

SASKATCHEWAN REGISTERED
NURSES BUILDING EQUITY
THROUGH PRACTICE

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ABSTRACT

The goal of nursing is to promote health and alleviate suffering. Using Appreciative Inquiry, this study explored the possibilities for the nursing profession to reduce the health implications of poverty. Select Saskatchewan registered nurses (RNs) engaged in appreciative interviews that identified positive experiences working with low income clients. The participants were activists challenging the status quo through their practice. Analysis illuminated the best practices of these RNs, constructing a vision for change rooted in their understanding clients' realities and communicating those realities through advocacy. By bringing their personal passions to client interactions, and connecting with a broader social justice context, RNs create an opportunity to respond to the effects of income inequities on health.

Key Words: Registered nurses, low income, activism/advocacy, Appreciative Inquiry

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LIST OF ABBREVIATIONS

Registered Nurses (RNs)	2
World Health Organization (WHO)	2
International Council of Nurses (ICN)	2
Canadian Nurses Association (CNA)	2
Appreciative Inquiry (AI)	4
Saskatchewan Registered Nurses' Association (SRNA)	10

Saskatchewan Registered Nurses Building Equity Through Practice

CHAPTER ONE

Implications of Income Injustice

The implications of being poor are evident, “even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illness than the rich” (Wilkinson & Marmot, 2003, p. 7). “In Canada, poverty is the strongest determinant of health, and poverty rates have not improved over the last two decades” (Raphael, 2007 as cited in McGibbon, Etowa, & McPherson, 2008, p. 24). Saskatchewan has both privilege and poverty:

Inner-city Regina...is among the poorest spots in urban Canada. Thirty per cent of residents depend on government assistance. Local food banks deal with more than 3,600 requests a month. The health authority, which last year distributed 1.8 million needles, estimates there are more IV drug users per capita than on Vancouver's Downtown Eastside. Girls as young as 11 or 12 regularly work the stroll. Regina... [is] at the top of Canada's urban crime rankings for nine of the past 10 years...The median household income is just over \$25,000 -- half the city average (Gatehouse, 2007, ¶ 4).

The *2004 Health Status Report* for the Saskatoon Health Region noted that even when it appears that the number of people living in poverty is decreasing, the gap between the rich and poor after tax is widening, showing disposable income gains are not distributed equitably (Saskatoon Health Region, 2004). Such disproportion is echoed by the *2004 Health Status Report* for the Regina Qu'Appelle Health Region that stated income growth occurred unequally in higher income brackets while lower income brackets remained stable in earning (Regina Qu'Appelle Health Region). Despite economic booms, income distribution is not proportionate among all socioeconomic levels. Wealth concentrates in higher income groups while the poor are excluded from benefits.

Poverty in Saskatchewan is persistent. In 2000, the incidence of low income in unattached individuals over 15 years of age was 36% (Canadian Council on Social Development, 2007). *The 2006 Report Card on Child Poverty in Saskatchewan* showed the child poverty incidence rate of 20.1% in Saskatchewan is consistently above the national average of 17.7% (Hunter, Douglas, Bell, & Delany, 2006). Rates remain steady over time: the 2008 report A

Question of Prosperity: Poverty in Saskatchewan highlighted child poverty rates remaining high at 19.9% above the national average of 15.8% (Hunter, Douglas, & Pedersen, 2008). The overall rate of poverty in Saskatchewan is 15.3%, above Canada's average of 14.5%; 40.7% of unattached persons under 65 live in poverty and unattached elderly over 65 face a rate of 28% living in poverty (Hunter et al.). The persistent nature of the issue shows little mitigation of poverty in Saskatchewan over time.

Economic status affects health through its mediating effect on people's ability to secure resources and services (Byrne, 2006; DeLashmutt & Rankin, 2005; Morgan, 2007). The implications of having a low income can result in stress and an inability to provide the needed personal and family material goods and options required to support health. Registered nurses (RNs) see the effects of these implications and understand the relationship they have with the health status of clients.

