

Perceptions of public health nursing consultations: tacit understanding of the importance of relationships

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Aim: This study aims to describe and reflect upon how a sample of nurses, parents and young people experience consultations at local clinics and school health services. Central to the concept of health promotion is ensuring that focus is on the empowerment of clients through dialogue and participation. This study aims to explore public health nursing consultations with this in mind. **Background:** Norwegian public health nurses are in contact with almost all families at the child health clinic. They meet children and young people at school health services and youth clinics; putting them in an important position to promote health and prevent illnesses. **Methods:** Participant observations and in-depth interviews are the methods chosen. The data were analysed using qualitative content analysis. **Findings:** The study shows that good relationships are not only sustained by pleasantness but also by honesty and directness, provided that the relationship is based on trust and sincerity. Continuity and trust in services seem paramount to the service users' satisfaction. Service users were not always able to put the reason for their appreciation into words, just as the nurses had difficulty verbalising their strategies. Words often fall short when attempts are made to capture the essence of caring, trust and other life phenomena. Openness on agenda and focus on feedback from service users are important in order to ensure empowering services. Further studies should address the interconnectedness of the service and the subtleties of public health nursing consultations.

Key words: interpersonal relationships; Norway; perceptions; public health nursing; qualitative content analysis

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Introduction

This study is part of a larger ongoing study that explores different perceptions of Norwegian public health nursing practice. The purpose of this substudy is to look at the public health nurses'

(PHNs') approach during consultations and to describe and interpret how PHNs, parents and young people experience the consultations. The first author observed 12 consultations at three different public health nursing settings (local child health clinics, clinics for young people and at the PHN's office at an upper secondary school). The nurses and service users were then interviewed in order to find out how they experienced the session. There is a paucity of studies pertaining to the PHN's daily practice, her strategies and interventions (Tveiten, 2006) and the ways in which

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nurses establish, pursue, change and develop joint work relationships with service users (Baggens, 2002). Dialogue and participation are central to empowering relationships. This study explores these aspects of public health nursing consultations and attempts to fill the gap in the field of knowledge development.

Background

PHNs in Norway are authorised nurses with a 1-year postgraduate training in public health nursing. They do not partake in hands-on nursing but promote health and prevent illness through their work with families, schoolchildren and young people. The terms PHN and school nurse are used interchangeably in the study.

Local hospitals inform the PHN of new births in her district; the nurse then carries out a home visit and gives information on the follow-up services at the local child health clinic. The clinic provides a universal health service and almost 100% of Norwegian families frequent these clinics (Glavin *et al.*, 2007). Parents come to the clinic with their babies regularly during the first year and less often as the child gets older. The nurse carries out immunisations and developmental screening; she also counsels and gives advice to parents, individually and in groups. Well-functioning universal services are important as they can contribute to the well-being of all children and at the same time follow up children with special needs (Elkan *et al.*, 2001).

Baggens (2001) used audiotaped and videotaped recordings from the child health clinic in order to study the communication that takes place in encounters between the nurses and their service users. The study showed that the programme at the clinic steered the interaction to a great extent but that parents and children also introduced new topics. Neumann (2007) interviewed both nurses and parents at local clinics and carried out observations in waiting rooms, with the intention of examining normality and deviation; what PHNs see and do not see in mother–child relationships. Neumann's study showed that even though the service is universal the PHNs may not always discover children who receive deficient parental care. Tveiten's (2006: p. 18) review of the literature shows that there is limited research on public health nursing strategies and interventions.

The school health services can be seen as a continuation of the clinics' immunisation, screening and counselling services. The PHN has usually office hours at primary, secondary and upper secondary schools and is available for pupils, school administration and collaborators at certain times of the week. School nurses are there for pupils and are responsible for keeping broader issues visible to administrators, teachers, students, families and communities (Abrams, 2005). PHNs can play an important role for pupils in susceptible situations (Borup, 2002; Johansson and Ehnfors, 2006; Clausson, 2008; Tinnfält, 2008).

