants explained that the fear of reprisal hung over nurses' heads, and this stopped some of them in their tracks. A phrase commonly used by participants was "nobody listens." This has been referred to as the "deaf effect" in healthcare organizations, whereby those who can take action do not hear, or ignore reports of bad news, resulting in leader inaction (Cleary & Doyle, 2016). When this happened, nurses in my study stopped putting their ideas and concerns forward to leaders. Several PHNs in my study also stated that they did not know where to direct their voices to be heard.

The silencing of nurses appears to reflect a number of intersecting factors influencing the nursing profession and discipline. Several authors have discussed a range of forces at play shaping the professionalization of nursing, such as the wider social and economic forces influencing the nursing profession and the political foundation of health and healthcare (e.g., Andrews & Waerness, 2011; Gunn et al., 2018; Varcoe & Rodney, 2009). In a recent report by the Royal College of Nursing (2020), experts in the UK reported that nurses remain undervalued in status and in pay because nurses are mostly women. Nurses in that study explained that old-fashioned perceptions of nursing remained, that their value was often unrecognized, and their voices unheard (Royal College of Nursing, 2020). For example, even though nurses are the largest group of providers within healthcare, they are greatly underrepresented at leadership tables (Davis, 2017). This is paradoxical, given that researchers have shown nurses' participation

in decision-making improves quality of care and patient satisfaction (Aiken et al., 2008).

Thus, gender continues to play a significant role in affecting the status of nursing, a predominantly female profession.

American journalists Buresh and Gordon (2006), authors of the book "From Silence to Voice", explained how their metaphor, and consequently what they wrote about, changed over time from a focus on the invisibility of nursing, to the silence of nursing. Several PHNs in my study noted the invisibility of their work, and I too, used to focus on the idea of the invisibility of nurses and the systems responsible for creating it, but my thinking has shifted along with Buresh and Gordon. The notion of nursing invisibility is important, but I think part of the root cause of this phenomenon is the silencing of nursing, which is taking place from both inside and outside of nursing.

The phenomenon of leaders silencing nurses was rampant in my participant interviews. Silencing, as a phenomenon, however, is not likely isolated to nursing, and is probably experienced by other professionals both inside and outside of healthcare. Most healthcare workers, other than physicians, are women, so gender is likely a key factor. PHNs in my study were silenced from speaking out publicly about the injustices they witnessed in their communities and inequities in services. A few nurses who went public with their concerns about inadequate service in their community were formally reprimanded. Many participants also spoke often about bringing their concerns forward to leaders, and predominantly discussed inaction by leaders. These nurses often felt pulled between addressing community issues and respecting their leaders. Some nurses used the phrase "you get your hand slapped" to refer to instances of getting into trouble for addressing issues they believed were being overlooked in their communities. As a result, many nurses in my study were left feeling cautious in their approach to raising concerns

to leaders, or engaging in activities without permission, for fear of reprisal. A number of participants in my study explained that the personal and professional values that guided their decision-making were often at odds with the values underlying decision-making of healthcare leaders, a notion echoed in other PHNsg research (Misund Dahl et al., 2014).

There have been several recent accounts in the media of nurses being punished for voicing their concerns. For example, a Registered Nurse in Saskatchewan was found guilty of professional misconduct for posting on social media about the inadequate care for her dying grandfather (Healy, 2016). In this case, the nursing regulatory body (Saskatchewan Registered Nurses Association) convicted the nurse of professional misconduct for speaking out. Similarly, a nurse working in Ontario was fired for talking publicly about violence in the workplace (CBC News, 2016). These cases demonstrate how nurses are punished for pointing out inadequacies in the healthcare system. Picard (2017) writes that our healthcare system suffers when nurses are muzzled in advocating for better patient care. As a result, nurses learn that there are significant professional consequences for advocating for themselves, family members, and patients, thereby perpetuating the silence of nurses.

In a recent memoir, a well-known Canadian street nurse, Cathy Crowe (2019), discussed the suppression of nurse advocacy, and described how she was muzzled from speaking about what she saw in practice. Crowe wrote her book during a recent period of unemployment. She struggled to find a job and remained unemployed for 4 years. She was told that she had been blacklisted for her efforts to address issues of homelessness and housing, and that hiring her could be potentially detrimental to an employer's future funding. What is perplexing is that on a provincial government level, Ministry leaders threatened to cut funding to organizations that hired her, and yet, on a federal government level, Crowe was awarded the Order of Canada in

2018 for her work. She was also given an honorary doctorate by the University of Victoria.

Crowe demonstrates how nurses' jobs are threatened because of using their voice to fight for social justice, but she continues her efforts to speak up for and on behalf of marginalized voices.

The silencing of nurses is an international problem (Buresh & Gordon, 2006; Kay et al., 2015), and is reflective of the dysfunctional culture in many healthcare organizations globally (Cleary & Doyle, 2016; Pope, 2019). Some authors were perplexed by the lack of disputes and conflict of PHNs in Norway with regard to the deprofessionalization process of their role (Andrews & Waerness, 2011). In some cases, it seems that silence was the default, or perhaps the safer or easier option for nurses when denied the opportunity to be heard in England (Pope, 2019).

In a recent systematic narrative review, a team of UK researchers explored whistleblowing in healthcare, in which over 80% of study participants were nurses (Blenkinsopp et al., 2019). They identified factors, such as healthcare providers' sense of security, and leaders' appropriate and adequate response to professionals' issues, that influenced whether providers voiced concerns about unsafe, unethical, and poor quality care. This research team indicated that, for the number of nurses who did speak up about inadequate care, there are many more who remained silent (Blenkinsopp et al., 2019). And yet, these situations could be avoided if there were adequate governance mechanisms in place and a culture that supported healthcare providers safely to report inadequacies in care delivery (Cleary and Doyle, 2016). When management adequately responded to health professionals' concerns within the organization, whistleblowing outside the organization was avoided (Cleary & Doyle, 2016).

The silencing of nurses is not new. A journalist highlighted the muzzling of PHNs in a newspaper article almost three decades ago (Vaughan, 1993). Although nurses have surfaced the

negative implications of speaking out about issues (Crowe, 2019; Healy, 2016), we also need to consider the outcomes of nurses' silence. For example, some researchers refer to moral disengagement of nurses, in which some nurses emotionally withdraw to cope with ethical issues, and the negative impact on patient safety (Hyatt, 2017). Nurses are tasked not only with facing the day-to-day challenges of practice in their interactions with clients, but are encouraged to work towards creating conditions that support ethical practice environments for both clients and providers (CNA, 2017). A greater nursing voice in policy could be of benefit to all (Varcoe & Rodney, 2009).

Canadian nurses, as self-regulated professionals, are guided by a Code of Ethics (CNA, 2017) that sets the expectation that nurses advocate for conditions that support clients and each other in providing safe and effective care. Nurses in all settings are to be advocates for health and wellbeing of clients at all levels (individual, family, community, and population). Social justice is at the core of PHNsg (CHNC, 2019; Schim et al., 2007), and yet there have been negative personal and professional consequences for nurses who speak out about injustices (e.g., Crowe, 2019; Pope, 2019). This has left some nurses internalizing the values of adaptability and flexibility because they believe that if they do not go along with imposed changes, they will be replaced with those who would (Rafael, 2000). Others have also referred to this state whereby nurses are treated as disposable (Varcoe & Rodney, 2009). Nurses, at times, are presented with the challenge of navigating in a system in which they work in-between their personal values, professional standards, and organizational factors, with the potential risk of losing their jobs and failing to meet client health needs. PHNs in my study were faced with numerous ethical and moral challenges. The silencing of nurses by their leaders is one example of a moral conflict that nurses faced.

Navigating a Moral Landscape

There is an ethical basis to much of this discussion and the findings of this dissertation study. The title of the theory, *managing the eroding PHN role*, and the basic social problem, *when it is no longer your call*, convey the ethical nature of the nurses' actions and concerns. Nurses in this study talked about organizational and policy changes that have constrained PHN autonomy, flexibility, and support for PHNs in practice, and their frustration and distress because of these changes. Many participants explained that contextual changes have compromised nurses in their ability to provide high quality care and in meeting the needs of their communities, leading to moral distress. When nurses are impeded in practicing according to their values and professional standards, it creates an ethical dilemma and moral distress (Rafael, 2000; Oberle & Tenove, 2000; Varcoe & Rodney, 2009).

Jameton (1984) described three types of moral or ethical problems that can be experienced by nurses in practice: moral uncertainty, moral dilemma, and moral distress. Moral uncertainty occurs when nurses are unsure of what moral principles apply to a situation, or even what the ethical problem is (Jameton, 1984). Moral dilemma arises when nurses are presented with two or more moral principles, but either one would result in conflicting courses of action. Moral distress occurs when a nurse believes she/he knows what ought to be done, but is prevented from doing so by organizational or other constraints. PHNs in my dissertation research experienced all three kinds of moral problems, with moral distress or uncertainty occurring most often.

Although PHNs in my study did not typically frame their challenges as ethical problems, they discussed negative feelings from acting inconsistently with their values and from not meeting their professional responsibilities. For example, a number of participants spoke about

several public health restructuring initiatives that eroded their role and their effectiveness in practice. Varcoe and Rodney (2009) explained that, although many reform initiatives were usually intended to reduce inefficiencies and save healthcare dollars, it is care that has been reduced. Some authors even suggest that the tenets of Canadian Medicare (universality, comprehensiveness, accessibility, portability, and a publicly administered healthcare system) are under siege (Storch et al., 2009). Healthcare reform, and the reorganization of nurses' work, is rooted in the social ideology of political leaders in each individual province (Storch et al., 2009). Nurses often experience moral distress when external factors compromise their care.

It is important for researchers to consider the framing of moral distress in relation to both individual and structural factors (Pauly et al., 2012). PHN participants in this dissertation research faced challenges that reflected the socio-political context in which they worked. The socio-ecological framework underlying this study helped me to surface the range of contextual issues. Thus, a significant focus of this analysis was on the structural factors and the climate within the organizations that were largely responsible for varying degrees of nurses' ethical issues. For example, many nurses in my study witnessed a growing distance between leaders and nurses, which some believe has resulted in nurses having less influence on decision making, with significant implications for their practice and for client health outcomes. Interestingly, researchers have also found that mid- and senior-level managers experienced moral distress when they did not feel they were able to act according to their personal and professional values, such as when they are obligated "to sell" a policy they may disagree with (Mitton et al., 2011).

In their social critique of contemporary ethics issues in Canadian healthcare, Storch et al. (2009) distinguished between ethical issues related to the context of healthcare, ethics, and social policy issues. They discussed health and social policy ethical issues, which include topics such as

human reproduction, genetic testing, organ donation, and end of life, in contrast to everyday ethical issues in the delivery of healthcare. Pauly et al. (2012) also described some ethical issues in nursing practice as everyday issues in healthcare. Everyday issues include contextual issues in the delivery of healthcare, such as resource allocation. This dissertation research adds to this discussion, that is, it focuses on the contextual issues in the delivery of nursing practice and how nurses navigate the ethical terrain in everyday nursing practice. Thus, in this research, I focused on the impact of health system structures and processes on care, and the moral climate of healthcare agencies. The moral climate of organizations reflects the implicit and explicit values that shape healthcare delivery and influence the practice environment (Rodney et al., 2006). By exploring ethical issues in everyday practice, researchers address issues that affect all individuals involved in the health system and could develop recommendations to create healthy work environments (CNA, 2017; Storch et al., 2009).

Several significant forces that arose from outside of healthcare have contoured the moral landscape of healthcare. These broad social, political and economic factors often create ethical issues within day-to-day community health nursing practice (Duncan, 1992). The context in which nurses' work is constantly evolving and can play a large role in influencing their practice (CNA, 2017). Several nursing researchers and scholars set the stage for their work by accounting for a number of significant forces on nursing practice and nursing knowledge (e.g., Browne, 2001; Choiniere 2011; Gunn et al., 2018; Misund Dahl et al., 2014; Varcoe & Rodney, 2009). They have identified the influence of neoliberalism, managerialism, and corporatism on the organization, financing, and governance of healthcare (Pauly, van Roode, et al., 2017; Rankin & Campbell, 2006; Storch et al., 2009; Varcoe & Rodney, 2009). A number of nursing researchers have attributed the changes they witnessed in the organization and delivery of healthcare to these

broader forces that have compromised nursing practice (e.g., Falk-Rafael & Betker, 2012a; Pauly, et al., 2017; Rankin & Campbell, 2006; Storch et al., 2009; Varcoe & Rodney, 2009). The confluence of forces outside of nursing shaping the organizational climate, compromising nursing practice and resulting in everyday ethical issues, was also apparent in my study.

This aligns with what Varcoe and Rodney (2009) called “corporate streamlining” (p. 128). These researchers discussed the frequent reorganization in healthcare settings, such as changing programs, management structures, and mandated requirements, in the pursuit of efficiency. For example, several nursing authors explained how the adoption of managed care models compromised nursing practice by directing nurses’ activities, privileging notions of efficiency and standardized care based on economic and political values (Andrews, 2006; Choinere, 2011; McMillan, 2016; Rankin, 2009). Nurses, globally, have raised similar concerns about the philosophical and ideological conflict underlying many healthcare reform initiatives and the negative implications for healthcare culture and providers, not to mention health outcomes for clients (Aiken et al., 2001; Debesay et al., 2014). As a result, nurses, including PHNs in my study, are challenged to navigate the changing organizational and moral landscape of healthcare. Nurses in my study struggled to provide high quality services in settings fraught with political, economic, and ideological shifts undermining their role.

PHNs in my study were not alone in experiencing feelings of frustration and distress in managing their practice within organizational and policy changes that conflicted with how they perceived optimal care. PHNs in two other Canadian studies struggled with changes that constrained nurses in addressing issues in their communities, an essential component of their role (Rafael, 2000; Falk-Rafael & Betker, 2012a). Falk-Rafael and Betker (2012a) described “barriers to moral agency,” preventing PHNs from fulfilling their moral responsibility and accountability.

PHNs talked about their struggle to find a balance between what they believed was the right thing to do and organizational priorities and mandates (Falk-Rafael & Betker, 2012b). Other researchers wrote about the issue of “constrained agency” of nurses in their studies, which often resulted from restrictions and cutbacks in the workplace (Varcoe et al., 2004; Varcoe & Rodney, 2009; Rodney & Varcoe, 2012). Varcoe and Rodney (2009) explained that nurses’ constrained agency resulted in compromised care and moral distress in nurses. These descriptions fit with what PHNs in my study talked about and are consistent with their shared concerns in the basic social problem.

In the literature I reviewed, it became evident that scholars and researchers clearly acknowledged the impact of nurses’ work environments on the quality of professional nursing practice and nurses’ wellbeing. Varcoe and Rodney (2009) referred to nurses’ strategies in response to external change undermining their role as forms of moral resistance, conveying the ethical component of nurses’ action. Varcoe and colleagues explained nurses’ actions in response to moral distress (Varcoe et al., 2012), and outlined their means of enacting moral agency by manoeuvring in-between their own values and those of the organization (Varcoe et al., 2004). It seems that PHNs in my study were also engaging in forms of moral resistance in the face of organizational constraints on their role.

Varcoe and colleagues (2012) also suggested that nurses’ moral distress can result from the lack of response and the feeling of dismissal within the organization. Thus, moral distress can arise from a failure of the nurse to act, but often also includes unsuccessful actions aimed at resolving an issue. This conceptualization of moral distress considers both context and power dynamics, drawing attention to the nature of organizational structures and healthcare culture and its effect on nurses, and fits closely with the experiences of several PHNs in my dissertation

research. Although my intent was not to examine ethical responses of nurses, the explanations by Varcoe and others helped me to understand how my dissertation findings fit squarely in the context of ethical decision-making in nursing practice.

