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The Politics of Health Promotion: Influences on Public Health Promoting Nursing Practice in Ontario, Canada from Nightingale to the Nineties

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Abstract

The marked and significant differences in the various meanings ascribed to health promotion in professional literature provide evidence of the concept's evolution over the last half of the 20th century and testify both to the powerful influences of dominant ideologies and the invisibility of others. The "new public health" marks a return to a conceptualization of health that is consistent with a nursing paradigm and thus potentially useful in supporting nursing health promotion practice. To take full advantage of this knowledge, however, it is critical that nurses reclaim their legacy in health promotion, critically appraise outside influences that threaten to undermine their work, and educate the public and other disciplines about nursing's unique focus on health promotion.

IN 1994 A LABOR arbiter in Ontario, Canada dismissed a nursing union's claim that health promotion was "exclusively" nurses' work. 1 In finding against the public health nurse, the arbiter cited federal and provincial health policy documents and concluded,

While practitioners in the health care field have obviously always been involved in elements of what could broadly be termed "health promotion" the evidence and case material indicate the term "health promotion" is coming to be used in a more specialized way. 1(p2)

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His judgment raises some important questions for nursing: What is health promotion? What is the "specialized way" into which it is evolving? What forces have been responsible for this evolution? And, how does that specialized way relate to nursing's legacy in health promotion and nurses' current conceptualization and practice of health promotion? The answers to these questions are important in orderfor nurses to reflect on their own conceptualization of health and the activities that promote it, as well as to understand the philosophical and political pressures that have brought about change in the way health promotion is being understood globally.

This article addresses those questions through examining one aspect of findings of a 1996 oral history of public health nursing in southern Ontario. 2 Fourteen staff-level public health nurses participated in the study. Transcripts of their 27 interviews were used as primary data sources. When possible, critical factual information was corroborated with newspaper accounts and available written documents. To provide a historical context for the 14 narrators' accounts, the study's review of literature included extant knowledge regarding the origins of health promotion and public health nursing as well as a brief history of the evolution of public health in Canada. Informed by feminist, postmodern philosophies, the literature review further entailed an examination of power relations in health promotion discourse, including whose voice was heard, whose was silent, and who stood to benefit from the knowledge generated. More comprehensive accounts of the findings and methodology have been reported elsewhere. 3-5 The purpose of this article is to use both the literature review and study findings to explore contemporary conceptualizations of health promotion, trace the external influences that have shaped nurses' understanding and practice of health promotion over time, and illustrate those influences with excerpts from the narrators' accounts.

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THE (R)EVOLVING CONCEPTUALIZATION OF HEALTH PROMOTION

An examination of contemporary public health and health promotion literature provides some clues as to the (r)evolving conceptualization of health promotion. Its long-standing medical/public health definition as a primary disease prevention strategy 6 continues to be strongly present in literature. Health promotion is commonly interchanged with terms such as health education and disease prevention. 7-10 In contrast, it has been described as the epitome of empowerment, 11,12 a process that enables people to use health as a resource for their daily lives, 13 and one that focuses on the broad determinants of health rather than causes of disease. 14-18 Health promotion has been acclaimed on one hand as an emancipating social movement 19,20 and critiqued on the other as a carefully disguised bureaucratic control mechanism. 21-25

A similar array of seemingly incongruent conceptualizations of health promotion is found in nursing literature. Here, too, health promotion is frequently used to describe disease prevention 8,26-31 or life-style change. 32,33 Yet, increasingly nursing scholars have critiqued the inadequacy of prevailing conceptualizations of health promotion and the nursing practice that results from them. 34-38 Some have expanded the conceptualization of health to include wellness, 31,33,39-41 while others have conceptually linked health promotion with a philosophy of primary health care and have reconceptualized health promotion to include political activism that addresses social, environmental, political, and economic determinants of health. 42-53 Whereas there is some concern expressed in these critiques that nurses' practice of health promotion is inconsistent with a changing global approach to health promotion as articulated, for example, in the Ottawa Charter 13, there is also concern that it is inconsistent with a nursing paradigm, its holistic conceptualization of health, and its legacy of health promotion.