A Swedish study reveals that 15-year-old pupils feel that trustiness, attentiveness, respectfulness, authenticity as well as accessibility are the most important factors in promoting a good health dialogue with the school nurse (Johansson and Ehnfors, 2006).

The clinic for young people provides a 'drop-in' health service for teenagers. Many of these youth clinics focus on contraception and sexually transmitted diseases. Norwegian PHNs have limited prescription rights and can prescribe the contraceptive pill for young people between the age of 16 and 19 years. They also counsel and give advice at the clinics. Jentoft (2005) carried out a study on health clinics for young people. The study showed that the young people trusted both the service and the health professionals working there.

This study is complimentary to earlier studies as few studies involve data from both direct observations and interviews. The first author was present and observed the interaction, audiotaped the consultations and carried out open interviews with the participants immediately afterwards.

Method

Since the intention of this study was to explore interactions and perceptions, a qualitative approach was chosen. Because of the wealth of data the focus in this study is mainly on the results from the interviews. The analysis from the observations in this study is limited to the PHNs' approach, and to issues that were followed up by the researcher in the interviews. A forthcoming ethnographic study will delve deeper into the observations.

Table 1 Overview of the field observations and interviews from eight site visits

The child health clinic		The clinic for young people	Nurses' office at upper secondary school
Researcher present at five counselling sessions	Ten interviews	Researcher present at six counselling sessions Eight interviews	Researcher present at one session Two interviews
Two individual interviews with parents	(1) Mother and a 9-month-old baby boy (2) Mother and a 15-month-old boy	Four Individual interviews with 17-year-old girls (6, 7, 8 and 9)	Individual interview with a 17-year-old girl (12)
Three interviews with couples	(3) Mother, father and an 8-month-old baby girl (4) Mother, father, twin babies 7-month-old and a 2-year-old boy (5) Mother, father and 6-month-old baby boy	One individual interview with a 19-year-old girl (10) One individual interview with a 17-year-old boy (11)	
Five individual interviews with nurses	Individual interviews with: Three nurses having >10 years of experience Two nurses having <5 years of experience	Two individual interviews with nurses having experience between 5 and 10 years	Individual interview with nurse having >20 years of experience

Sampling

Investigating a public health service that has diffuse boundaries and a multitude of tasks requires an open and discovery-oriented approach and not a narrow focus based on an ideal type that does not exist in reality. The sampling strategy in this explorative descriptive design was to gather data from natural PHN settings. Gaining access and maintaining it throughout the research process is a well-known problem in ethnographic studies (Hammersley and Atkinson, 2007; Neumann, 2007). Because of the uncertainty regarding access to the field, willingness to take part in the study was the determining factor for sample selection. The study was carried out in urban, suburban and rural communities. Initially, one supervisor was contacted and asked to recruit ten nurses – ten responded. Six of these nurses contacted service users who gave the researcher permission to participate at a public health nursing consultation with their nurse. The remaining four nurses did not take part in the study; either due to lack of time, that they were unable to recruit service users or they did not give any reason. The authors deemed that the collected

data were insufficient and contacted a supervisor in another municipality who recruited a further two nurses. The researcher observed four consultations and carried out subsequent interviews in this municipality.

Data collection

The rationale for the original number of participants was tentative; data collection was ceased when the authors considered there was sufficient data to carry out the analysis. The data were collected over a period of seven months from November 2006 to May 2007. The first author participated at 12 consultations and interviewed 8 PHNs and 15 service users (three couples). Table 1 gives an overview of the eight site visits and the participants in the 12 consultations.

Each consultation was taped and recorded verbatim. In each observation attention was fixed on meticulously describing the setting and activities. Observations from the consultations provided the researcher with data on the nurses' approach and with themes that were delved deeper into during the interviews.

Following observation of the consultations, the first author conducted 20 interviews with the nurses and their service users. The interviews were mainly with females, three interviews were with couples and one interview at the clinic for young people was with a teenage boy. Four of the young people did not know the nurse on duty; the other service users were all familiar with their nurse.