Researchers have conducted numerous studies on the ethical climate in acute care settings (e.g., Beagan & Ells, 2007; Corley et al., 2005; Hart, 2005; Varcoe et al., 2012). Several researchers have also explored the ethical climate in public health settings, but to a much less extent than in acute care settings (Asahara et al., 2012; Duncan, 1992; Misund Dahl et al., 2014; Oberle & Tenove, 2000). Researchers, both nationally and internationally, have described ethical issues in PHNsg practice (Andrews, 2006; Asahara et al., 2012; Aroskar, 1989; Duncan, 1992; Misund Dahl et al., 2014; Oberle & Tenove, 2000). For example, Oberle and Tenove (2000) noted that many features of ethical decision making by PHNs are highly relational, such as establishing trust, maintaining confidentiality, and preserving relationships in the interest of care because clients can end PHNsg services at any time. These authors indicated that PHNs must work to empower clients, establish boundaries, and maintain long term relationships, which may challenge PHNs in their decision-making. The importance of a relational response in PHNsg practice is a consistent finding in the literature (Browne et al., 2010; Falk-Rafael & Betker, 2012a; Hill, 2017; Marcellus, 2005). Several researchers also found that PHNs were concerned about their leaders' values and knowledge and the implications of their leaders' decisions (e.g., Asahara et al., 2012; Oberle & Tenove, 2000), which again, is consistent with my findings.

My dissertation research fits with the limited, but growing body of evidence examining ethical issues in PHNsg practice. PHNs have been clear that organizational changes, such as policy and financial support, have restricted their role (Falk-Rafael & Betker, 2012b). Nurses across settings often experience ethical problems when their personal and professional values

conflict with organizational priorities and demands. These feelings arise amid issues of scarce resources, expectations of efficiency, increased standardization and electronic documentation, which often creates difficulties in providing adequate care and contradicts the core function of improving health and wellbeing. My dissertation research has helped to shed light on the significant impact of the frequency of change and the nature of changes unfolding over time that slowly chipped away at the PHN role, eroding support for PHNs, and PHN autonomy and flexibility. The ethical struggles of PHNs in my dissertation research were layered and ongoing.

By bringing to light this ethical morass, it helps us to understand why PHNs in my study responded to and managed contextual changes in the ways that they did. PHN ethical decision-making processes are rooted in context and are not often black and white because they have multiple intersecting complexities to consider in each encounter, including organizational demands, differing client issues, and professional values and standards (Duncan, 1992; Oberle & Tenove, 2000). The population focus of PHNsg could also provide some rationale for why PHNs experience unique ethical issues (MacDonald, 2013), which go beyond the individual focus of ethical issues common in acute care. PHNs work across levels in practice by initiating and maintaining relationships with individuals, families, and communities to improve population health and reduce health inequities. After placing key study findings within the literature, I now discuss the implications of my dissertation research for nursing practice, education, policy, and further research.

Implications for Practice, Education, Policy, and Research

In my dissertation research, I explored PHNsg practice and issues related to PHNs. In the previous section of this chapter, I explained that many of my study findings are applicable to and

align with nursing and public health more broadly. In this final section, however, I remain focussed on PHNs and provide a few reflections and ideas, many derived from my research, on how to move forward and next steps. To begin, I discuss implications of my research for practice, follow with a discussion of education, policy, and end with research.

Implications for Practice

By inquiring into PHN concerns and listening closely to their experiences in this study, I highlighted several contextual factors undermining the PHN role. PHN participants talked about a series of organizational and policy changes that have eroded PHNs practice. PHNs are well positioned to improve the quality of programs and services, and to bring important practice knowledge and insight to the decision-making table, but they have been limited in these activities. The findings from my dissertation research may be useful to PHNs as one tool to advocate for their practice and the health of their communities. For example, they could use these findings to help others to see how a range of external factors have negatively influenced PHNs practice and the ethical distress experienced by PHNs who were constrained in their ability to address community need adequately and were witnessing worsening health outcomes. Duncan (1992) highlighted the need for nurses to be supported in their experiences with ethical challenges in the work settings, and drawing attention to PHN ethical dilemmas described in this research could help in such efforts.

PHNs in my dissertation study did not frame their concerns as ethical issues, but there was notable consistency between descriptions of moral distress, dilemmas, and uncertainty in the literature and PHN participant accounts. Oberle and Tenove (2000) suggest that it may be important to help nurses frame their experiences as ethical issues. They encourage an ethical

frame because it could help nurses to locate their experience in a wider context and to recognize that their concerns are not unique to them.

Several authors also urged nurses to engage in self-reflection, as well as to come together as nurses with other healthcare providers and administrators to dialogue, clarify values, support one another, and work towards true collaboration (CNA, 2017; Oberle & Tenove, 2000; Rodney et al., 2006). The authors of the Code of Ethics indicated that nurses' self-reflection and dialogue with others are essential components of ethical nursing practice (CNA, 2017). Rodney et al. (2006) argued that these efforts will help to improve the moral climate of workplaces. Nurses need to be supported in their workplace to engage in reflective thinking and to have the opportunity to come together to provide support within the healthcare team.

It is also troublesome that, with older PHNs in my study looking to take early retirement in *contemplating getting out*, newer PHNs will not have as many role models to help them learn the broader aspects of community development and health promotion. New PHNs will not have the on-the-ground PHN leaders to show them how to reach out in their communities, and to provide a historical perspective on community issues and services offered. This is especially critical at a time when the average age of nurses is increasing. There will be a whole new wave of younger, less experienced PHNs. To address this issue, older PHNs could be supported to stay in practice longer and to act as mentors to new PHNs. Leaders could also facilitate this process by extending orientation periods, planning overlap between novice and experienced PHNs in health units, and providing more structure to encourage relationships between new and experienced nurses to support learning about the range of PHN activities that shifts throughout the year.

Nurses are expected to advocate for conditions that promote and support health, including quality practice environments (CNA, 2017). PHNs in my study were often constrained in their advocacy efforts in *standing tall*. Nurses require the necessary organizational structures and resources, not only for their effectiveness in practice, but to ensure positive client outcomes. PHNs require support to work as autonomous healthcare professionals with the flexibility to build trusting relationships and partnerships, and work across levels of practice to bring communities to health. We can help nurses to work in this way by encouraging PHNs to take on leadership roles, providing opportunities for group education and discussion, taking strides to shift local health unit and organizational culture by encouraging creativity and local problem solving.

Public health professionals are encouraged to speak up and advocate more forcefully than they have in the past (Rutty & Sullivan, 2010), but there are few mechanisms and safeguards in place to support these activities. This is particularly the case with the turnover in leaders who do not understand public health or the PHN role. By strengthening the link between PHNs and their national body, the CHNC, there could be a broader national forum for PHN support, ideas, and vision. The CNA could play an important stewardship role in this work. Nurses need to learn about the resources available to them to continue their efforts in advocating for the PHN role and health in their communities.

Implications for Education

After learning more about PHNsg, there are a number of skills that I believe are important within nursing educational programs that, in my experience, have been lacking. For example, nursing students need support and guidance to develop knowledge and skills for activities such as policy development, leadership decision-making and delegating, and advocacy

in healthcare. Hassmiller (2014) indicates that leadership content is critical in nursing programs. These skills will help nurses not only to develop important skills in nursing advocacy and leadership, but also to help them to see themselves as advocates for health. Even though nurses deliver the vast majority of healthcare services, nurses' presence at decision-making tables is minimal (Davis, 2017). Nurses have been encouraged to play a central role in leading healthcare change and health (Institute of Medicine, 2011). By strengthening nurses' leadership and advocacy skills within nursing education, nurses can be better positioned to advance nursing leadership and to take a seat at decision-making tables. I believe nursing educators play an important role in shaping how nursing students view themselves as healthcare leaders.

Within nursing education, I also think it is important for nursing students to experience a range of practice activities by working alongside nurses in a number of positions, such as direct service provider, manager, educator, researcher, and administrator. Nursing students, and others, often struggle to understand nurses' roles outside of direct patient care in a hospital setting. Nursing educators also need to ensure that public and community health content, which has been wavering with the implementation of the NCLEX entry to practice exams in Canada, is well secured within nursing baccalaureate programs. Nursing educators need to ensure that they teach the theoretical foundations of PHNsg practice in baccalaureate nursing programs, including the wider range of activities that are at risk of fading away.

In a study by the Canadian Association of Schools of Nursing (CASN) Task Force on Public Health Education (2007), researchers found that baccalaureate-level nursing students may feel discouraged from working in community health nursing based on their sense that acute care nursing is more valued. In fact, PHN scholars in the United States recently raised concerns about the perception that PHNsg is not valued as a speciality within the nursing discipline and

profession (Canales et al., 2018). A better connection between the university and local public health units could help by providing more nursing students the opportunity of community placements in public health and sharing public health knowledge and experience with nurses in academia. There does, however, appear to be some movement within nursing in this regard (Hermer et al., 2019). The authors of the CASN report also noted that there was a shortage of qualified faculty to educate nursing students about PHNsg (CASN Task Force on Public Health Education, 2007). Recently graduated nurses reported that they had limited exposure to community health nursing experiences during their education (Pijl-Zieber et al., 2015). These shortcomings within schools of nursing may contribute to, and perpetuate, the invisibility of PHNsg.

PHNs need to educate others about their role because there is often limited understanding of public health and PHNsg both inside and outside of healthcare. For example, last year, during National Immunization Awareness Week, April 20-27, 2019, the Nurses and Nurse Practitioners of British Columbia (NNPBC, 2019) published a statement outlining the critical role of PHNs in the delivery of immunization programs and services in their communities and in addressing vaccine hesitancy (WHO, 2019). They did so to draw attention to the PHN role during an international measles outbreak. The authors of this statement were clear that PHNs offer more than merely the injection of a vaccine. PHNs deliver a whole host of activities, including: (a) planning and promoting accessible clinics; (b) addressing vaccine hesitancy in a relational approach that respects and acknowledges concerns; (c) communicating best evidence on vaccine efficacy to the public; (d) providing comfort for children and families receiving multiple injections; and (e) advocating for best practices in both cold chain maintenance and the informed

consent process for individuals (NNPBC, 2019). Nurses, in public health and other settings, need to continue to share what they do to improve others' understanding of their role.

Nursing students need a solid understanding of PHNsg and the benefit of long-term investment in the health of our communities. For example, a PHN supporting a new mother to breastfeed her baby is not only helping this woman in establishing a relationship with her baby and offering feeding guidance, but PHNs are also supporting this woman, child, and family to create a supportive home and community environment to optimize healthy childhood development. This investment in the early years is paramount and has been labelled as a determinant of lifelong health and wellbeing (Hertzman & Boyce, 2010). It is part of a long-term investment with an array of social and economic benefits (Rutty & Sullivan, 2010). Nursing educators need to ensure they are adequately preparing the future nursing workforce to understand a socio-environmental view of health, and to be politically savvy and engaged.

Implications for Policy

The impact of provincial level policy making on PHNsg practice was evident in this study. For example, the increase of provincially-mandated targeted PHNsg programs and the subsequent decrease in universal programs is a fundamental shift in how PHNs provide care. Many nurses in my study were clear that this shift in programming was reaching fewer people and leading to worsening health outcomes in their communities. Decision makers need to consider fully the implications of organizational and policy change on PHN practice because it has a substantial effect on the outcomes achieved (Hill, 2017).

PHNs in my study have identified several other organizational and policy factors that were significant to their effectiveness in practice. The number and frequency of organizational and policy changes disrupt the continuity required for the effectiveness of many PHNsg

programs to improve population health and health inequity. For example, participants spoke of the importance of clear policy direction and vision, having leaders who understand and have experience in public health, transparent and timely communication, and sustained long-term investment in PHNsg programs. PHNs, as the largest contingent of the public health workforce, need policy makers to understand the broad focus of the PHN role and to develop policy to support a range of PHN activities in their communities to improve health and health equity at a population level. PHNs in Manitoba echoed these sentiments, but also noted the need for PHN participation in decision making and policy making (Cusack et al., 2017).

In my dissertation findings, many participants highlighted the lack of PHN involvement in public health program development and policy decision-making. And yet, nurses in my study were grounded in client and community knowledge, and could offer creative and innovative solutions to challenging healthcare issues. Healthcare executives have been urged to invite nurses to decision-making tables, leveraging their practice knowledge of caring for clients, and their insight into the implications of policy decisions on staff, client experience, quality of service, health outcomes, the organization, and the broader community (Benson & Hassmiller, 2016). I encourage healthcare policymakers to ensure decision-making processes are inclusive and participatory, representing a range of perspectives. Moving forward, we need strong PHN leaders willing to put forth good ideas and well prepared with evidence to support their positions. By developing a good reputation and relationships at all levels, nursing leaders are more likely to be listened to, and invited to participate at decision-making tables.

Policymakers are central in creating a culture that supports leaders to adopt traits that are important to promote health equity. Effective public health leaders bring people together, draw on each other's expertise, and are relational and connected (Betker, 2016). It is important that

leaders reflect values of social justice and solidarity, drawing on participatory approaches to building trust and inspiration, being willing to take risks, empowering staff to tackle issues of health equity, and remaining connected to their communities (Betker, 2016). Managers with public health or PHNsg experience often supported PHNs to work beyond narrow policy by creating flexibility in practice and encouraging nurses to address local issues.

We need to begin by rebuilding trust between administrators and nurses because this relationship has often become strained throughout recent reform measures. Norrish and Rundall (2001) suggest that it is important to start this process of rebuilding with values clarification, clear communication, and participatory decision-making. Gunn et al. (2018) suggested that administrators need to create policies that promote equitable political representation and involvement in governance. In this way, leaders can enable the participation of nurses in policy and decision making in healthcare, as well as in other government institutions that have control over funding, organizing, and licensing (Gunn et al., 2018). Hassmiller (2014) explained that PHNs bring a unique focus across multiple levels from individuals and families to populations and systems, making them well situated to contribute to policy development and to lead within a health system undergoing transformation focusing on health promotion and prevention.

The theory developed in this dissertation research, *managing the eroding PHN role*, could be useful for policymakers to help them to understand the ways in which PHNs manage the erosion of their role. By understanding the process, leaders might be better able to recognize and support PHNs in achieving their goals. This, in turn, could inform policy focussed on nurse retention that could lead to less turnover of nurses, a costly item for the system, and to maintaining the capacity of the workforce (O'Brien-Pallas et al., 2006).

Pauly et al. (2012) acknowledged the importance of policy and political factors that influence the context of nursing, and the limited discussion as to what interventions are required to prevent moral distress. The appointment of public health and PHNsg leaders and the inclusion of nurses in the policy-making process, could help to alleviate some of the ethical issues experienced by PHNs in this study. By preventing issues of moral distress, leaders can help to create a strong and healthy workforce, and work to ensure safe, competent, and ethical care (Pauly et al., 2012). Some stated that investment in resolving ethical issues is cost effective (Hart, 2005). Norrish and Rundall (2001) explained that shared governance would provide a mechanism to reconcile potential conflict between organizational and professional values as well as to provide steps to work towards shared goals in decision-making and policy-making processes.

To reap the benefits of PHNs in their communities, leaders must work to ameliorate organizational and policy obstacles inhibiting their practice (Institute of Medicine, 2011). Administrators need to consider these factors to create supportive practice environments, creating policy that enables PHNs to practice to the full scope of their role with the goal of improving population health and reducing health inequities. To support the complex and interdisciplinary public health workforce, healthcare organizations also need to continue to build capacity by investing in tailored training to meet the needs of public health professionals, including PHNs (Sibbald et al., 2020). These authors stated that policy supporting training and education is an investment not only into the public health workforce, but also into the quality of services provided in communities.

PHNs in my study noted several significant changes in the PHN role, whereby leaders' policy and decision making decreased numbers of PHNs, narrowed the PHN role, and reduced

the PHNsg budget. PHNs are already established around the province in small communities everywhere. Often, they are the only service in town, and have become a trusted resource over generations. It is regressive to reduce or eliminate something that is already established, based on the fiscal bottom line rather than on a wider population health perspective whereby PHNs work to improve population health and health equity.

Implications for Research

This dissertation research provides a preliminary step in understanding how public health restructuring initiatives have affected PHNs and influenced PHNsg practice. By drawing on a socio-ecological framework, I explored a range of multi-level contextual factors that have influenced the PHN role. I captured these contextual factors, along with several personal factors, in the theoretical model depicted in chapter 4. In the description of this model, I provided insight into a number of organizational and policy changes that have had a considerable influence on PHNs in my study. To develop this model further, we need to examine PHNsg practice in other settings, both inside and outside of Canada, as well as PHN responses to other significant healthcare changes. As healthcare reform continues to unfold, researchers could determine whether PHN strategies persist amid different healthcare changes. We could also test the fit of this model outside of PHNsg practice, such as with nurses in other settings or other healthcare providers. Researchers could also use my theoretical model to help sensitize themselves to external factors that shape healthcare practice and healthcare providers' responses to change, as a point of departure in future research. It could also help to guide healthcare leaders in implementing restructuring initiatives.