In an effort to explicate nursing's approach to health promotion, Smith 54 examined five contemporary nursing theorists' conceptualizations of health promotion and identified characteristics they shared. These characteristics, she

asserted, make nursing's focus on health promotion unique: it is more than and different from disease prevention; it encompasses the whole client; it involves changing relationships with the environment and occurs within the context of intense interhuman relationships; and its outcomes are subjectively evaluated by the client. Yet, the question must be asked: Is nursing philosophy and theory the only and/or major influence on nurses' health promotion practice and, if not, what other forces determine how nurses conceptualize and practice health promotion?

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CAUGHT IN A PARADIGM STRUGGLE

The diverse conceptualizations of health promotion present in the literature reflect conflicting underlying philosophical assumptions; that is, a paradigmatic struggle is evident in which the dominance of the biomedical model is being challenged by an "anti-medical-establishment" health promotion movement. [55] This movement has established a new and competing knowledge-base with its own discourse and produced a new group of health promotion "experts." [11,16] The paradigmatic struggle has transcended the realm of abstract ideology and impacted nursing in a number of ways. Specifically, in Canada it has translated into rapidly changing and often contradictory agency policies that have restricted nurses' health promotion practices to conform to dominant ideologies. [4,16,56,57] Second, it has resulted in the creation of new health promoter positions, frequently at the expense of nursing positions, for which nurses are often ineligible to apply. [2] Such actions have undermined nurses' sense of identity, purpose, and confidence in their ability to promote health. [5] Within such an organizational climate, the nursing union's claim to health promotion as an exclusive nursing role is a little more understandable. It was perhaps made in the spirit of a 1919 editorial in *Public Health Nursing* that asked "Why not come boldly forth, one and all, and claim the right to exercise the promotion of health as a profession?" [58]

On a larger scale, the invisibility of nursing's legacy in and unique contribution to health promotion extends beyond Canadian workplaces to dominant health promotion discourse and the political forums in which health care decisions are made. Herein lies the most pervasive and potentially harmful repercussion of the paradigmatic struggle between medicine and the health promotion movement: the exclusion of a nursing voice in the naming and redefining of health promotion work. Because of this invisibility, the legitimacy of nurses as promoters of health is challenged not only by health care workers who enjoy the status and privilege of determining what counts as health promotion knowledge, but also by employers, members of the public (as in the case of the arbiter), and, all too often, nurses themselves. This challenge threatens both the right of nurses to "exercise the promotion of health" and the right of individuals, families, and communities to have access to services that have long been instrumental in the empowerment of clients to gain some measure of control over their health. [5,58-63]

Without both being grounded in nursing's strong tradition of health promotion practice and being aware of the politics of health promotion, nurses may not be able to withstand the pressures to conform their own practices to prevailing ideologies and administrative directions, and they may lose the unique characteristics a nursing approach to health promotion offers. A brief review of the historical and political context of nursing health promotion practice is, therefore, instructive.

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IN THE BEGINNING ...

Modern nursing traces its origins to Florence Nightingale. What is often not recognized, however, is that our legacy of health promotion begins there as well. During the mid-19th century, public health was focused on social and economic issues that affected health. Not surprisingly, Nightingale's curriculum for the first training school to educate district nurses in 1862 reflected that focus. [64] One full year was devoted to district nursing and promoting the health of communities. [46]