No pilot interviews were conducted. The length of the interviews varied from 10 min to over an hour. Most interviews lasted 30–40 min. The shortest interview was with a young person at the clinic (rushing off for a driving lesson); the longest was with the young person at the school health service. All the interviews had an open approach. The interviewees were asked to elaborate on how they experienced the consultation. The researcher focused on the parents' and young peoples' expectations and on positive and negative aspects of the consultations. The nurses were asked specifically about their goals, strategies, what they were pleased with and their shortcomings. Follow-up questions were asked in order to gain a deeper understanding and to clarify themes from the field observations. The interviews were recorded and transcribed verbatim.

Analysis of data

During the observations the researcher observed the nurses' approach, and how each session started, progressed and came to a close. All transcribed data were analysed using qualitative content analysis. Patton (2002) refers to content analysis as any qualitative data reduction and sense-making effort that attempts to identify the data's core consistencies and meanings.

Descriptive categories that described the respondents' statements from the interviews were created. The analysis process is described in Table 2. The second author checked the credibility of the categories in order to validate that they corresponded to the statements from the interviews. With focus on the service users' and nurses' perceptions of the consultation four descriptive categories emerged from the data: *honesty and openness, a sense of fellowship, a respectful, caring relationship built on trust; and talking things through*. These four categories were then merged into a unifying theme: *the importance of relationships*.

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Ethical considerations

The study was approved by the Norwegian Social Science Data Services and the Regional Ethical Committee for the north of Norway. Permission to conduct the study was given by the public health nursing supervisors. They recruited the participating PHNs; both nurses and supervisors recruited willing service users (all above the age of 16 years). All participants signed the consent forms.

Description of findings

The observations

The focus during the routine consultations at the child health clinics was confined, in the sense that it was related to child and family health, but the topics discussed were broad and open and included all the basic phenomena of the cares, joys and worries of normal daily life. Parents sometimes addressed sensitive topics that they were worried about. Both nurses and service users picked up where they had left off at the previous visit and ended the consultations by referring to their next appointment. The nurses spent time examining the children; subjects were brought up by both nurse and service user. There was a type of continuity that gave the impression that these consultations were not isolated incidents but more events on a continuum.

The young people who came to the clinics for young people did not have set appointments. The consultations were short and to the point guided by a specific issue brought up by the young person. The stringent focus and shortness of the session did not prevent the emergence of delicate, complex topics. All the young people were familiar with the public health nursing services even though they were not always familiar with the nurse on duty. The nurses checked that young people who needed extra support were followed up by the school nurse. It seemed that each visit was an incident in its own right.

The session at the upper secondary school had a broader focus. The young person visited the school nurse regularly. The young girl broached a myriad of topics and the nurse's mode of questioning and her supportive comments made it clear to the researcher that the relationship between the nurse and young person had developed over time.

Table 2 Overview of analysis with examples of data transformation process

- (1) Sentences, words and phrases in the transcribed text, that could describe the respondents' experiences of the sessions were highlighted as meaning units.
 (2) These meaning units were further abbreviated into condensed meaning units.
 (3) The condensed units were examined further to see whether they were inter-related in any way and then abstracted into fewer categories.
 (4) The categories were then merged into one main theme. All notes and transcriptions were then reexamined to see whether they supported the construction.

(1) Meaning units	(2) Condensed meaning units	(3) Categories	(4) Theme
PHN: 'I feel that I have to acknowledge what I see and signalise that we can talk about it'	Open about what I see/signalise we can talk		
PHN: 'Well, when she said she was worried about her blood pressure, I felt I had to speak up about her weight'	Bringing things into the open	Honesty and openness	
Young person: 'She helps me by talking about things, bringing things out into the open just as they are'	Bringing things out into the open/talking things through		
Young person: 'I get to talk about what's bothering me and they are interested in what I have to say'	I get to talk about what's bothering me	Talking things through	The importance of relationships
Father: '...like she understands that we take our children swimming in the ocean, everything really, nothing we do with the children shocks her (...). I feel that we are on the same wavelength'	We are on the same wavelength	A sense of fellowship	
PHN: 'It is what I feel inside me; that they should feel in a sense, looked after, that's really my goal'	That they should feel looked after	A respectful, caring relationship built on trust	
Mother: 'I feel very safe and its nice being continually followed up with our child in mid-life, he is the most important part of our lives'	Feeling safe		
Mother: 'I feel a sense of security with the PHN that enables me to trust her'	Trust in PHN		