Healthcare leaders need research to guide future reform measures to ensure a strong public health workforce and improved population health and health equity. Some state that

organizational and policy changes within public health restructuring, as well as broader healthcare reform were not often based on evidence (CPHA, 2019a). Leaders require additional research in multiple areas, such as on the outcomes of PHNsg interventions (Quad Council of Public Health Nursing Organizations, 2011), and evidence of the impact on care and cost-effectiveness (Hassmiller, 2014). Nurses have an important role to play in contributing to PHNsg research as well as multidisciplinary public health research. Currently, there is limited means to inform leader healthcare reform decision-making, but where there is robust research, leaders need to be encouraged, and have the courage and will, to base decisions on evidence. By looking for underlying mechanisms that affect service delivery, such as trust and connection, researchers will be able to understand better the impact of organizational and policy changes on PHN practice and health outcomes, and to share these outcomes with decision makers.

There are several issues researchers need to consider as they work towards strengthening the evidence base to guide decision making. PHNs in my study were clear that PHNsg programs and services require sustained investment and a long-term time frame to evaluate whether their activities are achieving their anticipated outcomes. Researchers and healthcare leaders need to track PHN activities at multiple levels and link them to broader changes (e.g., population, staffing, budget, policy changes), as well as connect PHN programs and services to individual, family, and population level outcomes over time. One way to do this is to work toward adequate data systems and proper use of existing data to guide organization, delivery, and finance decisions. Monsen et al. (2012) proposed that adequate data infrastructure will improve accountability mechanisms within public health systems, and demonstrate the added value of PHN practice and improvement in the overall health and wellbeing of communities. By strengthening the ability to collect data, including PHN documentation, policymakers would be

better positioned to make evidence-informed decisions, and researchers would be able to evaluate the effectiveness of PHN services, and conduct longitudinal studies exploring the relationship between PHN services and community and population health.

Many PHNs in my dissertation study stated that current documentation systems did not capture their community development or population focussed efforts because many PHN activities are not amenable to measurement or “captured by a tick box.” Electronic documentation systems do not currently capture budget changes or staffing levels either, so looking at outcomes without information on the broader picture provides an inaccurate result. Other researchers have also expressed concern over the lack of tools available to gauge PHN contributions within the public health system (Aston et al., 2014; Cusack, 2017; Ganann et al., 2010). When nurses do not demonstrate the impact of PHN interventions on health outcomes, they are limited in their ability to advocate adequately for the PHN role and the health of communities. Several PHNs in my study reported that this has led them to lose traction in some of their activities, such as their community development efforts. Research efforts are needed to continue to surface PHN experiences, to demonstrate the difference PHNs can make to the health and wellbeing of their communities, and to ensure that broader population health has a place within healthcare priorities.

Practice-based knowledge is important to understand and guide PHN utilization and public health decision-making (Bekemeier et al., 2013; Bekemeier & Ensign, 2017; Judd & Keleher, 2013; O’Byrne, 2011; Scutchfield et al., 2009; Thorne, 2008). My hope is that the practice-based evidence generated in this research can help to inform organizational decision-making, and to advance the understanding of PHN practice and service delivery. Nursing

researchers are making progress demonstrating the effectiveness of PHN involvement (e.g., Aston et al., 2016; Cusack et al., 2017; Hill, 2017).

Aston and colleagues have urged nursing researchers to continue to study less tangible health outcomes of PHN interventions, such as maternal self-confidence, self-esteem, empowerment, and social support, in addition to more common physical outcomes, such as breastfeeding rates and hospital admissions (Aston et al., 2016). By doing so, researchers can demonstrate a full range of PHN practice outcomes. When administrators evaluate PHN practice, and nursing more broadly, based on accounting or medical outcomes, they fail to capture the nature of practice.

Canadian nursing researchers have made strides in collecting data exploring the nature and effectiveness of PHN practice (e.g., Aston et al., 2016; Cusack et al., 2017; Hill, 2017). Researchers invested in PHNsg research in Canada can look to work taking place in the United States for guidance (e.g., Monsen et al., 2017; Park et al., 2019). Nursing researchers can draw on the work of others as well as extend the evidence base to reflect the Canadian context or identify where gaps exist. Researchers providing evidence to support decision-making in public health is critical, but the organizational context in which PHNs work must be considered in the analysis because it is instrumental in shaping the PHN role and health outcomes.

Strengths and Limitations of this Study

In this section, I provide a brief but thorough account of the strengths and limitations of this dissertation research. I also discuss the rigour of my research process. The aim of this section is to support one's interpretation of my research process and findings.

Strengths

Kearney (2009) urged nursing researchers employing the grounded theory method to address context, to go beyond describing psychological processes to theorizing about social and environmental structure shaping participant action. In this dissertation research, I used the grounded theory method informed by critical realism to examine how the context of public health restructuring has influenced PHNs in practice, ensuring that contextual factors influencing PHN action were addressed. The findings from my study help to deepen our understanding of how provincial and organizational level change in BC has eroded the PHN role, and as a consequence, how PHNs have managed their practice in the face of change that has undermined their ability to provide high quality care. The theory that I produced in my dissertation research meets Kearney's request.

Kearney argues that theorizing is about more than merely understanding individual experience, that "theory is an essential tool for transforming systems and improving interventions" (2009, p. 568). I advance that grounded theory, particularly when informed by the philosophical stance of critical realism, can assist nursing researchers to do just that. Grounded theory, as a methodological approach, can help researchers to understand and to explain why something is taking place and under which conditions, enabling researchers to address human issues, the context surrounding a phenomenon, and the underlying mechanisms influencing action and meaning. By drawing on the philosophical lens of critical realism, I examined the underlying mechanisms influencing participant action and meaning. This philosophical lens was useful because it helped me to surface mechanisms such as trust, open communication, and shared values that were important to PHNs within their organizational milieu. Again, the theory

that I developed captures underlying factors influencing context and action, important in understanding processes and outcomes.

The grounded theory method is a rigorous research method. Cooney (2011) states that a researcher must take care in applying grounded theory techniques to ensure rigour. The process of constant comparison throughout the cycle of inductive-deductive theory generation ensures that emerging codes, concepts, and categories fit participant meaning. The repeated presence of information in the data earns its way into the theory through the process of constant comparison. By checking to see whether my categories captured experiences and action in the data, explained participant processes, and reflected their experiences, I worked to establish rigour in my research. In this way, I developed a theory that had fit, work, and grab – the basic requirement for scientific rigour in grounded theory (Glaser, 1978).

By remaining open to the emergent nature of the research process and listening closely to participants' concerns and experiences, I allowed them to guide the inquiry process and ensured that the research reflected their concerns. By beginning the interviews with open ended questions, I created space for participants to guide the discussion. The focus of the research and interview questions shifted after the first few interviews because participants wanted to discuss the impact of changes other than the implementation of public health renewal on their practice. By transcribing interviews immediately after the interview and concurrent data collection and analysis, new information shaped the questions I asked in subsequent interviews. To ensure the codes and concepts reflected participants' experiences, I used their words in the first round of coding and tried to stick closely to their phrases and language throughout theory development. I also wrote a memo after each interview to record my initial thoughts about the participant's experiences and how their experiences related to other participants' experiences and emerging

codes. I continued to memo throughout the analytical process to think through and capture methodological decisions, theoretical ideas, and reflexive thinking.

The emergent nature of the grounded theory method, and through defining the basic social problem and core category, researchers develop a theory that reflects participants' shared concerns and how they, over time, manage the problem. I developed a tentative preliminary model after the first ten interviews, which I continued to (re)shape throughout the remaining interviews. I reached theoretical saturation around the 20th interview, but the remaining interviews helped to affirm, elaborate, and clarify the basic social process, as well as conditional factors. By the last handful of interviews, I had no new theoretical insights and my categories were conceptually complete.

Additional strengths of this study were that it included PHNs from three HAs in BC. Collecting data from multiple contexts provided breadth to the research and allowed for an examination of PHN experiences across a number of work settings. I also interviewed PHNs with different levels of experience and from different settings. I talked with nurses who worked in rural one-nurse offices as generalist PHNs. There were other nurses in this study who worked in urban settings in a team environment, and as specialist PHNs. The diversity of PHN settings and range of experience from three HAs provided breadth and depth to understanding the changing nature of the PHN role in the province. It was also helpful to have included the perspectives of three PHN managers to have some, albeit limited, glimpse into their experience and views on the changing nature of the PHN role.

Limitations

Even though I recruited participants from three HAs, who had a range of experience from various regions, PHNs in my study may not represent the experience of other PHNs in the

province or country. Nurses interested in participating in my research may have had particularly strong feelings regarding the changing nature of the PHN role. There may be regions in the province where PHNs continue to be supported to work to their full scope of practice in a supportive work environment. This research provides some insight into the experience of a sample of PHNs in BC and is not intended to represent the experience of all PHNs. All grounded theory studies are reflective of, and limited to, the time and place of data collection. Nonetheless, this dissertation study provides some common experience and understanding of the organizational and policy factors influencing PHNs practice, and how some PHNs manage their eroding role. My findings, however, were supported and confirmed by other studies.

Although many researchers have completed grounded theory studies based solely on interview data, I believe triangulation of multiple data sources often bolsters research findings. I drew on several provincial documents and auditor general reports to enhance my understanding of the context. Although I did not use participant observation in my approach, this form of data could have provided another lens into the research.

Applicability Beyond Borders

What has been confirmed for me is the timeliness and relevance of this research to PHNs outside of BC. I have been contacted by PHNs from other Canadian provinces, including Manitoba, Ontario, and Nova Scotia, regarding this dissertation research. These PHNs heard about my project through various avenues, such as word of mouth, an editorial published in the *Canadian Journal of Public Health*, or a presentation that I had completed that was available online. These PHNs wanted to talk to me about their experiences and concerns about the changing nature of PHN practice in their province, and to discuss their local efforts to advocate for the PHN role. I am also currently involved in a national working group comprising nursing

academics and PHN leaders who are concerned about the current state of PHNsg practice, and are strategizing ways to advocate for the PHN role on a national level.

What has also intrigued me was the international response I received from my study. I witnessed the resonance of my research beyond Canadian borders while attending the International Union for Health Promotion and Education Conference in Brazil in 2016. I presented very preliminary findings of my dissertation research, and many nurses from around the world were eager to discuss what they had been witnessing in their practice, and their concerns over the narrowing of the PHN role in their jurisdictions. These PHNs spoke with passion about their activities in communities, and were looking for ways to push back against the erosion of their role so they could continue to promote health.

Concluding Thoughts

In this dissertation research, I described how a number of organizational and policy changes have eroded the PHN role in BC. Using the grounded theory method, informed by critical realism, I explained how PHNs engaged in five strategies to manage contextual factors compromising their practice. By examining the state of PHN practice within the context of public health restructuring, we are better positioned to advocate with and for PHNs, to ensure that a focus on prevention and health promotion remains firmly planted in healthcare reform. Even though the findings of this research surfaced many difficulties within our healthcare system, they also help us to understand what factors are important in the provision of PHNsg services. These factors could be useful to guide decisions regarding the organization, financing, and delivery of PHNsg programs and services.

This year, 2020, the World Health Organization has declared it the year of the nurse and midwife. This international declaration will highlight not only the progress of nursing and its

potential, but also the problems. It seems we have our work cut out for us. Health system reform alongside fiscal constraint has marked the healthcare climate in BC. Health system change has reflected neoliberal ideals, as we have witnessed a weakening in the social safety net such as our publicly funded healthcare system. Public health system restructuring has created a number of challenges for PHNs by reducing autonomy, flexibility, and support for PHNs in their role.

Public health restructuring initiatives have compromised PHNsg programs and services. Participants explained that a series of events, unfolding over time, have slowly eroded the nature of PHNsg practice. Leaders undermined and limited PHN activities and reduced PHN reach in their communities. When leaders limited PHN outreach activities, participants stated that the needs of those most at risk went overlooked. Public health is often long and slow work that requires sustained investment and flexibility, which can be challenging within the current healthcare climate. PHNs require an organizational context that has structures and processes that facilitate PHN autonomy to take action on prevention and promotion in their communities to address health inequities and improve population health.

Working to improve population health and reduce inequities, often starts by working in partnership with and learning from those affected by structural inequities in our society. PHNs are well positioned for this pursuit because they are already established in many communities around the province, and have the necessary skills and knowledge. PHNs are highly skilled collaborators, bringing people together, and maintaining relationships, both of which are key in advancing a health agenda (CHNC, 2019). By examining how public health restructuring has unfolded within the realm of healthcare reform, it provides leaders with insight into this process and can inform steps to strengthen our healthcare systems. By creating supportive environments

conducive to health promotion and prevention activities, we empower PHNs, along with other providers, delivering public health programs to have flexibility, support, and autonomy in their role to respond to local issues and work with partners to improve population health.

By conducting this grounded theory study, I surfaced PHN concerns regarding their practice, described how organizational and policy change have compromised the PHN role, and explained how PHNs managed the erosion of their role in BC. PHNs in my study have voiced their concerns regarding the undermining of public health aims within the current healthcare milieu. Some nurses in my study believed that the PHN profession is at risk because public health restructuring has compromised PHNs' effectiveness in their role. Equipped with this evidence, we will be better positioned to highlight how external forces are compromising PHN care, weakening public health, and worsening health outcomes. Despite the negative impact of organizational and policy change on PHNs, PHNs are a valuable resource that is already well established in communities around the province, and have been providing care for the past 100 years (Green, 1984). Currently, PHNs across the country are diligently working on the surveillance, contact tracing, and follow up for this COVID-19 pandemic, reminding us about the importance of strong public health infrastructure and systems, the value of the PHN role, as well as the need for effective collaboration between and among sectors.

References

- Abbott, L. S., & Elliott, L. T. (2017). Eliminating health disparities through action on the social determinants of health: A systematic review of home visiting in the United States, 2005-2015. *Public Health Nursing, 34*(1), 2-30.
- Aiken, L. H., Sochalski, J., Lake, E. T. (1997). Studying outcomes of organizational change in health services. *Medical Care, 35*(11), NS6-NS18.
- Aiken, L. H., Clarke, S., & Sloane, D. (2000). Hospital restructuring: Does it adversely affect care and outcomes? *Journal of Nursing Administration, 30*(1), 457-465.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, J., Giovannetti, P., Hunt, J., Rafferty, A. M., & Shamian, J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43-53.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of American Medical Association, 288*(16), 1987-1993.
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Lake, E., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration, 38*(5), 223-229.
- Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kozka, M., Lesaffre, E., McHugh, M. D., Moreno-Casbas, M. T., Rafferty, A. M., Schwendimann, R., Scott, A., Tishelman, C., van Achterberg, T., & Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet, 383*(9931), 1824-1830.

- Allen, L. (2015). Why cutting spending on public health is a false economy. *The Conversation*. Retrieved from: <https://theconversation.com/why-cutting-spending-on-public-health-is-a-false-economy-51159>
- Andrews, T. (2006). Conflicting public health discourses – tensions and dilemmas in practice: The case of the Norwegian mother and child health services. *Critical Public Health*, 16(3), 191-204.
- Andrews, T. M., & Waerness, K. (2011). Deprofessionalization of a female occupation: Challenges for the sociology of professions. *Current Sociology*, 59(1), 42-58.
- Andrews, R., & Boyne, G. (2012). Structural change and public services performance: The impact of the reorganization process in English local government. *Public Administration*, 90(2), 297-312.
- Aroskar, M. A. (1989). Community health nurses: Their most significant ethical decision-making problems. *Nursing Clinics of North America*, 24, 957-975.
- Asahara, K., Kobayashi, M., Ono, W., Omori, J., Todome, H., Konishi, E., & Miyazaki, T. (2012). Ethical issues in practice: A survey of public health nurses in Japan. *Public Health Nursing*, 29(3), 266-275
- Association of State and Territorial Directors of Nursing. (2008). *Report on a Public Health Nurse to Population Ratio*. Retrieved from <http://www.quadcouncilphn.org/documents-3/2008-astdn-report-on-a-public-health-nurse-to-population-ratio/>
- Aston, M., Meagher-Stewart, D., Sheppard-LeMoine, D., Vukic, A., & Chircop, A. (2006). Family health nursing and empowering relations. *Pediatric Nursing*, 32, 61-7.