Within the curriculum, Nightingale stressed not only promoting self-care, but also addressing individual, social, and health reforms. 64 She was influential in shaping British health policy related to a number of issues, one of which was the institution of workhouse reforms to reduce air pollution. Monteiro 64 noted that the filthy workhouses sheltered British paupers who, when they were ill, were treated in crowded workhouse infirmaries. Nightingale not only was instrumental in providing trained nurses to address immediate needs, but also in influencing legislation to improve workhouse conditions. Poverty was a particular concern of hers. She described it as a state of mind, not only of economics, and believed nurses could "depauperize" those in poverty by addressing that state of mind and bringing about social reform. 44 In retrospect, her vision was remarkable. More than six decades before McKeown 65 would challenge the ineffectiveness of a treatment-and-cure approach to improving the health of populations, Nightingale wrote that "money would be better spent in maintaining health in infancy and childhood than in building hospitals to cure disease." 64(p102) The focus of Nightingale's activities to promote health extended from individuals to communities and their nature ranged from personal care to political activism. It is clear that her multifaceted approach is consistent with contemporary conceptualizations of health promotion articulated in health policy statements, 13,17,66 health promotion models, 16,67,68 and health promotion and nursing discourses. Even during Nightingale's lifetime, however, changes were occurring that would eventually take public health (and its promotion) in a new direction. Toward the last quarter of the 19th century, the application of scientific principles to the issue of health catapulted medicine to a dominant position in public health. Germ theory, which emerged in 1870, gave to the developing science of medicine a model with which it would view disease to the present time (ie, disease as an entity that "attacks" a person). 39 Epidemiology and the advancement of statistics provided tools by which population norms could be created and deviations from those norms identified. 55 As these advancements were incorporated into the field of public health, a biomedicalized view of health gained dominance, and approaches to improving health shifted to the treatment and prevention of disease. Public health knowledge suddenly became useful for both governments and industries. Healthier populations meant healthier work forces to advance industry and healthier armies to win wars. 55

In North America, in the waning years of the 19th century and early 20th century, Nightingale's vision for health nursing was embodied by the work of Lillian Wald in the United States and the Victorian Order of Nurses in Canada. Wald, who added the term *public* to Nightingale's health nursing, is best known for her establishment of the Henry Street Settlement.

Early public health nursing in North America was grounded in a nursing paradigm and existed outside of medical jurisdiction. 69 Public health nurses were, therefore, able to resist the biomedicalization of health longer than nurses who worked in institutions under medical control. The work of the nurses in the Henry Street Settlement in providing both personal care and political activism is well known. Wald continued Nightingale's tradition of addressing broad determinants of health. Among her many social activist activities were: political lobbying to obtain health care for those in poverty, establishing school nursing, 70,71 establishing rural nursing, and influencing the founding of the Children's Bureau to address child labor and welfare. 69

Wald strongly emphasized the "development of community coalitions for influencing health and social policy." 44 She believed that the nurse, because of an "organic relationship with the neighborhood" was in a pivotal position to be linked to "all agencies and groups of whatever creed which were working for social betterment, private as well as municipal." 72 Wald's approach, like Nightingale's, reflects a philosophy of health promotion that resonates with the philosophy of the health promotion movement. The coalition building that she advocated and the mediation of varying societal interests in the promotion of health form the cornerstones of landmark documents such as the Ottawa Charter 13 and contemporary models of health promotion. 16 Unfortunately, the contributions and foresight of this public health nursing visionary also remain invisible in dominant discourse.

Community health nursing in Canada was strongly influenced by both Nightingale and Wald. Before the rise of public health nursing as a provincial public health service, similar work was performed first by women in religious orders, then by nurses trained in nursing schools patterned after the Nightingale model who left the hospital for community nursing work upon graduation. 73 As in the United States, early Canadian nurses working in the community enjoyed more freedom to continue to practice within a nursing paradigm than did nurses who worked in hospitals. In 1897, over the protests of physicians, community health nurses were organized into the Victorian Order of Nurses (VON). 73 From its inception until after World War II, VON nurses were involved in disease prevention and health promotion activities in addition to providing nursing care to those who were ill. 74

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A LOSS OF INNOCENCE

The existence of public health nursing practice outside of medical jurisdiction was about to change, however, as the biomedicalized approach to health gained momentum in North America. The Flexner report of 1910 pivoted medicine to a scientific model, initially in the United States but very quickly in Canada as well. The elimination of the apprenticeship model and the move to a university entry to practice requirement, along with its male exclusiveness and cozy relationship with corporate philanthropy, made medicine a powerful social and political force. 75 Its adoption of a reductionist, disease focus to health, therefore, influenced the way North Americans, including nurses, reconceptualized health. As physicians extended their dominance outside of hospitals to public health, the latter shifted its focus from broad determinants of health to biomedical causes of disease as it had in England. Nurses who continued to incorporate a broader vision of health promotion not only had failed to keep up with "progress," but also competed with physicians for health care dollars.