The interviews

Honesty and openness

The PHNs (1, 2, 4, 5, 10 and 12) spoke of being open and honest with their clients. Just as the parents (1, 3 and 4) and young people (4, 11, 10 and 12) spoke of their appreciation on an honest, open nurse. This issue is exemplified in the following examples: During a short session at the clinic for young people a young girl (10) with a weight problem spoke of breathlessness when walking up hills. The nurse was direct and spoke about the importance of physical activity and diet. When the nurse was interviewed she was asked how she felt about her approach.

PHN: Well, when she said she was worried about her blood pressure, I felt I had to speak up about her weight (...). At times I feel that I become involved in situations where I have a responsibility to speak out (...). I feel that I have to acknowledge what I see and signalise that we can talk about it.

During the interview the young person spoke about the nurse's open, direct approach.

Young girl: I though it was ok, no problem (...) in many other cases you meet people who are afraid to say things. I find it quite ok

that the PHN can guide the conversation in different directions (...).

A nurse (2) at the child health clinic also spoke about the importance of being open:

PHN: We have to broach other issues, like now when the mother hadn't made the stairway secure. I had to find out what she had and what she hadn't secured to see if she had given the issue careful consideration.

An experienced school nurse (12) said that if she was worried about pupils being suicidal, she was open about it and not afraid to ask them. Another PHN (4) agreed that it was important for PHNs to be supportive but felt that the 'kind, pleasant approach' did not really suit her. She said that she liked to confront parents and make demands, but felt that she could not always be as supportive as the parents required.

Being direct and open did not come easily to all the nurses in the study. One nurse (3) at a child health clinic spoke about having difficulty in being straightforward and said that she needed to practice being more direct. When asked what she was afraid of she said: 'Rejection; that's what I am most afraid of, that it will destroy our relationship'.

Even when probed about the matter none of the service users in the study had anything negative to say about the PHNs. It became apparent, however, that two mothers knew of other parents who had negative experiences. A mother (1) spoke of a friend who pretended that she still breastfed, because she felt that the nurse expected her to be. The mother felt that this was a pity because it meant that her friend did not receive the help and support she needed. Two PHNs (4 and 5) knew of other parents who were dissatisfied with the services as one nurse said 'It has to do with trust, advice that didn't suit; that the parents were not seen in the right way, or not seen at all'. The PHN felt that parents, generally speaking, do not make enough demands.

A sense of fellowship

Parents and PHNs at the child health clinic all shared a common interest in the well-being of the child. One couple (4) spoke about being on the same wavelength as the nurse that she would have been their first choice if asked to choose, because she had the same attitude to child rearing and physical activity that they had. The father said,

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...Like she understands that we take our children swimming in the ocean, everything really, nothing we do with the children shocks her (...). I feel that we are on the same wavelength.

The nurse said that she thrived on the chaos and action this active family of five brought with them. The father suggested having access to PHN profiles in order to choose a suitable nurse. The mother added:

It's nice to get some advice. Most of the information you get here you can read about but there is one big difference and that is the relationship with a living person that sees and looks at the kids and talks to us.

A respectful, caring relationship built on trust

The PHNs spoke of strategies about counselling without giving advice (1), about being courteous (5) and asking questions (12). One PHN (2) said that she regarded empowering parents as an 'intervention' and spoke of how she had supported and encouraged a young single mother to contact the child protection services. As one father (5) said 'Dialogue is important, that you feel a sense of security'. The parents (3, 4 and 5) said that the nurses' knowledge of normal development promoted trust. The mothers continued that 'she continually shows me that he is normal' (5); that 'this is normal, this isn't' (4).