- Aston, M., Meagher-Stewart, D., Edwards, N., & Young, L. (2009). Public health nurses' primary health care practice: Strategies for fostering citizen participation. *Journal of Community Health Nursing, 26*(1), 24-34.
- Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E., & Randel, P. (2014). Universal and targeted early home visiting: Perspectives of public health nurses, managers, and mothers. *Nursing Reports, 4*(1), 12-18.
- Aston, M., Etowa, J., Price, S., Vukic, A., Hart, C., MacLeod, E., & Randel, P. (2016). Public health nurses and mothers challenge and shift the meaning of health outcomes. *Global Qualitative Nursing Research, 3*, 1-10.
- Baldwin, K. A., & Chen, S. C. (1989). The effectiveness of public health nursing services to prenatal care: An integrated review. *Public Health Nursing, 6*(1), 80-87.
- Baldwin, K.A., Lyons R.L., & Issel L.M. (2011). Creating a brand image for public health nursing. *Public Health Nursing, 28*(1), 57-67.
- Ballard, J., George, L., Zazueta-Lara, E., Turner, L., Aguado, J., Law, J., & Alger, R. (2019). Trauma informed public health nursing visits to parents and children. *Public Health Nursing, 36*, 694-701.
- Bambra, C., Garthwaite, K., & Hunter, D. (2014). All things being equal: Does it matter for equity how you organize and pay for health care? A review of the international evidence. *International Journal of Health Services, 44*(3), 457-77.
- Barnes, C. (2005). The nature of social justice. In M. de Chesnay (Ed.), *Caring for the vulnerable: Perspectives in nursing theory, practice and research* (pp. 13-19). Sudbury, MA: Jones and Bartless Publishers.

- Battle Haugh, E., & Mildon, B. (2008). Nursing roles, functions and practice setting. In L. L. Stamler and L. Yiu (Eds.), *Community health nursing* (2nd ed) (pp. 55-71). Toronto, ON: Pearson Prentice Hall.
- Baumann, A., & Blythe, J. (2003). Restructuring, reconsidering, reconstructing: Implications for health human resources. *International Journal of Public Administration*, 26(14), 1561-1579.
- Beaudet, N., Richard, L., Gendron, S., & Boisvert, N. (2011). Advancing population-based health-promotion and prevention practice in community-health nursing. *Advances in Nursing Science*, 34(4), E1-E12.
- Beagan, B., & Ells, C. (2007). Values that matter, barriers that interfere: The struggle of Canadian nurses to enact their values. *Canadian Journal of Nursing Research*, 39(4), 36-57.
- Bekemeier, B., Chen, A. L. T., Kawakyu, N., & Yang, Y. (2013). Local public health resource allocation: Limited choices and strategic decisions. *American Journal of Preventive Medicine*, 45(6), 769-775.
- Bekemeier, B., Yang, Y., Dunbar, M., Pantazis, A., & Grembowski, D. (2014). Targeted health department expenditures benefit birth outcomes at the county level. *American Journal of Preventive Medicine*, 46(6), 569-677.
- Bekemeier, B., Zahner, S. J., Kulbok, P., Merrill, J., & Kub, J. (2016). Assuring a strong foundation for our nation's public health systems. *Nursing Outlook*, 64, 557-565.
- Bekemeier, B., & Ensign, K. (2017). Wanted: Academic health departments to foster evidence-based practice and practice-based evidence. *Journal of Public Health Management and Practice*, 23(3), 328-330.

- Benoit, C., Carroll, D., & Millar, A. (2002). But is it good for non-urban women's health? Regionalizing maternity care services in British Columbia. *Canadian Review of Sociology*, 39(4), 373-395.
- Benson, L., & Hassmiller, S. (2016). Improve the patient experience – ask a nurse to join the board. Retrieved from:
<https://www.nursesonboardscoalition.org/wpcontent/uploads/2017/06/ImprovethePatientExperience-Article.pdf>
- Bergum, V. (2013). Relational ethics for health care. In J. L. Storch, P. Rodney, & R. Starzomski (Eds.), *Towards a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 127-142). Toronto, ON: Pearson Canada.
- Best, M. F., & Thurston, N. E. (2006). Canadian public health nurses' job satisfaction. *Public Health Nursing*, 23(3), 250-255.
- Betker, R.C. (2016). *Public Health Leadership to Advance Health Equity: A Scoping Review and Metasummary*. (Doctoral dissertation). Retrieved from HARVEST.
- Betker, C., MacDonald, M., Hill, M., & Kirk, M. (2016). Theoretical foundations of community health nursing. In L. L. Stamler, L. Yiu, and A. Dosani (Eds.), *Community health nursing: A Canadian perspective* (4th ed., pp. 101-134). Toronto, ON: Pearson
- Betker, C., Hill, M., Kirk, M., & MacDonald, M. (2020). Theoretical foundations of community health nursing. In L. L. Stamler, L. Yiu, A. Dosani, J. Etowa, & C. van Daalen-Smith (Eds.), *Community health nursing: A Canadian perspective* (5th ed., pp. 102-136). Toronto, ON: Pearson
- Bhaskar, R. (1978). *A realist theory of science*. Brighton, UK: Harvester Press.

- Bhaskar, R. (1998). Facts and values: Theory and practice/reason and the dialectic of human emancipation/depth, rationality and change. In M. Archer, R. Bhaskar, A. Collier, T. Lawson, & A. Norrie (Eds), *Critical realism: Essential readings* (pp. 409-43). London, UK: Routledge.
- Bigbee, J.L., & Issel, L.M. (2012). Conceptual models for population-focused public health nursing interventions and outcomes: The state of the art. *Public Health Nursing, 29*(4), 370-379.
- Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide*. Thousand Oaks, CA: Sage Publications.
- Black, M., & Fierlbeck, K. (2006). Whatever happened to regionalization? The curious case of Nova Scotia. *Canadian Public Administration, 49*(4), 506-526.
- Blenkinsopp, J., Snowden, N., Mannion, R., Powell, M., Davies, H., Millar, R., & McHale, J. (2019). Whistleblowing over patient safety and care quality: A review of the literature. *Journal of Health Organization and Management, 33*(6), 737-756.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Los Angeles, CA: University of California Press.
- Blythe, J., Baumann, A., & Giovannetti, P. (2001). Nurses' experiences of restructuring in three Ontario hospitals. *Health Policy and Systems, 33*(1), 61-68.
- Bocken, N. M. P., & Short, S. W. (2016). Towards a sufficiency-driven business model: Experiences and opportunities. *Environmental Innovation and Societal Transitions, 18*, 41-61.

- Boutain, D. M. (2005). Social justice in nursing: A review of the literature. In M. de Chesnay (Ed.), *Caring for the vulnerable: Perspectives in nursing theory, practice, and research* (pp. 21-30). Sudbury, MA: Jones and Bartlett Publishers.
- British Columbia Ministry of Health Services. (2005). *A Framework for Core Functions in Public Health – Resource Document*. Victoria, British Columbia: Author.
- British Columbia Ministry of Health. (2017). *Promote, Protect, Prevent: Our Health Begins Here: BC's Guiding Framework for Public Health*. Victoria, British Columbia Author.
- British Columbia Royal Commission on Health Care and Costs, & Seaton, P. (1991). *Closer to home: The report of the British Columbia Royal Commission on Health Care and Costs*. Retrieved from <https://www.llbc.leg.bc.ca/public/Pubdocs/bcdocs/53108/CloserToHomeVoll.pdf>
- Browne, A. J. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry*, 8(2), 118-129.
- Browne, A. J., Hartrick Doane, G., Reimer, J., MacLeod, M. L. P., & McLelland, E. (2010). Public health nursing practice with 'high priority' families: The significance of contextualizing 'risk.' *Nursing Inquiry*, 17(1), 27-38.
- Bunt, S. (2018). Critical realism and grounded theory: Analyzing the adoption outcomes for disabled children using the retroduction framework. *Qualitative Social Work*, 17(2), 176-94.
- Buresh, B., & Gordon, S. (2006). *From silence to voice: What nurses know and must communicate to the public* (2nd ed.). Cornell University Press: Ithaca, NY.
- Buresh, B., & Gordon, S. (2013). *From silence to voice: What nurses know and must communicate to the public* (3rd Ed.). London: ILR Press.

- Butler-Jones, D. (2020). A forgotten lesson on SARS: The need for public health specialists and expertise. *The Globe and Mail*. Retrieved from:
https://www.theglobeandmail.com/opinion/article-a-forgotten-lesson-of-sars-the-need-for-public-health-specialists-and/?utm_source=Shared+Article+Sent+to+User&utm_medium=E-mail:+Newsletters+/+E-Blasts+/+etc.&utm_campaign=Shared+Web+Article+Links
- Butterfield, P. G. (1990). Thinking upstream: Nurturing a conceptual understanding of the societal context of health behaviour. *Advances in Nursing Science*, 12(2), 1-8.
- Byrd, M. E. (1997). A typology of the potential outcomes of maternal-child home visits: A literature analysis. *Public Health Nursing*, 14(1), 3-11.
- Campbell, S. L., Fowles, E. R., & Wever, B. J. (2004). Organizational structure and job satisfaction in public health nursing. *Public Health Nursing*, 21(6), 564-571.
- Canadian Association of Schools of Nursing Task Force on Public Health Education (2007). *Final report: Public health nursing education at the baccalaureate level in Canada today*. Retrieved from:
<https://casn.ca/wp-content/uploads/2014/12/1FinalReportPublicHealthSeptember2007.pdf>
- Canadian Broadcasting Corporation (CBC) News. (2016). North Bay nurse fired for comments about hospital violence, CUPE leaders say. CBC News. Retrieved from:
<https://www.cbc.ca/news/canada/sudbury/north-bay-nurse-fired-violence-1.3429850>
- Canadian Nurses Association. (2006). *Social justice: A means to an end, an end in itself*. Ottawa, ON: Author.
- Canadian Nurses Association. (2017). *Code of ethics*. Ottawa, ON: Author.

- Canadian Public Health Association. (n.d.). *12 great achievements*. Ottawa, ON: Author.
- Canadian Public Health Association. (2010). *Public Health ~ Community Health Nursing Practice in Canada: Roles and Activities* (4th ed.). Ottawa, ON: Author.
- Canadian Public Health Association. (2019a). *Public Health in the Context of Health System Renewal in Canada* (background document). Author: Ottawa, ON.
- Canadian Public Health Association. (2019b). *Public Health in the Context of Health System Renewal in Canada* (position statement). Author: Ottawa, ON.
- Canales, M. K., & Drevdahl, D. J. (2014). Community/Public health nursing: Is there a future for the specialty? *Nursing Outlook*, 62, 448-458.
- Canales, M. K., Drevdahl, D. J., & Kneipp, S. M. (2018). Letter to the editor: Public health nursing. *Nursing Outlook*, 66(2), 110-111.
- Carter, F. A. (2005). Postnatal home visits from healthcare professionals show promise for preventing postnatal depression. *Evidence-based Mental Health*, 8(4), 108.
- Cartier, C. (2003). From home to hospital and back again: Economic restructuring, end of life, and the gendered problems of place-switching health services. *Social Science & Medicine*, 56(11), 2289-2301.
- Cawley, T., & P.M. McNamara. (2011). Public health nurse perceptions of empowerment and advocacy in child health surveillance in West Ireland. *Public Health Nursing*, 28(2), 150-158.
- Charmaz, K. (2006). *Constructing grounded theory: A practice guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications.
- Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications.

- Choiniere, J. A. (2011). Accounting for care: Exploring tensions and contradictions. *Advances in Nursing Science, 34*(4), 330-344.
- Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage Publications.
- Clarke, A. E. (2009). From grounded theory to situational analysis: What's new? Why? How? In J. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. Clarke (Eds), *Developing grounded theory: The second generation* (pp. 194-235). Walnut Creek, CA: Left Coast Press.
- Clark, A., Lissel, S., & Davis, C. (2008). Complex critical realism: Tenets and application in nursing research. *Advances in Nursing Science, 31*(4), E67-79.
- Clark, A., & Thompson, D. (2010). What heart failure programme works best? Wrong question, wrong assumptions. *European Journal of Heart Failure, 12*, 1271-1273.
- Cleary, S. R., & Doyle, K. E. (2016). Whistleblowing need not occur if internal voices are heard: From deaf effect to hearer courage. *International Journal of Health Policy and Management, 5*(1), 59-61.
- Clemen-Stone, S., Gerber Eigsti, E., & McGuire, S. L. (1995). Ethics in community health nursing practice. In S. Clemen-Stone, E. Gerber Eigsti, & S. L. McGuire (Eds.), *Comprehensive community health nursing: Family, aggregate and community practice* (pp. 908-911). St. Louis, MO: Mosby.
- Cohen, B. (2006). Barriers to population-focused health promotion: The experience of public health nurses in the province of Manitoba. *Canadian Journal of Nursing Research, 38*(3), 52-67.

- Combs-Orme, T., Reis, J., & Ward, L. D. (1985). Effectiveness of home visits by public health nurses in maternal and child health: An empirical review. *Public Health Nursing, 100*, 490-499.
- Community Health Nurses Association of Canada. (2002). *Canadian Community Health Nursing Standards of Practice*. Toronto, ON: Author.
- Community Health Nurses of Canada. (2009). *Public health nursing discipline specific competencies* (1st ed.). Toronto, ON: Author.
- Community Health Nurses of Canada. (2011). *Canadian community health nursing professional practice model and standards of practice*. Toronto, ON: Author.
- Community Health Nurses of Canada. (2019). *Canadian community health nursing professional practice model and standards of practice*. Toronto, ON: Author.
- Cooney, A. (2011). Rigour and grounded theory. *Nurse Researcher, 18*(4), 17-22.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd Ed.). Thousand Oaks, CA: Sage Publications.
- Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse moral distress and ethical work environment. *Nursing Ethics, 12*(4), 381-390.
- Coughlan, R., & Ward, L. (2007). Experiences of recently relocated residents of long-term care facility in Ontario: Assessing quality qualitatively. *International Journal of Nursing Studies, 44*(1), 47-57.
- Creswell, J. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage Publications.

- Crowe, C. (2019). *A knapsack full of dreams: Memoirs of a street nurse*. Victoria, BC: Friesen Press.
- Cummings, G. G., & Estabrooks, C. A. (2003). The effects of hospital restructuring that included layoffs on individual nurses who remained employed: A systematic review. *International Journal of Sociology & Social Policy*, 23(8-9), 8-53.
- Cusack, C., Cohen, B., Mignone, J., Chartier, M.J., & Lutfiyya, Z. (2017). Reorienting public health nurses' practice with a professional practice model. *Canadian Journal of Nursing Research*, 49(1), 16-27.
- Curtis, E. A., & Glacken, M. (2014). Job satisfaction among public health nurses: A national survey. *Journal of Nursing Management*, 22, 653-663.
- Davis, S. (2017). Why nurses are the unsung heroes of global health. *Huff Post*. Retrieved from: https://www.huffpost.com/entry/international-nurses-week_b_1499802?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xiLmNvbS8&guce_referrer_sig=AQAAAHqMj1OEJ9N0TExy_Y067bXmaRcVNUjditcaGNIQQ4ZVFnjBvVso23COowxqwP5ue7iLD6pCSUuvCYKkM1PwigMxb-sEBlyq-sElaLdMfhv95j8konlSD6DL02gK6yEq8u1b7miE80qnAirie5z5okYIWIEk3egj-9KbkBXhjEpT
- Debesay, J., Harslof, I., Rechel, B., & Vike, H. (2014). Dispensing emotions: Norwegian community nurses' handling of diversity in a changing organizational context. *Social Science & Medicine*, 119, 74-80.
- de Chesnay, M., Wharton, R., & Pamp, C. (2005). Cultural competence, resilience, and advocacy. In M. de Chesnay (Ed.), *Caring for the vulnerable: Perspectives in nursing theory, practice, and research* (pp. 31-42). Sudbury, MA: Barlett and Jones Publishers.