Novak 69 documented the demise of early public health nursing that resulted. Following World War I, public health nurses in the United States had received substantial funding from the federal government which, concerned by the poor health of recruits and fearful of another war, wanted to ensure healthier soldiers. Because the rural nursing programs initiated by Wald had demonstrated success in controlling communicable diseases and in lowering the infant mortality rate, maternal and infant welfare programs were instituted in 45 states. With the shift in public health and strengthening of medical power, however, the public health nursing approach was deemed outdated and out of step with scientific advancements. Despite outcomes evidence of the effectiveness of the nursing program, the American Medical Association opposed it on the grounds that it was "unsound in policy, wasteful, extravagant, and [that it] promoted communism." 69(p13) Funding was subsequently withdrawn in 1929, and without it, public health nurses saw no alternative but to align themselves with public health. As medical dominance extended from hospitals to the public health arena, public health nurses found themselves working in bureaucracies under medical control.

In Canada, although provincial and local public health departments in the first half of the 20th century had hired a few nurses, most health promotion and disease prevention activities were performed by the VON. 74 Around the time of World War II, the publicly funded provincial health branches began to expand their mandate from sanitation and outbreak control to include health promotion and disease prevention activities. It is not surprising, therefore, that VON was advised by a public health medical expert to narrow its mandate to the care of ill people in their homes. 74 Unfortunately, VON heeded this egregious advice and thus, by the early 1950s, the last obstacle to the complete domination of public health nursing by medicine had been removed in Ontario.

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CONTEMPORARY INFLUENCES ON PUBLIC HEALTH PROMOTING

NURSING PRACTICE IN ONTARIO

The accounts of the public health nurses who participated in the oral history revealed three major external influences on their health promotion practice. Two were the ideologies involved in the paradigm shift from a biomedicalized to a socialized conceptualization of health promotion. The third represented the political and administrative power of medicine in controlling public health in Ontario.

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The medical model of health promotion

In the late 1950s, Leavell and Clark, 6 two public health physicians, developed a model for family practitioners that became widely used as a theoretical framework for public health practice. Their model focused on three levels of disease prevention: primary, secondary, and tertiary. Along with specific strategies, health promotion was identified as a primary disease prevention strategy. Although Leavell and Clark stressed health promotion as a strategy to promote general health and well-being outside of the context of disease, their model's unfortunate positioning of health promotion as a "prepathogenesis" strategy allowed it to be narrowly interpreted and used to justify the withdrawal or reduction of many public health nursing services in Ontario in the late 1980s and early 1990s. 2 Within this medical framework, anyone who had been unfortunate enough to suffer from heart disease or mental illness was no longer considered an appropriate candidate for health promotion services.

The powerful influence of that model on public health nurses' conceptualizations of health promotion was clearly evident. 4 A narrow medicalized interpretation of health promotion as primary disease prevention was readily accepted by many of the nurses and often led them to actively support decisions to eliminate nursing services that did not meet this definition. One nurse narrator's comments graphically illustrate this influence: "We also looked at our post coronary [cases]. When public health was supposed to be health promotion and prevention of illness and you are going in after the person has had a coronary, that doesn't make sense.... This is not primary prevention."

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The winds of change

In England, Thomas McKeown, 65 a contemporary of Leavell and Clark, challenged common wisdom that medical interventions were responsible for declining morbidity and mortality rates. His studies showed that these rates were more directly linked to nutrition, family planning, adequate housing, and other such factors than to medical interventions, thus once again redirecting attention to broader determinants of health. McKeown's work is particularly noteworthy because it indirectly but profoundly influenced public health promoting nursing practice. First his work influenced the Lalonde 10 report of 1974, and then it led to the development of the population health movement in the early 1980s.

The issuance of the Lalonde report was a watershed event in Canadian and global approaches to health. First, it marked the beginning of the paradigm shift in public health that gave rise to the anti-medical-establishment health promotion movement. To some enthusiastic proponents of that movement, health promotion itself began with Lalonde. 19 Second, the Lalonde report marked the first time in Canadian history that a federal government document acknowledged the limitations of the treatment paradigm that it had so wholeheartedly supported through legislation and funding. The report proposed a framework for health that stepped beyond the treatment paradigm and encompassed a "health field" composed of human biology, environment, life style, and health care organization. The document was remarkably visionary for its time, preceding the Alma-Ata Declaration 76 by several years. It challenged the supremacy of scientific knowledge by encouraging a creative and innovative approach to health "even when scientific certainty and predictability are in question." 10(p58) It advocated

elevating care to the same level as cure so that people with chronic illnesses could be cared for adequately and stressed that cost-effectiveness included issues of access and effectiveness, not only cost. Unfortunately, the major thrust of activities arising out of the Lalonde report was a life-style approach to health promotion that overly emphasized individual solutions to health problems precipitated by broader social factors.