One mother (5) mentioned the intimate nature of the relationship between mother and child. She acknowledged the nurses' interest and her professional competence and felt that it was important that the nurse showed her that she cared.

Mother: I feel very safe and its nice being continually followed up with our child in mid-life, he is the most important part of our lives.

The nurse said that she tried to meet the parents in a respectful way and show them that she cared about them. She said that she felt very humble when they trusted her enough to discuss intimate problems. She added:

PHN: I spend time with the child, establish contact (...). In a sense, work with the parents, get them involved and then acknowledge their efforts.

Other parents (3) said that they appreciated their nurse's gentle manner and liked her as a person. Mother: 'I feel a sense of security with the PHN that enables me to trust her'. The husband worked away a lot leaving the mother alone with their first baby.

A 17-year-old girl (12) had been attending the school nurse regularly for over a year. It was obvious that they knew each other well. They discussed school, home, mood swings, contraception and referral to a psychologist. During the interview the PHN spoke of her relationship with the pupil; how the young girl had tried to commit suicide, had bouts of depression and that she deliberately cut herself. She said that the young girl trusted her, felt acknowledged and understood. When asked about her strategies, she said that she did not have concrete strategies.

PHN: It is what I feel inside me; that they should feel in a sense, looked after, that's really my goal (...). Yes, that they can be, I don't know, helped on their way; don't think I can say more than that.

The young person visiting the school nurse was asked to describe how the PHN helped.

Young girl: She helps me by talking about things, bringing things out into the open just as they are; the events from primary school and everything (...). Instead of sitting at home and cutting myself; letting my body suffer, or simply telling someone off, my boyfriend for example (...). (Interviewer: So the cutting has got better?) I have not done it for a long time now; it feels ok to have got things out. A lot can come out in that short space of time.

Talking things through

All the consultations at the clinic for young people were short, focused and to the point. A 17-year-old boy (11) attended the clinic for young people in order to get treatment for a Chlamydia infection. During the interview he said that he not only attended the clinic but went twice weekly to his school nurse. He visited the PHN every Wednesday and went back on Thursdays to test his urine for hashish. He gave the following reasons for his visits:

I like having somebody to talk to; there are a lot of things happening in my life at the

moment (...). To put it this way; I'm satisfied, I get to talk about what's bothering me and they are interested, they don't just sit there and nod.

When asked how the PHN helped, he answered:

They don't do anything as such, it just feels good to talk things through and get things out of my head; it's hard keeping things to yourself.

The session at the upper secondary school was neither short, nor focused or confined to any one topic. The pupil who visited the school nurse spoke of how she needed someone to talk to and that she trusted the PHN. During the interview the young girl spoke spontaneously about why she visited the nurse.

Young girl: I am a self harmer (Interviewer: a... ?) I cut myself (Interviewer: Ohh) I realise that much, that I am unstable, my mood swings and everything, my ups and downs.

The young girl said that she felt in control when she spoke to the nurse. She decided the topics and the PHN helped to push things forward. She felt relaxed due to client confidentiality and the fact that the nurse was no stranger to her. Referring to PHNs in general she said that they were not all that different, they were nice, they sat and listened and they gave advice.

Nurses, parents and young people felt the need for more extensive PHN services. When referring to the PHNs' services to young people, one nurse (11) said that the clinic for young people was entirely dependent on the support of the school health services.

The importance of relationships

All the respondents were concerned about maintaining good relationships. Even though the settings differed, different aspects of this common theme emerged. Some parents commented on the consultation's pleasant atmosphere; others said that they appreciated an open direct approach from the nurse. The young people mentioned specifically client confidentiality, their appreciation of the nurses open approach and that they valued her as a guiding influence, an advisor and a listener.