- De Lima, L. D., Viana, A. L., Machado, C. V., de Albuquerque, M. V., de Oliveira, R. G. Iozzi, F. L., Scatena, J. H., Mello, G. A., Pereira, A. M., & Coelho, A. P. (2012). Regionalization and access to healthcare in Brazilian states: Historical and political-institutional condition factors. *Ciencia & Saude Coletiva*, *17*(11), 2881-92.
- Denis, J. L., Bergevin, Y., Habib, B., Elicksen, K., Adaime, C., & Rochon, J. (2015). *Is there a future for regionalization in Canada?* Ottawa, ON: Canadian Association for Health Services and Policy Research. Retrieved from:
<https://www.cahspr.ca/en/presentation/5574f6a537dee8b718501959>
- Dewey, J. (1922). *Human nature and conduct*. New York, NY: Holt.
- Dickson, G., Lindstrom, R., Black, C., & Van der Gucht, D. (2012). *Evidence-informed change management in Canadian healthcare organizations*. Canadian Health Services Research Foundation. Retrieved from: https://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Dickson-EN.sflb.ashx
- Diekemper, M., SmithBattle, L., Drake, M. A. (1999a). Bringing the population into focus: A natural development in community health nursing practice. Part I. *Public Health Nursing*, *16*(1), 3-10.
- Diekemper, M., SmithBattle, L., Drake, M. A. (1999b). Sharpening the focus on populations: an intentional community health nursing approach. Part II. *Public Health Nursing*, *16*(1), 11-16.
- Doi, L., Jepson, R., & Hardie, S. (2017). Realist evaluation of an enhanced health visiting programme. *PLoS ONE*, *12*(7). Retrieved from:
<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180569>

- Dosani, A., Hemraj, J., Premji, S. S., Currie, G., Reilly, S. M., Lodha, A., Young, M., & Hall, M. (2017). Breastfeeding the late preterm infant: Experiences of mothers and perceptions of public health nurses. *International Breastfeeding Journal, 12*(23), 1-10.
- Drevdahl, D. (1995). Coming to voice: The power of emancipatory community interventions, *Advances in Nursing Science, 18*(2), 13-24.
- Drevdahl, D. (1999). Sailing beyond: Nursing theory and the person. *Advances in Nursing Science, 21*(4), 1-13.
- Drevdahl, D. (2002). Social justice or market justice? The paradoxes of public health partnerships with managed care. *Public Health Nursing, 19*(3), 161-169.
- Drevdahl, D., Kneipp, S. M., Canales, M. K., & Dorcy, K. S. (2001). Reinvesting in social justice: A capital idea for public health nursing? *Advances in Nursing Science, 24*(2), 19-31.
- Dubois, C. A., Bentein, K., Mansour, J. B., Gilbert, F., & Bedard, J. L. (2014). Why some employees adopt or resist reorganization of work practices in health care: Associations between perceived loss of resources, burnout, and attitudes of change. *International Journal of Environmental Research and Public Health, 11*, 187-201.
- Duckett, S. (2016). Regionalization as one manifestation of the pursuit of the holy grail. *Healthcare Papers, 16*(1), 53-57.
- Duffield, C., Kearin, M., Johnston, J., & Leonard, J. (2007). The impact of hospital structure and restructuring on the nursing workforce. *Australian Journal of Advanced Nursing, 24*(3), 42-46.
- Duncan, S. (1992). Ethical challenges in community health nursing. *Journal of Advanced Nursing, 17*, 1035-1041.

- Duncan, S. (2016). The history of community health nursing in Canada. In L. L. Stamler, L. Yiu, & A. Dosani (Eds.), *Community health nursing: A Canadian Perspective* (4th ed, pp. 1-16). Toronto, ON: Pearson.
- Duncan, S. M., Leipart, B. D., & Mill, J. E. (1999). "Nurses as health evangelists"?: The evolution of public health nursing in Canada, 1918-1939. *Advances in Nursing Science*, 22(1), 40-51.
- Eastwood, J. G., Jalaludin, B. B., & Kemp, L. A. (2014). Realist explanatory theory building method for social epidemiology: A protocol for a mixed method multilevel study of neighbourhood context and postnatal depression. *SpringerPlus*, 3(12), 1-12.
- Erwin, P. C., Greene, S. B., Mays, G. P., Ricketts, T. C., & Davis, M. V. (2011). The association of changes in local health department resources with changes in state-level health outcomes. *American Journal of Public Health*, 101(4), 609-615.
- Erwin, P. C., Mays, G. P., & Riley, W. J. (2012). Resources that may matter: The impact of local health department expenditures on health status. *Public Health Reports*, 127, 89-95.
- Estabrooks, C.A. Midodzi, W. K., Cummings, G. G., Ricker, K. L., & Giovanetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research*, 54(2), 74-84.
- Evans, R. G., Barer, M., L., & Marmor, T. R. (1994). *Why are some people healthy and others not? The determinants of health of populations*. New York, NY: Aldine De Gruyter.
- Falk Rafael, A. (1999). The politics of health promotion: Influences on public health promoting nursing practice in Ontario, Canada from Nightingale to the nineties. *Advances in Nursing Science*, 22(1), 23-39.

- Falk-Rafael, A. R. (2001). Empowerment as a process of evolving consciousness: A model of empowered caring. *Advances in Nursing Science, 24*, 1-16.
- Falk-Rafael, A., Fox, J., & Bewick, D. (2005). Report of a 1999 survey of public health nurses: Is public health restructuring in Ontario, Canada moving toward primary health care? *Primary Health Care Research and Development, 6*, 172-183.
- Falk-Rafael, A. (2005). Speaking truth to power: Nursing's legacy and moral imperative. *Advances in Nursing Science, 28*(3), 212-223.
- Falk-Rafael, A., & Betker, C. (2012a). The primacy of relationship: A study of public health nursing practice from a critical caring perspective. *Advances in Nursing Science, 35*(4), 315-32.
- Falk-Rafael, A., & Betker, C. (2012b). Witnessing social injustice downstream and advocating for health equity upstream: "The trombone slide" of nursing. *Advances in Nursing Science, 35*(2), 98-112.
- Fayerman, P. (2019, November 1). Significant increase in health spending planned for B.C. *Vancouver Sun*, Retrieved from <https://vancouver.sun.com/news/local-news/significant-increase-in-health-spending-planned-for-b-c>
- Federal, Provincial, Territorial Advisory Committee on Population Health. (1994). *Strategies for population health: Investing in the health of Canadians*. Ottawa, ON: Ministry of Supply and Services.
- Fetrick, A., Christenson, M., & Mitchell, C. (2003). Does public health nurse home visitation make a difference in the outcomes of pregnant clients and their offspring? *Public Health Nursing, 20*(3), 184-189.
- Fierlbeck, K. (2016). The politics of regionalization. *Healthcare Papers, 16*(1), 58-62.

- Fierlbeck, K. (2019). Amalgamating provincial health authorities: Assessing the experience of Nova Scotia. *Health Reform Observer*, 7(3), 1-12.
- Fitzpatrick, M. L. (1975). The origin of public health nursing. In *The National Organization for Public Health Nursing, 1912-1952: Development of a Practice Field* (pp. 1-17). New York, NY: National League for Nursing.
- Flodgren, G., Pomey, M., Taber, S., & Eccles, M. P. (2011). Effectiveness of external inspection of compliance with standards in improving healthcare organization behaviour, healthcare professional behaviour or patient outcomes. *Cochrane Database of Systematic Reviews*, 11, CD008992.
- Flodgren, G., Rojas Reyes, X., Cole, N., & Foxcroft, D. R. (2012). Effectiveness of organizational infrastructures to promote evidence-based nursing practice. *Cochrane Database of Systematic Reviews*, 2, CD002212.
- Ganann, R., Underwood, J., Matthews, S., Goodyear, R., Stamler, L. L., Meagher-Stewart, D. M., & Munroe, V. (2010). Leadership attributes: A key to optimal utilization of the community health nursing workforce. *Nursing Leadership*, 23(2), 60-71.
- Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.
- Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: The Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: The Sociology Press.
- Glaser, B. (2002). Constructivist grounded theory? *Forum Qualitative Sozialforschung*, 3(3), 1-14.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Hawthorne, NY: Aldine De Gruyter.

- Graham, K. R., Davies, B. L., Woodend, A. K., Simpson, J., & Mantha, S. (2011). Impacting Canadian public health nurses' job satisfaction. *Canadian Journal of Public Health, 102*(6), 427-431.
- Green, M. M. (1984). *Through the years with public health nursing*. Ottawa, ON: The Canadian Public Health Association.
- Greenglass, E. R., & Burke, R. J. (2001). Stress and the effects of hospital restructuring on nurses. *Canadian Journal of Nursing Research, 33*(2), 93-108.
- Griffith, A. I., & Smith, D. E. (2014). Introduction. In A. I. Griffith & D. E. Smith (Eds), *Under new public management: Institutional Ethnographies of Changing front-line work* (pp. 3-21). Toronto, ON: University of Toronto Press.
- Gunn, V., Muntaner, C., Villeneuve, M., Chung, H., & Gea-Sanchez, M. (2018). Nursing professionalization and welfare state policies: A critical review of structural factors influencing the development of nursing and the nursing workforce. *Nursing Inquiry, 26*, 1-12.
- Guyon, A. & Perreault, R. (2016). Public health systems under attack in Canada: Evidence on public health system performance challenges arbitrary reform. *Canadian Journal of Public Health, 107*(3), e326-e329.
- Guyon, A., Hancock, T., Kirk, M., MacDonald, M., Neudorf, C., Sutcliffe, P., & Talbot, J. (2017). The weakening of public health: A threat to population health and health care system sustainability. *Canadian Journal of Public Health, 108*(1), e1-e6.
- Hancock, T., & McLaren, L. (2019). Why public health matters today. *Canadian Journal of Public Health, 110*, 259-263.

- Hardill, K. (2006). From the Grey Nuns to the streets: A critical history of outreach nursing in Canada. *Public Health Nursing, 24*(1), 91-97.
- Hart, S. E. (2005). Hospital ethical climates and registered nurses' turnover intentions. *Journal of Nursing Scholarship, 37*(2), 173-177.
- Hassmiller, S. B. (2014). Leveraging public health nursing to build a culture of health. *American Journal of Preventive Medicine, 47*(5), S391-S392.
- Health Canada. (n.d. a). *Nutrition for healthy term infants: Recommendations from six to 24 months*. Retrieved from:
<https://www.canada.ca/en/health-canada/services/canada-food-guide/resources/infant-feeding/nutrition-healthy-term-infants-recommendations-birth-six-months/6-24-months.html>
- Health Canada. (n.d. b). *Nutrition for healthy term infants: Recommendations from birth to six months*. Retrieved from:
<https://www.canada.ca/en/health-canada/services/canada-food-guide/resources/infant-feeding/nutrition-healthy-term-infants-recommendations-birth-six-months.html#a4>
- Healy, R. (2016). Nurses lay into RN at hearing about 'inappropriate' post complaining about care for her dying grandpa. *National Post*. Retrieved from:
<https://news.nationalpost.com/news/canada/shes-attacking-me-as-a-colleague-registered-nurse-facing-discipline-over-critical-facebook-post>
- Heaman, M., Chalmers, K., Woodgate, R., & Brown, J. (2006). Early childhood home visiting programme: factors contributing to success. *Journal of Advanced Nursing, 55*(3), 291-300.

- Hermer, J., Hirsch, A., Bekemeier, B., Nyirati, C., Wojnar, D., Wild, L., Walsh Dotson, J. A., Smith, S., Griffin-Sobel, J. P., & Oneal, G. (2019). Integrating population health into nursing education: The process of gaining commitment from Washington's nursing deans and directors. *Journal of Professional Nursing* (in press).
- Hertzman, C., & Boyce, T. (2010). How experience gets under the skin to create gradients in developmental health. *Annual Review of Public Health, 31*, 329-347.
- Hill, M. E. (2017). *Public health nursing: What difference does it make for priority perinatal women?* (Doctoral dissertation). Retrieved from <https://dspace.library.uvic.ca/handle/1828/8475>
- Hurley, J., Lomas, J., & Bhatia, V. (1994). When tinkering is not enough: Provincial reform to manage health care resources. *Canadian Public Administration, 37*(3), 490-514.
- Human Early Learning Partnership. (2015). *Proportionate universality: Policy brief*. University of British Columbia, BC.
- Hutchinson, S. A. (1990). Responsible subversion: A study of rule-bending among nurses. *Scholarly Inquiry for Nursing Practice, 4*(1), 3-17.
- Hyatt, J. (2017). Recognizing moral disengagement and its impact on patient safety. *Journal of Nursing Regulation, 7*(4), 15-21.
- Ingersoll, G. L., Fisher, M., Ross, B., Soja, M., & Kidd, N. (2001). Employee response to major organizational redesign. *Applied Nursing Research, 14*(1), 18-28.
- Institute of Medicine. (1988). *The Future of Public Health*. Washington, DC: National Academy Press.
- Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: Author.

- Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. National Academies Press: Washington, DC.
- Ip, S., Chung, M., Raman, G., Chew, P., Magula, N., DeVine, D., Trikalinos, T., & Lau, J. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. In Tufts-New England Medical Center Evidence-Based Practice Center (Ed.), *AHRQ Publication No. 07-E007* (Evidence Report/Technology Assessment Number 153). Rockville, MD: Agency for Healthcare Research and Quality.
- Issel, L.M., Bekemeier, B., & Kneipp, S. (2012). A public health nursing research agenda. *Public Health Nursing, 29*(4), 330-342.
- Jack, S. M., DiCenso, A., & Lohfeld, L. (2005). A theory of maternal engagement with public health nurses and family visitors. *Journal of Advanced Nursing, 49*(2), 182-190.
- Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice-Hall.
- Jantzen, D., Nowell, L., & Scott, P. (2017). Registered nurses' experiences of organizational change in acute care settings: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports, 17*(4), 855-861.
- Judd, J., & Keleher, H. (2013). Reorienting health services in the Northern Territory of Australia: A conceptual model for building health promotion capacity in the workforce. *Global Health Promotion, 20*(2), 53-63.
- Kay, K., Evans, A., & Glass, N. (2015). Moments of speaking and silencing: Nurses share their experiences of manual handling in healthcare. *Collegian, 22*, 61-70.
- Kearney, M., York, R., Deatrck, J. (2000). Effects of home visits to vulnerable young families. *Journal of Nursing Practice, 32*(4), 369-376.

- Kearney, M. H. (2009). Taking grounded theory beyond psychological process. *Research in Nursing & Health, 32*, 567-68.
- Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., Schmied, V., Aslam, H., & Zapart, S. (2011). Child and family outcomes of a long-term nurse home visitation programs: A randomized controlled trial. *Archives of Disease in Childhood, 96*(6), 533-540.
- Kempster, S., & Parry, K. W. (2011). Grounded theory and leadership research: A critical realist perspective. *The Leadership Quarterly, 22*, 106-120.
- Kim, C. S., Spahlinger, J. M., & Billi, J. E. (2006). Lean health care: What can hospitals learn from a world-class automaker? *Journal of Hospital Medicine, 1*(3), 191-199.
- King, M., Harrison, M. J., & Reutter, L. (1995). Public health nursing or community health nursing: What's in a name? In M. J. Stewart (Ed.), *Community nursing: Promoting Canadians' health* (pp. 400-412). Toronto, ON: W.B. Saunders.
- Kinsman, L., Rotter, T., Stevenson, K., Bath, B., Goodridge, D., Harrison, L., Dobson, R... (2014). "The largest lean transformation in the world": The implementation and evaluation of Lean in Saskatchewan healthcare. *Healthcare Quarterly, 17*(2), 29-32.
- Kirk, M., Tomm-Bonde, L., & Schreiber, R. (2014). Public health reform and health promotion in Canada. *Global Health Promotion, 21*(2), 15-22.
- Kirkham, S. R., & Anderson, J. M. (2002). Postcolonial nursing scholarship: From epistemology to method. *Advances in Nursing Science, 25*(1), 1-17.
- Koniak-Griffin, D., Anderson, N., Brecht, M., Verzemnieks, I., Lesser, J., & Kim, S. (2002). Public health nursing care for adolescent mothers: Impact on infant health and selected maternal outcomes at 1 year postbirth. *Journal of Adolescent Health, 30*(1), 44-54.