The influence of the life-style approach to public health nursing was evident in the language nurses often used to describe their work. Many referred to the need for changing life style and the importance of health teaching in improving health. This nurse's comment was typical of many:

There's [sic] no dollars to train children and educate them about the dangers of their actions.... The money isn't there for the education that we need to do to prevent this.... If we could just teach people to look after their mental health.... A healthy life style, that's where the money needs to go.

Despite the strong influences of the life-style model, nurses' reports of their work, even when focused on life styles, continued to demonstrate a nursing perspective. As illustrated in this narrative, mutuality, partnerships, and shared responsibility for health surfaced in nurse narrators' stories about interventions involving health teaching:

I first set some goals with the client, eg, "Do you have some needs I can help you with?" ... A man I visited was about 150 pounds overweight and he smoked two packages of cigarettes a day and we talked about some of the things he could do. He identified that he needed some life style changes so we negotiated [for how long I would come and how I could help].

The influence of the life-style movement and its emphasis on individual rather than social solutions was reflected in a 1986 article in *The Newsletter,* the publication of the Community Health Nurses Interest Group (CHNIG) of The Registered Nurses Association of Ontario. CHNIG had surveyed its membership regarding important practice concerns. In the report summarizing the results, some issues (including poverty) identified by members were omitted with the rationale that they were social-welfare rather than nursing concerns. 77

In 1978, the ideas put forth in the Lalonde report were reinforced and expanded in the Alma-Ata Declaration through the delineation of the tenets of primary health care. 76 The declaration emphasized the provision of health promotion, as well as essential preventive, curative, and rehabilitative services. It also identified essentials for health such as safe water, proper nutrition, family planning, and maternal and child care, among others. Nurses were considered by the World Health Organization to be pivotal in providing primary health care services and in achieving the goal of health for all by the year 2000. 78 Thus, nationally and internationally the paradigm shift away from the narrow disease-focused approach of medicine toward a broader vision of health and health care was beginning to take hold.

In 1986 that shift gained considerable momentum-first with another Canadian federal document 17 that further advanced thinking about health promotion and later with the Ottawa Charter. The Epp framework, as it is commonly known, adopted the World Health Organization definition of health promotion as "the process of enabling people to increase control over, and to improve, their health." 17 Three challenges to achieving health were identified: reducing inequities, increasing prevention efforts, and enhancing people's ability to cope. The framework included strategies such as fostering public participation, strengthening community health services, and coordinating healthy public policy. It concluded with a denouncement of strategies that focused on individual responsibility for health, or "blaming the victim," while ignoring the social and economic conditions

that support them.

The framework provided a basis for the Ottawa Charter, 13 the outcome of the first International Conference on Health Promotion held later that year in Ottawa, Canada. Based on the philosophy of primary health care articulated at Alma-Ata in 1977, the Ottawa Charter represented the commitment of the countries attending the conference to achieve the goal of health for all by the year 2000. The charter's well-known prerequisites to health and five strategies have recently been augmented in the Jakarta Declaration, 66 but its definition of health promotion has remained constant. Important to nurses are some less frequently emphasized (and sometimes ignored) aspects of the charter. These include references to caring, holism, and ecology as essential to health promotion; the identification of advocacy for health, enabling people to achieve their fullest health potential; and mediation of differing societal interests as cornerstones of health promotion.

Unlike their frequent references to the medical health promotion model, the study's narrators rarely referred to either nursing or contemporary health promotion models as guiding their practice. One nurse narrator hinted that the advances in health promotion created confusing and conflicting pressures to change her practice. She remarked, "kind of what bugs me [is that] every train that pulls into the station we all jump on." By far the most important influences that narrators identified as shaping their health promotion practices were administrative directives at both provincial and local levels.