All PHNs focused on dialogue and empowerment strategies. The nurses at the child health

clinic spoke of how they tried to encourage and enable parents and maintain a good interaction, through dialogue, by showing that they cared, by answering queries and by giving advice. They also spoke about the responsibility of being open. All the service users, both young people and parents expressed satisfaction with the nurses' services.

Discussion of findings

The PHNs approach

Observing the consultations has provided an understanding of the PHN's approach at the different settings. How the session was opened, progressed and came to a close. This study has contributed to further developing Chalmers (1992) and Helseth (1999) theoretical models of public health nursing approaches. The main categories in Chalmers (1992) model are *entry*, *health promotion* and *termination*; further developed by Helseth (1999) into *entry*, *health promotion* and *evaluation*.

The PHNs' approach for ongoing and already established relationships at the child health clinic and school health service is best described using an adapted version of Helseth's model. *Evaluation* of the former visit was the first stage before moving on to the *health promotive* interventions and finally providing an appointment as an *opening* or *entry* to the next meeting. This adapted model takes into consideration aspects of continuity inherent in these consultations. Chalmers (1992) model – *entry*, *health promotion* and *termination* – holds continued relevance as a theoretical model for the nurses' approach at 'drop-in' meetings at the clinics for young people.

The voice of the third

The service users expressed satisfaction with interactions with the PHN, her personality and her competence. Even though the service users were prompted to discuss dissatisfaction, the only issue that emerged was a critique at system level on the availability and accessibility of the service.

Philosopher Emmanuel Levinas writes about the Other in face-to-face relationships, but he also writes about the third: others not present to make their demands known (Levinas and Nemo, 1985;

Levinas, 2003). Stories of other parents' dissatisfaction show that the PHNs' intentions of being supportive, bringing things into the open, listening to the needs of the service users and promoting empowerment at an interpersonal level were not always successful.

Neumann (2007) interviewed both nurses and parents at local clinics and carried out observations in waiting rooms, with the intention of examining normality and deviation; what PHNs see and do not see in mother–child relationships. Neumann's study showed that even though the service is universal PHNs may not always discover children who receive deficient parental care. PHNs worry about those they do not see, nor respond to, who may need their help (Clancy and Svensson, 2007). Paying attention to 'the voice of the third' in this study has drawn attention to another group; those who in their desire to live up to what they feel are the PHN's expectations choose to remain silent and not seek help for their problems. Cowley and Houston (2004) write that, by nature, universal services will be viewed as supportive by some and interfering by others. Central to health promotion is a practice that allows and enables empowerment of clients at individual and structural levels. If a mother who stops breastfeeding feels inferior then goals of dialogue and participation have not been reached. According to Neumann (2007), knowledge, class and gender pave their way through the nurse's professional practice and become manifest in her thoughts on normality and deviation. The ability to treat problems as normal rather than deviances is a prerequisite for health visiting (Chalmers, 1992). The aspects of power in these relationships did not have so much to do with asymmetry in expert and non-expert knowledge but more with feelings of inferiority by not being able to live up to expectations. Being aware of what the right thing is and not managing to do it mothers feel inferior. Neumann (2007) describes the PHNs' view on normality as being very broad. This denotes that there should be room and acceptance for mothers who do not breastfeed. There is a type of power associated with knowing the agenda. The service users appreciated an open nurse. Being explicit about their agenda and their health-promoting intentions can create awareness for both nurse and service user as to the fundamental health promotive purpose of these consultations.

Speaking out

Two nurses mentioned their responsibility to speak out and broach difficult topics, whereas a third nurse mentioned fear of rejection as being a hindrance. Openness must always be balanced and acted out within certain boundaries. According to Martinsen (2006), the zone of untouchability balances openness. Discerning the correct approach always requires a professionally competent nurse with the power of judgement to discern whether an open approach should be toned down or cultivated. Balance is maintained by attentiveness to the ethical demand in the situation. A sensitive, attentive nurse can open up without being invasive, or close up and protect without restricting or shutting out and making the other feel inferior.