1.1 Significance

The Jakarta Declaration stated "above all, poverty is the greatest threat to health (World Health Organization (WHO), 1997, p. 2). The World Health Organization's report *Closing the gap in a generation: Health equity through action on the social determinants of health* (2008) has been highlighted as "a call to action to redress health inequities (Edwards & Smith, 2008, p. 35). Registered nurses must expand their scope from a narrow view of health to one that encompasses policies that are highly influential on health (Reutter & Duncan, 2002). The context of clients' realities must be addressed by RNs "incorporating this broad perspective of health into their care and addressing the root causes of physical and social environmental hazards that threaten health" (Rains-Warner, 2003, p. 136). By taking a comprehensive view of health, RNs are better prepared to facilitate population health through incorporating into their care the impact of multiple influences such as political ideologies or globalization. The International Council of Nurses (ICN) (n.d.) stated "the poor share an unequal burden of ill health" (p. 1). The Canadian Nurses Association (CNA) (2000) located nursing within the sphere of politics asserting, "nursing is political act" (p. 4). As a caring profession, nursing must address social, economic, and political agendas that have repercussions for health.

Health itself has become political. Registered nurses who interact with defining factors of health through addressing the social determinants, such as income, can be seen as political activists. Scholars have stated that political involvement is nursing's responsibility, describing it

as a social mandate (Falk-Rafael, 2005) and a responsibility not a privilege (Boswell, Cannon, & Miller, 2005). Antrobus (2003) stated “political awareness is needed by every nurse” (p. 42). In addition, Hagedorn (1995) noted “through conceptualizing health as political, the primary care nurse is reborn as an activist” (p. 1).

Advocacy is an essential role of nursing, and, “if the nursing profession fails to advocate for patients, it has little purpose beyond a technical role” (Vaartio & Leino-Kilpi, 2005, p. 713). Advocacy “actively support[s] a right and good cause; it support[s] others to speak for themselves or speak[s] on behalf of those who cannot” (CNA, 2008, p. 18). Speaking out uses the power of nursing as an act of resistance, it aims to enable the actualization of ethical values in practice (Peter, Lunardi, & Macfarlane, 2004). Through mobilizing collective power and utilizing networks, RNs can play a role in social change that is proportionate to their numbers (Cramer, 2002). Registered nurses must “shift from silent caregiver to visible resource” (Antrobus, 2003, p. 44). Advocacy becomes activism when the goal moves to rebalancing power at the societal level, addressing structures and systems that perpetuate inequities and obstruct the achievement of social justice (Faver, 2001; Hagedorn, 1995). The ICN (n.d.) states “nurses have a vital role in reducing poverty and its impact on health and well-being (p.1). Nursing must recognize the impact of poverty on health in their individual practice and join together and take action (Sheer, 2007).

Registered nurses have a unique and broad perspective of the healthcare system, with ‘presence in’ and invaluable ‘knowledge of’ all aspects, and are highly respected (Ellenbecker, Fawcett, & Glazer, 2005). They spend more time with clients than other healthcare professionals (Ellenbecker et al.) hence privileging them with a greater opportunity to access a holistic account of their clients inclusive of diverse needs. In Saskatchewan, there are programs that target low income populations such as the Saskatoon Health Region’s Street Health Program and poverty priority areas in their primary health services community development program. As well in the Regina Qu’Appelle Health Region, one core neighborhood has a community health nurse in a “health action centre”. The emergence of a nursing sub-specialty, ‘street nursing’ which deals specifically with low income populations with unstable housing, illuminates the increasing presence of nursing in arbitrating socio- economics.

Nursing groups have historically supported and cared for the poor, often providing outreach services and initiating ongoing service provisions to vulnerable groups (Hardhill, 2006).

The combination of “witnessing” and action in the history of nursing shows the significant contribution nursing can make when working with vulnerable populations (Hardhill). Registered nurses make assessments that reveal health disparities that they have a professional responsibility to address (Malone, 2005). Describing the perspective of RNs who respond to the implications of clients’ economic circumstances identified successes and opportunities in the design of future strategies to mitigate the current divide between theory and practice.

1.2 Research Objectives

Browne (2000) explained that the commitments of nursing research is twofold, to create nursing knowledge that guides practice and to enact knowledge as actions that lead to the advancement of health and the greater social good. Appreciative Inquiry (AI) potentially fulfills this promise as it focuses on successes and identifies contributing circumstances so that these successes can be repeated (Havens, Wood, & Leeman, 2006). This methodology enables insight into RNs’ activism when its prominence in practice has been supplanted. Through an AI approach, practicing RNs who are attending to the economic realities of their clients as part of their practice were asked to make available their actions and decisions as an evidence base for action in nursing.