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Continued medical dominance

The reason for nurses' confusion is not hard to understand given the continued medical dominance of public health. Administrative directives, although often using the rhetoric of health promotion, continued to reflect a medical perspective. Medical dominance of public health in Ontario was promoted and, to some extent, served by an increased medical presence in Ontario between 1972 and 1995. During that time, the growth in the number of physicians was approximately three times the increase in population. 79,80 This gave physicians a more powerful political lobby but, without extending the scope of services they provided, posed a serious threat to the sustainability of their income levels. Coincidentally or not, during that time period many public health nursing services, such as well-baby clinics, infant immunizations, comprehensive postnatal follow-up exams, childhood immunizations, and monitoring of elderly clients, were transferred from the practice of public health nurses to community physicians. Such a transfer was possible without public outcry because physicians' services had been insured through publicly funded health insurance since 1969. The transfer of services from nursing to medical practice, however, served to significantly curtail health promotion services available to the public.

In addition to increasing numbers of physicians in Ontario, two distinctly separate but intertwining series of events occurred during the 1980s that added significantly to medical control over nurses' health promotion practice and mitigated the challenge to medical dominance posed by the fledgling health promotion movement. In 1983, the Health Protection and Promotion Act (HPPA) was passed in Ontario to replace the Public Health Act that preceded it. The new act was designed on the surface, at least, to incorporate the "new public health" initiated by Lalonde and advanced at Alma-Ata. Its intent was to refocus public health away from the control of infectious diseases to health protection and promotion. Ironically, whether coincidentally or as a backlash to the emerging health promotion movement, the HPPA also served to further concentrate power in the hands of public health medicine in several ways. First, it ensured that medicine would continue to dominate the administration of public health in Ontario by stipulating that the chief executive officer of each of the province's 42 health units be a physician. Second, the act created a new position of Chief Medical Officer of Health (CMOH). That position, according to its first incumbent, Dr. David Korn, was given sweeping powers to protect the public's health, "to be able to do anything in Ontario under the Minister's direction to protect the public's

health" (D. Korn, personal communication, October 27, 1995). In 1987, again whether coincidentally or as a backlash to the 1986 federal and global challenges to a biomedicalized understanding of health and its promotion, the Public Health Branch reorganized, appointing a new CMOH and significantly strengthening his power base by adding administrative power over public health practice in Ontario.

With the positional power of physicians in public health secured, another feature of the HPPA provided an avenue for exercising that dominance. The act identified public health services and programs that local health units were legally required to provide. Developed by physicians at the provincial level, guidelines for the provision of these services were administered and interpreted by physicians at the local level. Although they were not the first guidelines issued under the act, the 1989 Mandatory Health Programs and Services Guidelines 81 were by far the most influential on health promotion practices reported by the narrators. The guidelines were an example of the conflicting directives issued to public health workers: on one hand they seemed to reflect at least some of the language of the health promotion movement, but on the other hand they were interpreted and implemented from a medical perspective.

The second development that strengthened medicine's position during the 1980s was the emergence of population health, an approach to health care credited to the work of a physician at McMaster University, Dr. Fraser Mustard. Population health, like the Lalonde report, was strongly influenced by the work of Thomas McKeown. 14 Population health further developed in the Canadian Institute of Advanced Research's Population Health Program, described as "a uniquely networked interdisciplinary group that has expertise in such fields as genetics, medicine, epidemiology, sociology, political science, economics, and policy analysis." 82(p1) The population health approach to health care focuses on broad determinants of health and is based on the premise that a nation's prosperity is linked to its health. It argues that health care expenditures that adversely affect a nation's wealth adversely affect its health; therefore cutbacks to health care spending will positively affect health. Not surprisingly, given the composition of the "experts," health care and medical care are used synonymously throughout population health discourse as though health providers whose foci lie outside of a context of treatment and cure are nonexistent. A nursing voice is conspicuously absent.