The nurses are professionals, but they are also persons with different interests, attitudes and personalities who meet different individuals during these consultations. One nurse's personal interest in physical activity and her direct approach was interpreted by the parents as being an asset. They felt that they could not be criticised for involving their children in certain outdoor activities as they knew that the nurse condoned them. Being on the same wavelength seemed the ideal situation for an empowering relationship, it too can have repercussions. Having sameness as an ideal can result in differences being ignored or toned down.

The father's suggestion of having access to PHNs' profiles gives rise to two interesting questions: Is the father's wish an affirmation of an empowered parent in a public health context? Is it a wish for support based on compliance and agreement? Solbrekke (2008) writes that more and more service users claim their right to negotiate with the professional to find the best solution in each case. The father liked the nurse's direct approach and felt that she could not be strict enough. This can illustrate that empowerment and participation are not about active service users and passive professionals, but about openness, honesty and meeting needs. Health promotive interventions are directed at helping people identify and select appropriate strategies that enable health and well-being in how they choose to live their lives (Besner, 2004), but not in how the professional would choose to.

The nurse and parents seemed well matched. Can acceptance of sameness in goals in turn inhibit the nurse from interpreting and responding to

possible differences and challenges? The question is a legitimate one, if sameness in goals is accepted without question by the nurse.

A cornerstone in Levinas' philosophy is the unique alterity of each individual. Levinas (1987) warns against the pitfall of reducing the other to the same. A challenge for the PHN is that even though closeness can promote trust, as a responsible professional she must accept differences and maintain a certain professional distance in order to give appropriate advice and help.

They don't do anything as such

Perceiving and verbalising the nurses' strategies was not easy for the nurses or service users. According to Millard *et al.* (2006), nursing tasks are embedded in and not distinct from social relationships; the relationship between the patient and the clinician has a profound impact on the level of participation. Lykkeslet and Gjengedal (2006) wrote about *being* and *doing* as two dimensions of nursing knowledge, and also wrote that the *being* dimension is easily overlooked. The *doing* dimension is explicated as adapting and exploring, whereas the *being* dimension has to do with understanding and being connected.

A framework of continuity and outside influences affected each situation. The consultations were not isolated incidents; the service users' knowledge of the nurse as a person and familiarity with her services created trust. The services' positive reputation can have resulted in, as Jentoft (2005) writes, that one person's experience becomes another's expectation. Trust in persons results from past experiences of concrete persons; knowing the tradition, culture and values of the group can generalise trust to all the members of that group (Offe, 1999).

Limitations

The scope of the study is small and the findings cannot be generalised, but they provide a variety of perspectives that can give an understanding of how consultations with PHNs are perceived. The service users seem to have very positive attitudes to the nurses. Can this hint at sample bias be due to hand picked participants? Eight participants were selected by the nurses in the study and the dates for the site visits presented to the

researcher. The other seven (six young people and a mother) were a random selection of service users asked to participate due to the fact that they were at the clinic on the days in which the researcher visited. This can eliminate sample bias to some extent. Two interviews with parents revealed that even though they were satisfied, they knew others who were not. Two nurses had the same experience. None of the young people expressed dissatisfaction with the nurses and all service users wished for more extensive public health nursing services.

Conclusions and implications for practice

The study showed that relationships are important and that they are not only sustained by pleasantness but also by honesty and directness, provided that the relationship is based on trust and sincerity. Not all consultations are empowering. Voicing the PHN's agenda and her health-promotive intentions as well as encouraging feedback from parents could further improve the PHNs' services. Further studies using snowballing techniques to explore perceptions of dissatisfaction could increase knowledge of disempowering relationships.

Even though the service users and nurses were satisfied after the consultations, they were not always able to put their appreciation into words. Interventions in supportive, caring services can be subtle and not easily standardised and categorised. The importance of continuity, familiarity with the nurse and nursing services and her supportive, caring role can easily be overlooked due to the tacit nature of many of the consultations. Using the data from the observations, a forthcoming observational study will attempt to gain a deeper understanding of the subtleties of public health nursing consultations. Aspects of continuity and the interdependence of these services require further study.

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