1.2.1 Research Purpose

This research describes and explores the roles of direct care RNs who, as part of their practice, are responding to the needs of low income clients in Saskatchewan.

1.2.2 Research Question

The overarching question for this research is what are the possibilities for the nursing profession to successfully reduce the implications of poverty on health based on the achievements of direct care RNs who respond to the low income circumstances of clients in Saskatchewan?

1.3 Conceptual Definitions

1.3.1 Activism

Hagedorn (1995) stated

activism is a passionate approach to everyday activities that is committed to seeking a more just social order through critical analysis, provocation, transformation, and rebalancing of power. Activism challenges the system that frames social inequities and provides a systematic process through which primary care clients can redress the core issues that negatively affect health (p. 2).

Faver (2001) discussed activism as an attempt to change the status quo and replace inequity with justice. Activism in primary care nursing is

both the individual care and the political action needed to unbalance the social power that may have prevented individuals, families, and communities from achieving well-being and health [and it] promotes exposing, provoking, and unbalancing the social power that maintains people in a state of disease, while simultaneously nurturing caring...Activist primary caring provides the knowledge and means of redressing the social inequities that maintain an environment of disease (Hagedorn, p. 2).

Registered nurses live and work within the “intersection of public policy and personal lives” and this position enables them to advocate for healthy public policy as part of their practice (Falk-Rafael, 2005, p. 212). Falk-Rafael identified “Critical Caring” as a mid range theory to guide public health nursing (p. 212). Critical Caring includes health promotion as well as “contributing to the creation of supportive and sustainable physical, social, political, and economic environments” (Falk-Rafael, p. 212). “Speaking truth to power” is a central concept in Critical Caring that calls for “influencing public policies that impact health, advocating for those whose voices have been silenced, and challenging ideologies that contribute to the exclusion of some groups for the benefit of others” (Falk-Rafael, p. 220). For this study, activism was defined as any action of advocacy undertaken by the RN participant that produced social or political change. Examples of such actions are seeking social justice, challenging systemic inequities, influencing policy, contributing to economic solutions, and attending to the implications of low income circumstances in their client population.

1.3.2 Low Income Populations

Poverty is defined as “the state or condition of having little or no money, goods, or means of support; condition of being poor; indigence” (Poverty, n.d., ¶ 1). Canada has no official poverty line. Therefore, the Low Income Cut Off Points (LICOs) act as surrogate indicators. Statistics Canada’s (StatsCan) LICOs, “reflect a consistent and well-defined methodology that identifies those who are substantially worse-off than the average” (StatsCan, 2001). The National Council of Welfare (2007) reported the 2004 poverty rates in Saskatchewan at 16% or 148,000 using before tax LICO, and at 10.1% or 93,000 using after tax LICO. For this study, low income populations were inclusive of all clients who struggle to meet their basic needs (housing, food,

security) and are vulnerable to adverse health impacts stemming from their economic status as identified through the study participants.

1.4 Research Gaps

Registered nurses who address low income client needs as part of their practice are contributing to social justice and social change regarding health disparities. Cohen and Reutter (2007) highlighted a gap in literature pertaining to the RNs' role in relation to poverty and recommended that research be conducted to explore this area. Ballou (2000) found strong evidence of RNs' obligation to participate in socio-political activities to address health needs but found a strong disconnect between theory and practice. Ballou stated that research which explored RNs' assessments of actual social, economic, and political injustices could yield valuable information upon which to base strategies to repair this discontinuity.