- Kramer, M., & Schmalenberg, C. E. (2003). Magnet hospital nurses describe control over nursing practice. *Western Journal of Nursing Research, 25*(4), 434-452.
- Kub, J. E., Kulbok, P. A., & Merrill, J. A. (2017). Increasing the capacity of public health nursing to strengthen the public health infrastructure and to promote and protect the health of communities and populations. *Nursing Outlook, 65*, 661-664.
- Kullen Engstrom, A., Rosengren, K., & Hallberg, L. M. (2002). Balancing involvement: Employees' experiences of merging hospital in Sweden. *Journal of Advanced Nursing, 38*(1), 11-18.
- Kuokkanen, L., Suominen, T., Rankinen, S., Savikko, M., Kukkurainen, M. L., & Irvine Doran, D. (2007). Organizational change and work-related empowerment. *Journal of Nursing Management, 15*, 500-507.
- Kutney-Lee, A., Germack, H., Hatfield, L., Kelly, S., Maguire, P., Dierkes, A., Del Guidice, M., & Aiken, L. H. (2016). Nurse engagement in shared governance and patient and nurse outcomes. *Journal of Nursing Administration, 46*(11), 605-612.
- Labonte, R., Frank, J., Ruggiero, E. (2008). Introduction. In J. Green & R. Labonte (Ed.), *Critical perspective in public health* (pp. 14-23). London, UK: Routledge.
- Labonté, R., & Stuckler, D. (2016). The rise of neoliberalism: How bad economics imperils health and what to do about it. *Journal of Epidemiology and Community Health, 70*(3), 312–318. <https://doi.org/10.1136/jech-2015-206295>
- Lee, F. (2012). Critical realism, grounded theory, and theory construction in heterodox economics. *Munich Personal RePEc Archive*. Retrieved from <http://mpra.ub.uni-muenchen.de/40341/>

- Lomas, J., Woods., J., & Veenstra, G. (1997). Devolving authority for health care in Canada's provinces: 1. An introduction to the issues. *Canadian Medical Association Journal*, 156(3), 371-377.
- MacDonald, M. (2001). Finding a critical perspective in grounded theory. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 113-157). New York, NY: Springer Publishing Company.
- MacDonald, M. (2004). From miasma to fractals: The epidemiology revolution and public health nursing. *Public Health Nursing*, 21(4), 380-391.
- MacDonald, M. (2013). Ethics of public health. In J. Storch, P. Rodney, & R. Starzomski (Eds.), *Towards a moral horizon: Nursing ethics in leadership and practice* (2nd ed., pp. 398-429). Don Mills: Pearson Education Canada.
- MacDonald, M., & Schreiber, R. S. (2001). Constructing and deconstructing: Grounded theory in a postmodern world. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 35-53). New York, NY: Springer Publishing Company.
- MacMillan, H., Thomas, B. H., Jamieson, E., Walsh, C., Boyle, M. H., Shannon, H. S., & Gafni, A. (2005). Effectiveness of home visitation by public health nurses in prevention of the recurrence of child physical abuse and neglect: A randomized controlled trial. *Lancet*, 365(9473), 1786-1793.
- Marcellus, L. (2005). The ethics of relation: Public health nurses and child protection clients. *Journal of Advanced Nursing*, 51(4), 414-420.
- Marchildon, G. (2019). The integration challenges in Canadian regionalization. *Cadernos de Saude Publica*, 35(2), Supplement 2. Retrieved from:
http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2019000800501

- Marmot, M. (2010). Fair society, health lives: Strategic review of health inequalities in England post-2010. Retrieved from: <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf>
- Masters, R., Anwar, E., Collins, B., Cookson, R., & Capewell, S. (2017). Return on investment of public health interventions: A systematic review. *Journal of Epidemiology and Community Health, 71*, 827-834.
- Mays, G. P., & Smith, S. A. (2011). Evidence links increases in public health spending to declines in preventable deaths. *Health Affairs, 30*(8), 1-9.
- McEvoy, P., & Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing, 11*(1), 66-80.
- McKay, M. (2012). The history of community health nursing in Canada. In L. L. Stamler & L. Yiu (Eds.), *Community health nursing: A Canadian perspective* (pp. 1-20). Toronto, ON: Pearson Canada.
- McLaren, L., & Hawe, P. (2005). Ecological perspectives in health research. *Journal of Epidemiology and Community Health, 59*(1), 6-14.
- McMillan, K. (2016). Politics of change: The discourses that inform organizational change and their capacity to silence. *Nursing Inquiry, 23*(3), 223-31.
- Mead, M. (1934). *Mind, self and society*. Chicago, IL: University of Chicago Press
- Meagher-Stewart, D., Edwards, N., Aston, M., & Young, L. (2009). Population health surveillance practice of public health nurses. *Public Health Nursing, 26*(6), 553-560.
- Meagher-Stewart, D., Underwood, J., Schoenfeld, B., Lavoie-Tremblay, M., Blythe, J., MacDonald, M., Ehrlich, A., Knibbs, K., & Munroe, V. (2009). Building Canadian public

- health nursing capacity: Implications for action: Health human resources series number 15. London, ON: Nursing Health Service Research Unit.
- Meagher-Stewart, D., Underwood, J., MacDonald, M., Schoenfeld, B., Blythe, J., Knibbs, K., Munroe, V., Lavoie-Tremblay, M., Ehrlich, A., Ganann, R., & Crea, M. (2010). Organizational attributes that assure optimal utilization of public health nurses. *Public Health Nursing, 27*(5), 433-441.
- Milliken, P. J., & Schreiber, R. S. (2001). Can you “Do” grounded theory without symbolic interactionism? In R.S. Schreiber & P.N. Stern (Eds.), *Using grounded theory in nursing* (pp. 35-53). New York, NY: Springer Publishing Company
- Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice, 12*(2), 8-13.
- Misund Dahl, B., Clancy, A., & Andrews, T. (2014). The meaning of ethically charged encounters and their possible influence on professional identity in Norwegian public health nursing: A phenomenological hermeneutic study. *Scandinavian Journal of Caring Sciences, 28*, 600-608.
- Mitton, C., Peacock, S., Storch, J., Smith, N., & Cornelissen, E. (2011). Moral distress among health system managers: Exploratory research in two British Columbia health authorities. *Health Care Analysis, 19*(2), 107-121.
- Monsen, K. A., Radosevich, D. M., Kerr, M. J., & Fulkerson, J. A. (2011). Public health nurses tailor interventions for families at risk. *Public Health Nursing, 28*(2), 119-128.
- Monsen, K.A., Bekemeier, B., Newhouse, R., & Scutchfield, S. (2012). Development of a public health nursing data infrastructure. *Public Health Nursing, 29*(4), 343-351.

- Monsen, K.A., Brandt, J.K., Brueshoff, B.L., Chi, C.L., Mathiason, M.A., Swenson, S.M., & Thorson, D.R. (2017). Social determinants and health disparities associated with outcomes of women of childbearing age who receive public health nurse home visiting services. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 46(2), 292-303.
- Moules, N.J., MacLeod, M.L.P., Thirsk, L.M., & Hanlon, N. (2010). "And then you'll see her in the grocery store": The working relationships of public health nurses and high-priority families in Northern Canadian communities. *Journal of Pediatric Nursing*, 25(5), 327-334.
- Musto, L. (2018). *Risking vulnerability: Enacting moral agency in the is/ought gap in mental health care*. (Doctoral dissertation). Retrieved from <http://hdl.handle.net/2429/66189>
- National Collaborating Center for Determinants of Health (2013). *Let's talk: Universal and targeted approaches to health equity*. Antigonish, NS: Author.
- National Collaborating Centre for Determinants of Health. (2014). Let's talk... Moving upstream. *Let's Talk Series*. Retrieved from <http://nccdh.ca/resources/entry/lets-talk-moving-upstream>
- National Collaborating Centre for Healthy Public Policy. (2018). *Structural Profile of Public Health in Canada*. Retrieved from: <http://www.ncchpp.ca/en/structuralprofile.aspx>
- Nauright, L. P. (2005). Preparing nursing professionals for advocacy: Service learning. In M. de Chesnay (Ed.), *Caring for the vulnerable: Perspectives in nursing theory, practice, and research*. Sudbury, MA: Bartlett and Jones Publishers.
- Naylor, D., Basrur, S., Bergeron, M., Brunham, R., Butler-Jones, D., Dafeo, G., Ferguson-Pare, M., Lussing, F., McGreer, A., Neufeld, K., & Plummer, F. (2003). *Learning from SARS: Renewal of public health in Canada*. Ottawa, ON: Health Canada

- Norrish, B., & Rundall, T. G. (2001). Hospital restructuring and the work of registered nurses. *The Millbank Quarterly*, 79(1), 55-79.
- Nurses and Nurse Practitioners of British Columbia. (2019). *National Immunization Awareness Week*. Burnaby, BC: Nurses and Nurse Practitioners of British Columbia.
- Oberle, K., & Tenove, S. (2000). Ethical issues in public health nursing. *Nursing Ethics*, 7(5), 425-438.
- O'Brien-Pallas, L., Alksnis, C., Wang, S., & Birch, S. (2003). Early retirement among RNs: Estimating the size of the problem in Canada. *Longwoods Review*, 1(4), 2-9.
- O'Brien-Pallas, L., Griffin, P., Shamian, J., Buchan, J., Duffield, C., Hughes, F., Spence Laschinger, H., North, N., & Stone, P. W. (2006). The impact of nurse turnover on patient, nurse, and system outcomes: A pilot study and focus for a multicenter international study. *Policy, Politics, & Nursing Practice*, 7(3), 169-170.
- O'Byrne, P. (2011). An argument for practice-based public health research on sexually transmitted infection management. *Public Health Nursing*, 28(4), 357-65.
- O'Connor DR (Hon.). (2002). *Walkerton Commission of Inquiry Reports*. Toronto, ON: Ontario Ministry of the Attorney General. Retrieved on August 17, 2019 from: <http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/walkerton/>.
- Oladele, D., Clark, A. M., Richter, S., & Laing, L. (2013). Critical realism: A practical ontology to explain the complexities of smoking and tobacco control in different resource settings. *Global Health Action*, 6, 1-14.
- Olds, D. L. (2006). The nurse-family partnership: An evidence-based preventive intervention. *Infant Mental Health*, 27(1), 5-25.

- Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlain, R. (1988). Improving the life-course development of socially disadvantaged mothers: A randomized trial of nurse home visitation. *American Journal of Public Health, 78*, 1436-1445.
- Olds, D., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M. & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*(8), 637-643.
- Olds, D., Robinson, J., O'Brien, R., Luckey, D., Pettitt, L., Henderson, C., Ng, R., Scheff, K., Korfmacher, J., Hiatt, S., & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110*(3), 486-496.
- Olds, D., Kitzman, H., Knudtson, M. D., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality: Results of a 2-decade follow up of a randomized clinical trial. *Journal of American Medical Association Pediatrics, 168*(9), 800-806.
- Oliver, C. (2012). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work, 42*, 371-87.
- Olson-Keller, L., Strohschein, S., Lia-Hoagberg, B., & Schaffer, M. A. (2004). Population-based public health interventions: Practice-based and evidence-supported. *Public Health Nursing, 21*, 453-468.
- Park, Y.S., McNaughton, D.B., Mathiason, M.A., & Monsen, K.A. (2019). Understanding tailored PHN interventions and outcomes of Latina mother. *Public Health Nursing, 36*, 87-95.

- Paton, C. (2014). Garbage-can policy-making meets neo-liberal ideology: Twenty five years of redundant reform of the English National Health Service. *Social Policy & Administration*, 48(3), 319–342. <https://doi.org/10.1111/spol.12044>
- Patrick, A., & Spence Laschinger, H. K. (2006). The effect of structural empowerment and perceived organizational support on middle level nurse managers' role satisfaction. *Journal of Nursing Management*, 14, 13-22.
- Pauly, B., Shahram, S. Z., van Roode, T., Strosher, H. W., & MacDonald, M. (2017). *Making health equity a priority*. Victoria, BC: The Equity Lens in Public Health (ELPH) Research Project.
- Pauly, B., van Roode, T., Strosher, H. W., Shahram, S. Z., & MacDonald, M. (2017). *How is a health equity lens being applied in British Columbia?* The Equity Lens in Public Health (ELPH) Research Project, Victoria, BC.
- Penn Nursing. (2020). *\$4 Million Grant to Improve Mental Health and Well-being of Health Professionals and Patient Safety*. Retrieved from: <https://www.nursing.upenn.edu/live/news/1547-4-million-grant-to-improve-mental-health-and?fbclid=IwAR3r5N6KZfD3kWkQX5o0FCAUkFR3-bD2jkiId4sL2RMWP2pFKWZ4V7m-ogc>
- Peter, E., Sweatman, L., & Carlin, K. (2016). Advocacy, ethical, and legal considerations. In L. L. Stamler, L. Yiu, & A. Dosani (Eds.), *Community health nursing: A Canadian Perspective* (4th ed, pp. 88-100). Toronto, ON: Pearson.
- Picard, A. (2017). *Our system suffers when health workers are muzzled*. The Globe and Mail. Retrieved from:

https://www.theglobeandmail.com/opinion/our-system-suffers-when-health-workers-are-muzzled/article33207845/?click=sf_globe

- Pijl-Zieber, E., Barton, S., Awosoga, O., & Konkin, J. (2015). Nursing students achieving community health competencies through undergraduate clinical experiences: A gap analysis. *International Journal of Nursing Education Scholarship*, *12*, 143-154.
- Poland, B., Frohlich, K. L., & Cargo, M. (2008). Context as a fundamental dimension of health promotion program evaluation. In L. Potvin & D. McQueen (Eds.), *Health Promotion Evaluation Practices in the Americas* (pp. 299-317). New York, NY: Springer.
- Pope, R. (2019). Organizational silence in the NHS: “Hear no, see no, speak no”. *Journal of Change Management*, *19*(1), 45-56.
- Porr, C., Drummond, J., & Olson, K. (2012). Establishing therapeutic relationships with vulnerable and potentially stigmatized clients. *Qualitative Health Research*, *22*(3), 384-396.
- Potvin, L. (2014). Canadian public health under siege. *Canadian Journal of Public Health*, *105*(6), e401-e403.
- Powers, M., & Faden, R. (2006). *Social justice: The moral foundations of public health and health policy*. Oxford University press, USA.
- Public Health Agency of Canada. (2003). *National immunization strategy: A report for the F/P/T advisory committee on population health and health security*. Retrieved from: https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/publicat/nis-sni-03/pdf/nat_imm_strat_e.pdf
- Public Health Agency of Canada. (2007). *Core Competencies for Public health in Canada Release 1.0*. Ottawa, ON: Author.

Public Health Agency of Canada. (2008). *Addressing health inequalities*. (HP2-10/2008E).

Ottawa, ON: Minister of Health, Retrieved from <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/pdf/cpho-report-eng.pdf>.

Public Health Agency of Canada. (2011). *Reducing health inequities: A challenge for our times*.

(HP35-22/2011E). Ottawa, ON: Her Majesty the Queen in Right of Canada, Retrieved from http://publications.gc.ca/collections/collection_2012/aspc-phac/HP35-22-2011-eng.pdf.

Pugh, L. C., Milligan, R. A., Frick, K. D., Spatz, D., & Bronner, Y. (2002). Breastfeeding duration, costs, and benefits of a support program for low-income breastfeeding women. *Birth, 29*(2), 95-100.

Purdy, N., Spence Laschinger, H. K., Finegan, J., Kerr, M., & Olivera, F. (2010). Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management, 18*, 901-913.

Quad Council of Public Health Nursing Organizations. (2011). *Research in nursing: Policy brief*.