Population health became a significant influence in shaping public health policy in Ontario, 83 as well as federal and provincial health care policy generally. 84 It is not difficult to understand why a position that advocated the reduction of health care spending would be appealing to politicians. Nevertheless, if governments' endorsements of population health had resulted in their serious attention to social determinants of health and appreciable improvements in the health of populations, it would have been more palatable. Instead, the rhetoric of population health was instrumental in eliminating many public health nursing programs, particularly those that provided direct services to individuals and families. Many public health nursing positions were lost as a result. Nursing administrators' estimates of the numbers of positions their agencies lost between 1987 and 1997 ranged from 20% to 45%. 85 Population health has much to offer in its critique of medical hegemony in public health and attention to broad determinants of health but is limited because of its own medicocentrism and failure to recognize the contributions of nurses in public health both in 19th century England and 20th century North America. The invisibility of public health nursing to the proponents of population health is reflective of the perception of their forefathers, that nursing remains "a skilled branch of modern medicine." 86(p25)

That invisibility and that perception were evident in a 1995 document issued by the Association of Local Official Health Agencies 83 and based on the premises of population health. The association, representing medical officers and boards of health in Ontario, appeared to endorse the Ottawa Charter's broad definition of health but identified communicable disease control and environmental protection as the essential cornerstones of public health services. It highlighted successful immunization as an example of public health activities with the greatest health

benefits but when it lauded the substantial increase of scientific contributors to public health, such as "nutritionists, planners, physiotherapists, health educators, and epidemiologists," 83 nurses who administer the immunizations were invisible. With its many inconsistencies, the document appeared at times to acknowledge the appropriateness of individual interventions and at other times to conflate them with treatment and contrast them with health promotion, equated to a population approach.

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PUBLIC HEALTH PROMOTING NURSING PRACTICE IN ONTARIO

The scope of public health nursing, as evidenced in the narratives of the study's participants, did reflect aspects of the "new" conceptualization of health promotion brought about by federal and global developments. Evidence of community development; empowerment; intersectoral collaboration; and activities directed at social, economic, and political determinants of health pervaded nurses' discussions of their practice. Their narratives provided some suggestion, however, that these were not recent changes but had been characteristics of their district nursing practice, an approach to public health nursing that fell out of favor during the 1980s. 4

As one nurse said, "community development, the partnerships and all that, we were doing it; we were calling it something else." Nurses described how integrally they were connected to their communities. They served as a trusted nexus that linked people with needs in the community to its resources. Because of this unique relationship, the nurse was often in a position to help the community identify health needs and assist the community in responding to those needs.

One nurse, for example, gave an account of an experience early in the 1980s, too early to be influenced by the charter's admonition for intersectoral collaboration but reminiscent of Wald's notion that nurses, because of their relationship with the community, were in a position to link to other groups working to improve health. She recalled, "I had been encouraged by somebody in the community to join them to start a support network for people with depression or mental health problems." The relational nature of nurses' heath promotion practice positioned them as *partners* with clients rather than providers of services. One nurse's reflection on the value of the prenatal classes she provided illustrated this: "I think if you can't build those kinds of relationships with individuals and even with groups, you just can't be effective in my mind; you are just that stranger, that expert that comes in."

The empowering and caring attributes of health promoting nursing practice were readily apparent, despite bureaucratic environments that devalued it. 5 Advocacy for health was a central feature of nurses' work when organizational flexibility allowed it. As one nurse mused, "I always saw the role [of the public health nurse] as one of real advocacy because you can have people who really need something and it's there; they just don't know what to call it; they don't know that they can ask for it." Another described her efforts in obtaining pro bono dental work for a family:

[There was an instance of] children that had a lot of dental caries and were missing a lot of school and weren't functioning well in school because of this and the family didn't have money to have the dental work done. Well, I contacted a local dentist and asked him if he would, on this particular large family, help out and so he did it for nothing.... There was a big advocacy role.

There was some evidence that social advocacy had been a feature of public health nursing practice prior to its being strongly refocused on individual health teaching in the life-style era. Nurses recalled playing an active role in promoting car seats and developing standards for crib safety that they felt influenced

eventual legislation in that regard. Articles in more recent issues of CHNIG's *The Newsletter* reflect a return to such activities. Family violence, homelessness, and poverty are among the issues that nurses are actively working to address. One nurse has been instrumental in focusing national attention on homelessness through lobbying to declare it a national disaster 87; another has focused professional and government attention on poverty. 88 Whereas some nurses never lost sight of the importance of social determinants of health such as poverty, others were enabled to return to incorporating social activism into their health promotion practice by the recent paradigm shift.