Retrieved from:

http://www.achne.org/files/Quad%20Council/QCStrategicBriefResearchinPHN_Practice.pdf

Rafael, A. R. F. (2000). Nurses' orientations to change: Debunking the "resistant to change" myth. *Journal of Professional Nursing, 16*(6), 336-344.

Raission, K. M., & Su, J. H. (2018). The best of intentions: Prenatal breastfeeding intentions and infant health. *SSM - Population Health, 5*, 86-100.

Rankin, J. M., & Campbell, M. L. (2006). *Managing to nurse: Inside Canada's health care reform*. Toronto, ON: University of Toronto Press.

- Rankin, J. M. (2009). The nurse project: An analysis for nurses to take back our work. *Nursing Inquiry, 16*, 275-286.
- Raphael, D. (2004). *Social determinants of health: Canadian perspectives*. Toronto, ON: Canadian Scholars' Press.
- Regan, S., MacDonald, M., Allen, D.E., Martin, C., & Perrof-Johnston, N. (2014). Public health human resources: A comparative analysis of policy documents in two Canadian provinces. *Human Resources for Health, 12*(13), 1-11.
- Registered Nurses Association of Ontario. (1998). *Public health nursing: Position paper*. Toronto, ON: Registered Nurses Association of Ontario.
- Renfrew, M. J., McCormick, F. M., Wade, A., Quinn, B., & Dowsell, T. (2012). Support for healthy breastfeeding mothers with health term babies. *Cochrane Database of Systematic Reviews, 5*.
- Reutter, L., & Ford, J. (1996). Perceptions of public health nursing: Views from the field. *Journal of Advanced Nursing, 24*, 7-15.
- Reutter, L., & Kushner, K. E. (2010). 'Health equity through action on the social determinants of health': Taking up the challenge in nursing. *Nursing Inquiry, 17*(3), 269-280.
- Rieger, K. L. (2019). Discriminating among grounded theory approaches. *Nursing Inquiry, 26*, 1-12.
- Roan, A., Lafferty, G., & Loudon, R. (2002). Survivors and victims: A case study of organizational restructuring in public health. *New Zealand Journal of Industrial Relations, 27*(2), 151-168.
- Rodney, P. A. (2017). What we know about moral distress. *American Journal of Nursing, 117*(2), S7-S10.

- Rodney, P., Hartrick Doane, G., Storch, J., & Varcoe, C. (2006). Toward a safer moral climate. *Canadian Nurse, 102*(8), 24-27.
- Rodney, P., & Varcoe, C. (2012). Constrained agency: The social structure of nurses' work. In F. Baylis, B. Hoffmaster, S. Sherwin, & K. Borgerson (Eds.). *Health care ethics in Canada* (3rd ed., p. 97-114). Toronto, ON: Nelson
- Rodney, P., Kadyschuk, S., Liaschenko, J., Brown, H., Musto, L., & Snyder, N. (2013). Moral agency: Relational connections and supports. In J. Storch, P. Rodney, & R. Starzomski (Eds.). *Towards a moral horizon: Nursing ethics for leadership and practice* (2nd ed., pp. 160-187). Don Mills, ON: Pearson
- Royal College of Nursing. (2020). *Gender and nursing as a profession: Valuing nurses and paying them their worth*. London: Author.
- Rutty, C. & Sullivan, S. (2010). *This is public health: A Canadian history*. Ottawa: Canadian Public Health Association. Retrieved from:
https://cpha.ca/sites/default/files/assets/history/book/history-book-print_all_e.pdf
- Salmela, S., Eriksson, K., & Fagerstrom, L. (2013). Nurse leaders' perceptions of an approaching organizational change. *Qualitative Health Research, 25*(5), 689-699.
- Schim, S., Benkert, R., Bell, S., Walker, D., & Danford, C. (2007). Social justice: Added metaparadigm concept for urban health nursing. *Public Health Nursing, 24*(1), 73-80.
- Schofield, R., Ganann, R., Brooks, S., McGugan, J., Dalla Bona, K., Betker, C., Dilworth, K., Parton, L., Reid-Haughian, C., Slepkov, M., & Watson, C. (2010). Community health nursing vision for 2020: Shaping the future. *Western Journal of Nursing Research, 33*(8), 1047-1068.

Schreiber, R. S., & Stern, P. N. (2001). Introduction. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. xvi-xviii). New York, NY: Springer Publishing Company

Scottish Executive. (2005). Health for All Children 4: Guidance on Implementation in Scotland.

Retrieved from:

<https://www2.gov.scot/Resource/Doc/37432/0011167.pdf>

Scottish Government. (2012). A guide to getting it right for every child. Retrieved from:

<https://www.gov.scot/policies/girfec/>

Scottish Government. (2016). A plan for Scotland: the Scottish Government's programme for 2016-2017. Retrieved from:

<https://www.gov.scot/publications/plan-scotland-scottish-governments-programme-scotland-2016-17/pages/6/>

Schaffer, M. A., Goodhue, A., Stennes, K., & Lanigan, C. (2012). Evaluation of the public health nursing visiting program for pregnant and parenting teens. *Public Health Nursing, 29*(3), 218-231.

Schaffer, M. A., Kellar, L. O., & Reckinger, D. (2015). Public health nursing activities: Visible of invisible? *Public Health Nursing 32*(6), 711-720.

Scutchfield, F.D., Mays, G.P., & Lurie, N. (2009). Applying health services research to public health practice: An emerging priority. *Health Services Research, 44*, 1775-87.

Sibbald, S., Jegatheeswaran, J., Pocock, H., & Penney, G. (2020). A national survey of educational and training preferences and practices for public health nurses in Canada. *The Journal of Continuing Education in Nursing, 51*(1), 25-31.

- Singh, S. R. (2014). Public health spending and population health: A systematic review. *American Journal of Preventative Medicine, 45*(5), 634-640.
- SmithBattle, L., Drake, M.A., & Diekemper, M. (1997) The responsive use of self in community health nursing. *Advances in Nursing Science, 20*(2), 75-89.
- Spence Laschinger, H. K., Sabiston, J. A., Finegan, J., & Shamian, J. (2001). Voices from the trenches: Nurses' experiences of hospital restructuring in Ontario. *Canadian Journal of Nursing Leadership, 14*(1), 6-13.
- Spence Laschinger, H. K. & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: the mediating role of burnout/engagement. *Journal of Nursing Administration, 36*(5), 259-267.
- Spence Laschinger, H. K., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management, 17*, 302-311.
- Spence Laschinger, H. K., Gilbert, S., Smith, L. M., & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: Applying Kanter's empowerment theory to patient care. *Journal of Nursing Management 18*, 4-13.
- Spenceley, S. M., Reutter, L., Allen, M. N. (2006). The road less travelled: Nursing advocacy at the policy level. *Policy, Politics, & Nursing Practice, 7*(3), 180-94.
- Starfield, B. (2001). Improving equity in health: A research agenda. *International Journal of Health Services, 31*(3), 545-566.
- Starn, J. R. (1992). Community health nursing visits for at-risk women and infants. *Journal of Community Health Nursing, 9*, 103-110.

- Stern, P. N. (1994). Eroding grounded theory. In Morse, J. M. (Eds.), *Critical Issues in Qualitative Research Methods* (pp. 212-223). Thousand Oaks, CA: Sage.
- Stokols, D. (1992). Establishing and maintaining healthy environments: Toward a social ecology of health promotion. *American Psychologist*, 47(1), 6-22.
- Storch, J., Rodney, P., & Starzomski, R. (2009). Ethics in health care in Canada. In B. Singh Bolaria & H. D. Dickinson (Eds.), *Health, Illness, and Health Care in Canada* (4th ed., pp. 458-490). Nelson Education: Toronto, ON.
- Storey, C., Cheater, F., Ford, J., & Leese, B. (2009). Retaining older nurses in primary care and the community. *Journal of Advanced Nursing*, 65(7), 1400-1411.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage Publications.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks: Sage Publications.
- Suominen, T., Harkonen, E., Rankinen, S., Kuokkanen, L., Kukkurainen, M. L., & Doran, D. (2011). Perceived organizational change and its connection to the work-related empowerment. *Nordic Journal of Nursing Research*, 31(1), 4-9.
- Swinder, S. M., Levin, P. F., & Kulbok, P. (2014). Quad council of public health nursing organizations invitation forum on the role and future of nurses in public health: Final report. Retrieved from http://www.quadcouncilphn.org/wp-content/uploads/2016/03/2014_QCC-Invitational-Forum-on-the-Role-and-Future-of-Nurses-in-Public-Health-.pdf
- Swinder, S. M., Levin, P. F., & Reisling, V. (2017). Evidence of public health nursing effectiveness: a realist review. *Public Health Nursing*, 34(4), 324-334.

The Standing Senate Committee on Social Affairs, Science and Technology, & Kirby M.

(2003). *Reforming health protection and promotion in Canada: Time to act*. Retrieved from: <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/repfinnov03-e.htm>.

Thorne, S. (2008). *Interpretive description*. Oakland, CA: Left Coast Press.

Times Colonist Editorial Board. (2019, November 8). Editorial: B.C.'s spending on health care isn't worth boasting about. *Times Colonist*. Retrieved from <https://www.timescolonist.com/opinion/editorials/editorial-b-c-s-spending-on-health-care-isn-t-worth-boasting-about-1.24001299>

Underwood, J. (2003). *The value of nurses in the community*. Ottawa, ON: Canadian Nurses Association.

Underwood, J. M., Mowat, D. L., Meagher-Stewart, D. M., Deber, R. B., Baumann, A. O., MacDonald, M. B., Akhtar-Danesh, N., Schoenfeld, B. M., Ciliska, D. K., Blythe, J. M., Lavoie-Tremblay, M., Ehrlich, A. S., Knibbs, K. M., & Munroe, V. J. (2009). Building community and public health capacity: A synthesis report of the National Community Health Nursing Study. *Canadian Journal of Public Health, 100*(5), I1-I11.

University of Michigan Center of Excellence in Public Health Workforce Studies. (2013). *Enumeration and Characterization of the Public Health Nurse Workforce: Findings of the 2012 Public Health Nurse Workforce Surveys*. Ann Arbor, MI: University of Michigan.

Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J. L., Mahoney, K., Mcpherson, G., Brown, H., & Starzomski, R. (2004). Ethical practice in nursing: Working the in-betweens. *Journal of Advanced Nursing, 45*(3), 316-325.

- Varcoe, C., & Rodney, P. (2009). Constrained agency: The social structure of nurses' work. In B. Singh Bolaria & H. D. Dickinson (Eds.), *Health, Illness, and Health Care in Canada* (4th ed., pp. 122-151). Nelson Education: Toronto, ON.
- Varcoe, C., Pauly, B., Storch, J., Newton, L., & Makaroff, K. (2012). Nurses' perceptions of and responses to morally distressing situations. *Nursing Ethics, 19*(4), 488-500.
- Vaughan, C. (1993). Public health nurses muzzled. *The Globe and Mail* (November 1, pp. A12). Toronto, ON.
- Wall, S. (2013). "We inform the experience of health": Perspectives on professionalism in nursing self-employment. *Qualitative Health Research, 23*(7), 976-88.
- Weinberg, D. B. (2006). When little thing are big things: The importance of relationships for nurses' professional practice. In S. Nelson & S. Gordon (Eds.), *The Complexities of Care: Nursing Reconsidered* (pp. 30-43). Cornell University Press: Ithaca, NY.
- Whitehead, D. (2003). Incorporating socio-political health promotion activities in clinical practice. *Journal of Clinical Nursing, 12*(5), 668-677.
- Whitehead, M., & Dahlgren, G. (2006). *Leveling up (part 1): A discussion paper on concepts and principles for tackling social inequities in health*. Copenhagen, Denmark: World Health Organization.
- Wilkinson, R. G., & Pickett, K. E. (2009). Income inequality and social dysfunction. *Annual Review of Sociology, 35*(1), 493-511.
- World Health Organization. (1978). *Declaration of Alma-Ata* (World Health Organization). Retrieved from:
https://www.who.int/publications/almaata_declaration_en.pdf
- World Health Organization. (1986). In World Health Organization (Ed.), *The Ottawa charter for*

- health promotion. Retrieved from:
www.who.int/healthpromotion/conferences/previous/ottawa/en/index3.html
- World Health Organization/UNICEF. (1990). *Innocenti Declaration* (World Health Organization). Retrieved from:
<https://www.unicef.org/programme/breastfeeding/innocenti.htm>
- World Health Organization. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Retrieved from:
https://www.who.int/social_determinants/thecommission/finalreport/en/
- World Health Organization. (2014). The case for investing in public health: Strengthening public health services and capacity. Retrieved from:
http://www.euro.who.int/_data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf
- World Health Organization. (2019). *Ten threats to global health in 2019*. Geneva, CH: World Health Organization.
- Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Health Research*, 5(1), 125-137.
- Zahner, S. (1999). Public health nursing and immunization surveillance. *Public Health Nursing*, 16(6), 384-389.

Appendix A

Ethics Approval

Board of Record
Island Health

Health Research Ethics Board (HREB)
1952 Bay Street
3rd Floor – Kenning Wing, Memorial Pavilion
Royal Jubilee Hospital
Victoria, BC V8R 1J8



Certificate of Ethical Approval for Harmonized Minimal Risk Health Study

Also reviewed and approved by:
University of Victoria
Interior Health Authority
University of British Columbia



Principal Investigator: MEGAN KIRK	Primary Appointment: University of Victoria	Board of Record Approval Reference #: BC2015-122
Study Title: Exploring the Changing Nature of Public Health Nursing Practice		
Study Approved: 17 DEC 2015	Expiry Date: 16 DEC 2016	
Research Team Members:	Dr. Anita Kothari Dr. Rita Schreiber Dr. Marjorie MacDonald	
Sponsoring Agencies:	n/a	
Documents included In this approval:	Academic Approval Letter Study Protocol Consent Form Recruitment Email Recruitment Email Alternate Version Recruitment Email Island Health Interview Questions	Version Date, 16 October 2015 Version 3, Dated 15 December 2015 Version 7, Dated 04 December 2015 Version 3, Dated 11 December 2015 Version 4, Dated 15 December 2015 Version 4, Dated 15 December 2015 Version 2, Dated 04 December 2015

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2014).

The "Board of Record" is the Research Ethics board designated on behalf of the participating REBs involved in a harmonized study to facilitate the ethics review and approval process. In the event that there are any changes or amendments to this approved protocol, please notify the Board of Record.

Board of Record Research Ethics Board Representative

Name: Lynn Cummings, BNSc, MN

Signature:

Title: Chair, Island Health HREB

Date: 17 Dec 2015

Appendix B

Participant Recruitment Email

Exploring the Changing Nature of Public Health Nursing Practice

You are invited to participate in a research study!

Background and Purpose of the Study

The purpose of this study is to learn how recent public health policy changes (e.g., Core Functions Framework, Key Result Areas) have shaped the nature of public health nursing practice in British Columbia (BC). Qualitative methods will be used to better understand the experience of public health nurses (PHNs) in the province given recent policy changes affecting their practice and to learn about what factors support or impede their practice. Given that PHNs provide a large proportion of public health services in BC, it would be useful to better understand how recent public health policy changes have affected the nature of their practice and how they manage these changes. Currently, there is minimal literature documenting how such policy changes within BC have shaped the nature of services offered by PHNs. The hope is that this project will continue the conversation around PHN utilization in order to begin to address some of the present challenges confronting PHN practice.

You are being asked to participate in this study because you are a public health nurse in BC, or you have knowledge about public health nursing practice.

Location of Research

This research study is being conducted under the auspices of the University of Victoria. Data will be collected either face to face in southern Vancouver Island at a location that is convenient for the participant, or by telephone for those who reside in other parts of the province or if a participant prefers this means of communication.

What is Required if I Participate?

You will be asked to participate in an interview 45 minutes to one hour long during non-work hours. If located in southern Vancouver Island, you have the option to meet with the Principal Investigator for a face-to-face interview at a convenient location, or over the phone if at a distance or if this is your preference.

Please note, the person who sent you this email has nothing to do with this research and you should not see this email as something that may influence your professional relationship with your health authority.