The influence of conflicting ideologies represented in administrative directives significantly influenced nurses' health promotion practices. Restructuring to a program focus estranged nurses from the integral connection to the communities that they were now being directed to "develop." Early in 1996 much of public health nurses' work in the province was effectively suspended for several months by Dr. Richard Schabas, the province's second CMOH, through his mandate that nurses administer measles vaccine to all Ontario school children by the end of the school year. As one nurse recalled,

People were probably really progressing at a nice level with some of these community development groups and committees and … [then] there was a mandated immunization program and people suddenly were told they had to terminate all of those relationships because there wouldn't be any time to continue.

As noted, the essence of community development had been a feature of nurses' district nursing practice and was fully congruent with nursing's legacy in health promotion. When it became a hallmark of "progress," by being named and valued in dominant discourse, however, nurses were urged-sometimes by nursing leaders-to abandon their services to individuals and families and follow the example of other disciplines that were developing communities. 89 The frenzy with which agencies attempted to demonstrate their progressiveness by "doing community development" often resulted in the imposition of community development activities that were inconsistent with the very premises of the approach. In many instances, nurses reported that community development was defined narrowly as a response to a self-identified community need, effectively eliminating vulnerable and marginalized populations who lacked the knowledge, awareness, and skills to approach them. Often, demands for outcomes were inappropriate and expected in unrealistically short time frames. One nurse contrasted the lack of "interference or intrusiveness" from her agency early in the 1980s as she did what she considered to be true community development work with "the [19]90s, when they suddenly discovered community development [and] made it so complicated that nurses were one, afraid to tackle it, and two, burdened down by all kinds of regimentation."

Both community development, a cornerstone of health promotion, and population health were widely interpreted in such a way as to eliminate health promotion services to individuals and families. This narrator nurse's comment was typical: "All of a sudden we weren't doing home visits; we were doing this community development and going out and empowering people and, you know, all those key words."

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IN THE FINAL ANALYSIS ...

Health promoting practice in public health nurses' accounts of their work was strongly influenced by dominant ideologies in the form of both the "old" and "new public health" and by administrative constraints. The paradigmatic struggle by public health medicine and the health promotion movement created confusion and a lost sense of identity for nurses who were caught in the middle, devalued as an ancillary medical service by each. Administrative controls not only tended to shape nursing practice to conform to prevailing ideologies, but also often seemed

politically motivated to divest public health of nursing services and thus, not surprisingly, were philosophically inconsistent with either paradigm.

Yet, despite the barriers, health promotion in public health nursing practice retained remnants of its historical roots and characteristics of nursing's unique focus on health promotion. 54 Despite the strong influence of the medical model, many nurses still believed that health could be promoted in the presence or absence of disease and did so when they had the opportunity. They understood "that a community's health is inextricably linked with the health of its constituent members and is often reflected first in individual and family health experiences." 90 Their integral relationship with the community advantaged them in giving voice to its most vulnerable members and strengthening the community's capacity to care for its members. Although the lack of "scientific" outcomes to demonstrate nurses' effectiveness contributed to their invisibility, clients' subjective evaluations were central to the reflective caring process of nursing health promotion practice.

The marked significant differences in the various meaning ascribed to health promotion in professional literature provides evidence of the concept's evolution over the last half of the 20th century and testifies both to the powerful influences of dominant ideologies and the invisibility of others. Often the knowledge generated in dominant discourse has been used to attain or maintain power in public health at the expense of those who are silenced. The "new public health" marks a return to a conceptualization of health that is consistent with a nursing paradigm and thus potentially useful in supporting nursing health promotion practices. However, to take full advantage of this knowledge and effectively challenge administrative constraints, it is critical that nurses reclaim their legacy in health promotion, critically appraise outside influences that threaten to undermine their work, and educate the public and other disciplines about nursing's unique focus on health promotion.

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Key words:: health promotion; new public health; nursing history; population health; public health nursing

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