PLEASE CONTACT:

Megan Kirk, Doctoral Candidate (Principal Investigator)
School of Nursing, University of Victoria
3800 Finnerty Road, HSD Building, Room A402a
kirkm@uvic.ca

Appendix C

Study Protocol

Exploring the Changing Nature of Public Health Nursing Practice

Principal Investigator:
Megan Kirk, MSc, PhD (c)
University of Victoria

Supervisory Committee:
Marjorie MacDonald, PhD
University of Victoria

Rita Schreiber, DNP
University of Victoria

Anita Kothari, PhD
University of Western Ontario

Protocol version 1
Application Ref No: 1169
September 30, 2015

1. Protocol Synopsis:

Public health in British Columbia (BC) has witnessed several recent provincial wide policy changes since the introduction of the Core Function Framework in 2005. Since this time, there has been a shift to Key Result Areas and then the Guiding Framework for Public Health. In this study, I will explore such recent policy changes have shaped the nature of public health nursing practice in BC. I will use qualitative interviews to better understand the experience of public health nurses (PHNs) in the province given recent policy changes affecting their practice and to learn about what factors support or impede their practice. I will use a qualitative methodology, the grounded theory method, to develop a theoretical explanation of how PHNs navigate practice changes. Findings from this study will be used to offer insights into how recent policy changes have affected programs and services offered by public health nursing and the impact this has had on overall community health.

2. Background & Rationale:

Since 2005, multiple provincial initiatives, intended to improve the organization and delivery of public health systems and services, have affected the programs and services provided by public health practitioners in BC. Currently, there is minimal literature addressing how recent policy changes have shaped the nature of services offered by PHNs across the province. There have also been recent calls for more research to evaluate and develop an evidence base for PHN practice. Researchers are suggesting that PHNs are finding it difficult to be effective in broader health promotion efforts due, in part, to the organizational structure in which they are located. Recent conversations I have had with PHNs in Island Health Authority suggest that they are concerned about the changing nature of their practice, and organizational changes are restricting their ability to provide programs and services that they believe will effectively address community need and improve population health. It is possible that these changes in public health service delivery may counter the overall efforts of public health practitioners to improve population health. Given that PHNs provide a large proportion of public health services in BC, it would be useful to better understand how recent public health policy changes at the provincial and organizational level have affected the nature of their practice, how they manage these changes, and the impact of these changes on the communities served. My overall guiding research question for this study is: How do public health nurses manage provincial and organizational level policy changes affecting the nature of their practice?

3. Study Objectives(s)/Purpose:

The purpose of this dissertation study is to explore issues related to PHN utilization within BC given recent public health policy changes. More specifically, I hope to understand how PHNs navigate the terrain of shifting public health priorities that often lead to practice change, explore contextual influences in which they navigate this terrain, as well as how they manage changes in their practice that they do not believe will improve population health.

4. Study Population:

PHNs from three health authorities will constitute the majority of the participants in my study. However, I will also include public health managers and other public health professionals who wish to participate and have knowledge of the current nature of public health nursing practice in the province.

Inclusion Criteria

Participants must be currently employed in public health in one of the three regional health authorities in BC. They must be able to communicate in English and been employed in for three years in public health. The most recent provincial shifts occurred in 2013, hence the cut-off of three years experience.

Exclusion Criteria

Participants will be excluded if they do not speak English or do not have three years experience in public health in BC.

5. Study Design & Procedures:

In this qualitative study I will use the grounded theory method to develop a theoretical explanation of how provincial and organizational changes have shaped PHN practice, how they navigate this often tenuous terrain, and the potential impact this has for community health outcomes. I will go beyond describing behaviour, to explain the meaning that motivates behaviour. By collecting interview data on PHN practice, I will use qualitative coding as a means to develop a theoretical conceptualization of what is going on for PHNs in the province in regards to their practice. Qualitative designs are emergent meaning that one's ongoing analysis and developing theoretical insights will guide subsequent data collection intended to support the researcher in their theorizing.

During the consent process, PHNs will be asked if they agree to participate in an interview. I will use semi-structured interviews and allow the participant to answer based on their knowledge and experience. Interviews will generally take 45 to 60 minutes and will be conducted outside of work hours.

The Principal Investigator will begin by analyzing secondary data, including interview and focus group data, already collected for two research projects at the University of Victoria, both of which have received ethics approval, including approval for secondary analysis by a student. Both of these studies are examining public health systems and services changes in BC. The Renewal of Public Health Systems (REPHS) study examined the implementation of the Core Function Framework and spanned from 2010-2014. The Equity Lens in Public Health (ELPH) study is examining how equity is being taken up and used in public health renewal, and spans 2011-2016. The data from both of these projects is collected from public health directors, managers, and frontline staff, many of which are PHNs. I will then collect primary data by interviewing PHNs about their practice, but also public health managers interested in

participating who are knowledgeable about PHN practice and are aware of their current practice, if deemed important to answer my research question.

6. Statistical Considerations:

Depending on the extent and diversity of participant experiences, I may need to adjust the sample size of my study accordingly. However, I am anticipating approximately 30 participants for my overall study. I aim to recruit 10 participants in each of the three health authorities. I will use common grounded theory analytical tools used by researchers, such as constant comparison, coding, and memoing to assist in my theoretical conceptualization.

7. Data Collection and Data Management:

The main source of data for this study is semi-structured interviews. I will use an interview guide that outlines ten general questions I intend to ask each potential participant. However, given the nature of semi-structured interviews, I may not cover all questions in every interview. I will conduct interviews in person if possible, but offer telephone interviews to participants who reside outside that area and to participants who prefer this means of communication. Telephone interviews will occur during non-work hours.

PHNs and PHN managers will receive an email from liaison person containing the study recruitment letter, which will be sent out possibly a total of three times depending on the need for additional participants.

The Principal Investigator's contact information is on the recruitment letter for potential participants. Potential participants will contact the Principal Investigator if interested in participating in study. At this time, the Principal Investigator will email the potential participant an Informed Consent Form for their review, the list of interview questions, and arrange the interview date and time. Before commencing the interview, the Principal Investigator will ask if the participant has reviewed the Consent Form, if they have any questions about the consent form and to send or provide a signed form if in person, or to give verbal consent if over the phone, which will be audio recorded.

Participants completing interviews will remain confidential and their interview transcripts will be de-identified by labeling with a code. The Principal Investigator will keep a master list linking coded transcripts to participant information in case a participant wishes to have their data withdrawn from the study and if it is necessary for interpreting the data during analysis. This master list will be kept solely on a University computer that is locked, password protected, and secured by the UVic network. Privacy will also be maintained during the interviews and I will only ask questions on the nature of their day-to-day professional practice. Pseudonyms will be used in reporting of qualitative quotes of study findings. I will use peer debriefing, meaning I will dialogue with other researchers and practitioners, about the emerging nature of my analysis to ensure the quality and depth of my analytic findings and that I have sufficient conceptual density.

8. Publication of Results

The Principal Investigator will take the lead in publication(s) and presentations of the results. My academic supervisor and co-investigators may also aid and be listed on the publications and presentations as co-authors. Participants will be acknowledged for their contributions.

9. Appendices

Interview Questions:

- 1) I am interested in learning about public health nursing practice and if it has changed over the past few years? For instance, there have been provincial policy changes that have led to changes in the home visitation for PHNs. Please tell me about your practice.
- 2) What does your current practice look like? How satisfied are you with your (PHN) current practice? Please explain.
- 3) Can you tell me about any provincial or organizational changes over the past few years that have affected your (PHN) practice? How has your (PHN) practice changed given these organizational changes? What do you think about these changes? Does your (PHN) current practice fit with your perception of quality PHN practice? In what way? Can you provide an example of this?
- 4) How have these organizational changes been perceived by PHNs? How do you (PHNs) manage given these organizational changes? Do you have an example of such changes?
- 5) How were the decisions made about organizational changes that impacted your (PHN) practice? What role do/did PHNs have in this decision-making? What are your thoughts about this?
- 6) Do you (PHNs) feel supported to practice in the way you (PHNs) would like to practice? If so, in what way? If not, what restricts your (PHN) practice? Please explain.
- 7) How has PHN practice changed over the course of your career? Why do you think these changes have come about?
- 8) What do you think is the unique contribution of public health nursing? What makes PHN practice distinct from other public health practitioners and other nursing specialties?
- 9) What difference do PHNs make? How do you know when you (PHNs) have made a difference? Can you share an example of how your (PHN) practice has made a difference to the health and wellbeing of a client or community?
- 10) Is there anything else I need to know about PHN practice today and how it has changed? Anything I forgot to ask you? Is there anyone else you think I should talk to about this?

Appendix D

Participant Consent Form

Exploring the Changing Nature of Public Health Nursing Practice

PARTICIPANT INFORMATION & CONSENT FORM

PRINCIPAL INVESTIGATOR:

Principal Investigator: Megan Kirk, University of Victoria
Address: 3800 Finnerty Road, HSD Building, Room A402a
Phone Number: 250-721-7954
Email: kirkm@uvic.ca

Background and Purpose of the Study

You are invited to participate in a research study. Your participation is free and voluntary. You can withdraw at any time. The purpose of this study is to learn how recent provincial level policy changes (e.g., Core Functions Framework, Key Result Areas) have shaped the nature of public health nursing practice in British Columbia (BC). Qualitative methods will be used to better understand the experience of public health nurses (PHNs) in the province given recent policy changes affecting their practice and to learn about what factors support or impede their practice. Given that PHNs provide a large proportion of public health services in BC, it would be useful to better understand how recent public health policy changes have affected the nature of their practice and how they manage these changes. Currently, there is minimal literature documenting how such policy changes within BC have shaped the nature of services offered by PHNs. The hope is that this project will continue the conversation around PHN utilization in order to begin to address some of the present challenges confronting PHN practice.

You are being asked to participate in this study because you are a public health nurse in BC, or because of your knowledge about public health nursing practice in the province.

Location of Research

This research study is being conducted under the auspices of the University of Victoria and is being undertaken as part of a graduate student's dissertation work. Data will be collected either face to face in some locations when convenient for the participant, or by telephone for those who reside in other parts of the province or if a participant prefers this means of communication.

Number of Participants

Thirty participants will be included in this study, consisting of 10 participants from each health authority.

What is Required if I Participate?

If you decide to participate in this study, you will be asked to participate in an interview 45 minutes to one hour long during non-work hours that will be audiotaped. Interview questions are about PHN practice and the changing nature of practice (example questions listed below). If located in southern Vancouver Island, you have the option to meet with the Principal Investigator for a face-to-face interview, or over the phone if at a distance or if this is your preference.

A few example interview questions are:

- 1) I am interested in learning about public health nursing practice and how (if) it has changed over the past few years with all the policy changes that have happened? Please tell me about your practice.
- 2) What does your current practice look like? How satisfied are you with your current practice?
- 3) Does your current practice fit with your perception of quality PHN practice? In what way?
- 4) How do you manage when organizational changes cause you to practice in ways that run counter to the practice you would prefer?

What are the Possible Risks or Inconveniences of Participating?

You may be exposed to the following risks and inconveniences:

An inconvenience could be the time commitment to complete the interview.

To reduce these risks, the following steps will be taken:

The Principal Investigator will arrange an interview time and location that is convenient for the potential participant.

What are the Possible Benefits of Participating?

The possible benefits of your participation include:

You will be contributing your knowledge and experience of public health nursing practice. Your contribution will help improve the evidence base for PHN practice and can be used to inform policy and decision-making affecting PHN practice. There is currently little literature outlining how recent public health policy shifts have shaped PHN practice and this research intends to address this gap.

Do I Have to Take Part?

You are free to participate or not. If you decide not to participate your employment status will not be affected in any way. By consenting, you have not waived any rights to legal recourse connected to research-related harm. If you do decide to participate and then change your mind later, you can withdraw without any consequences or explanation. If you do withdraw from the study, the Principal Investigator will ask you to still use your collected data with no identifying information. If you do not wish to have your data used, the Principal Investigator will try to respect your wishes. However, if the analysis is already complete, it may not be possible to remove your data.

Will I be Paid for Taking Part?

You are being asked to participate during non-work hours and will not be provided with any payments or coverage of costs for participating in this study.

Confidentiality & How my Personal Information will be Used?

Your audiotaped interview will be de-identified and transcribed by the Principal Investigator. At this time, a code will be placed on the transcript as your identifier. The Principal Investigator will keep a master list of participant name, code, and contact information on a locked and password protected computer in case a participant decides to withdraw from the study and requests that their data is deleted. Depending on the stage of analysis, deleting the transcript data may or may not be feasible, but participant wishes will be respected if possible. All study findings will be de-identified and will not be able to be linked with individual study participants.

Use, Storage, and Destruction of Data

Interview data will be collected in this study. The Principal Investigator is the sole person who will have access to the identifiable data. De-identified quotes will be used from the data, which is common in qualitative research to demonstrate central themes. Quotes will not be able to be linked to individual participants or an organization. De-identified data will remain with the Public Health Systems and Services research team at the University of Victoria upon study completion. The data will be stored on a UVic locked and protected computer with the requisite safeguards in place. Once the data is deemed no longer needed by the team, it will be destroyed. The data will be permanently deleted from the protected server. The University of Victoria has IT support for such a matter to ensure the data is permanently deleted.

Disposal of Data

The master study list identifying study participants will be deleted after 5 years from study end and will only be accessible to the Principal Investigator. De-identified data from this study will be kept until the data is no longer needed, and will then be destroyed. Future students and researchers who are also interested in this area of public health research could potentially use this de-identified data. The same ethics standards will be upheld in using this data, that is de-identified and confidentiality of participants will remain.

Sharing of Study Results

The Principal Investigator will email study participants with a one-page summary of key study findings. The study results will be published in peer-reviewed journals and presented at national and international conferences.

CONSENT

Your signature below indicates that:

1. All sections of this Consent form have been explained to your satisfaction
2. You understand the requirements, potential risks, and responsibilities of participating in the research project, and;
3. You understand how your information will be accessed, collected and used.
4. All of your questions have been fully answered by the Principal Investigator.

- I Agree to my interview being audio recorded.
- I understand my anonymized data may be used in the future by other students and researchers.

Name of Participant (Print)	Signature	Date
Name of Person Administering Informed Consent	Signature	Date
Role of Person Administering Informed Consent		

A copy of this consent form will be given to you, and the researcher will keep a copy.

Appendix E

Interview Questions

I would just like to remind you of your rights as a participant. Your participant must be free and voluntary, you can skip any question at any time, refuse to answer any question, or even stop the interview or withdraw from the study at any time. This interview will be audio recorded but your name will be replaced by a code. In the final report no identifying information about you will be included; all data will be de-identified and reported in aggregate form...however quotes made by you may be used...Have you had a chance to review the Informed Consent Form? Do you have any questions for me about your participation? Do you give me your consent to proceed with the interview?

- 1) I am interested in learning about public health nursing practice and if it has changed over the past few years? For instance, there have been provincial policy changes that have lead to changes in the home visitation of PHNs. Please tell me about your practice or the practice of PHNs.
- 2) What does current PHN practice look like? How satisfied are you with your (PHN) current practice? Please explain.
- 3) Can you tell me about any provincial or organizational changes over the past few years that have affected your (PHN) practice? How has your (PHN) practice changed given these organizational changes? What do you think about these changes? Does your (PHN) current practice fit with your perception of quality PHN practice? In what way? Can you provide an example of this?
- 4) How have these organizational changes been perceived by PHNs? How do you (PHNs) manage given these organizational changes? Do you have an example of such changes?
- 5) How were the decisions made about organizational changes that impacted your (PHN) practice? What role do/did PHNs have in this decision-making? What are your thoughts about this?
- 6) Do you (PHNs) feel supported to practice in the way you (PHNs) would like to practice? If so, in what way? If not, what restricts your (PHN) practice? Please explain.
- 7) How has PHN practice changed over the course of your career? Why do you think these changes have come about?
- 8) What do you think is the unique contribution of public health nursing? What makes PHN practice distinct from other public health practitioners and other nursing specialties?
- 9) What difference do PHNs make? How do you know when you (PHNs) have made a difference? Can you share an example of how your (PHN) practice has made a difference to the health and wellbeing of a client or community?

10) Is there anything else I need to know about PHN practice today and how it has changed? Anything I forgot to ask you? Is there anyone else you think I should talk to about this?