Registered nurses are responsible for advocating for vulnerable populations (Ballou, 2000; Byrne, 2006; Falk-Raphael, 2005). The health sector must monitor advocacy and actions responding to the implications of a client's low income status in order to communicate the implications of policy on poverty and health (Braveman & Gruskin, 2003). Exploring the actions of RNs' advocacy illuminates their motivation and view of this role (Vaartio & Leino-Kilpi, 2005). Morgan (2007) stated, "Nurses can reduce the effects of poverty...The role of nurses in poverty and human development is currently under researched" (p. 39). Ruetter et al. (2004) highlighted a qualitative research gap exploring the beliefs of practicing RNs around poverty. This knowledge could provide a deepened understanding of the relationship between poverty and health. Research from the perspective of the profession of nursing creates knowledge rooted in complex contextual factors that shape health. Specifically regarding the implications of income on health, nursing research can communicate realities of access, care, and policy impacts within a comprehensive caring framework that coexists alongside efforts for increased justice.

1.5 Summary

Despite the prevalence of poverty, and the understanding of its impact on health, the role of Saskatchewan RNs in addressing low income client needs as part of their direct care practice is not evident in the literature. This thesis will contribute to dialogue through a review of literature on advocacy and activism within nursing practice as well as social justice and nursing. Chapter Three will cover the conduct of research utilizing a theoretical framework of constructionism and critical theory and the application of the AI method. Findings from this

study are illuminated using participant quotes in Chapter Four with discussion, implications, and limitations following in Chapter Five. Chapter Six closes the thesis with a summary of knowledge created through the application of AI into participant's experiences with low income clients. Through acknowledging what these RNs are doing, and highlighting their successes, this research created knowledge towards a further understanding of social activism around income inequity within the profession of nursing in Saskatchewan.

CHAPTER TWO

Literature Review

Inequities in access are sustained through systematic, policy-based oppression. Nurses are well positioned to build on the profession's solid historical roots of advocacy and political action to break the cycle of oppression...It is imperative that the nursing profession begins to routinely incorporate social justice...As the largest group of health professionals in Canada, nurses have the power to promote and lobby for equity in the health-care system (McGibbon, Etowa, & McPherson, 2008, p. 27).

2.1 Advocacy and Activism

Registered nurses have acted as political catalysts, using their practice as a source of expertise, and communicating the necessary changes to ultimately increase people's chances of survival. Many studies identified the expectations and need for RNs to be active at the policy level (Cramer, 2002; Fawcett & Russell, 2001; Rains & Barton-Kriese, 2001; Spenceley, Ruetter & Allen, 2006; Wilson, 2002). Historically, advocacy was central to the role of the RN (Falk-Rafael, 2005). It is a significant component of nursing ethics and a guiding philosophical principle (Vaartio & Leino-Kilpi, 2005). The legacies left by RN activists provide a firm foundation for future activism as well as an opportunity for this legacy to be continued by validating activism as a part of professional nursing.

The efforts of nursing pioneers illuminate nursing's fundamental role in seeking out areas of most need and addressing their impact on health by contributing interventions which will formulate positive change. In the 19th and 20th centuries, Nightingale, Wald, Dock, and Sanger were leaders in nursing through their activism. They engaged in "political activism that grew out of the personal knowledge they gained in providing care for poor, immigrant, and otherwise vulnerable populations and understanding that their efforts to achieving social justice were as important to health as the more immediate downstream direct nursing care they provided" (Falk-Rafael, 2005, p. 214).

Nightingale, mid 1800s (Novak, 1991), recognized the importance of environment, and education, and utilized personal networks to improve the health of her patients as well as the betterment of the profession (Reutter & Duncan, 2002; Falk-Rafael, 2005). She combined care with political activism, highlighting that "justice making flowed naturally from compassion and

caring” (Falk-Rafael, p. 213). Nightingale also created the profession as a social movement (Drevdahl, Kneipp, Canales, & Dorcy, 2001) through simultaneously caring for the suffering and using her influence to change exacerbating environmental conditions and seek justice (Falk-Raphael). Therefore, the evolution of nursing as a profession is as much about nursing skills and care of the suffering as it is about the role of the RN in addressing the social factors that result in ill health.

Moving into the early 1900s, Wald, Dock, and Sanger continued to be strong forces in nursing activism in the United States. Wald, known as the founder of public health nursing, explicated the relationship between nursing and the public as a whole and developed activism as a public health intervention (Drevdahl et al.). She struggled for the poor, pioneered an understanding of the implications of income on health (Hardill, 2006), and “lobbied for changes to the social conditions that further disadvantaged already vulnerable populations” (Falk-Rafael, 2005, p. 214). Dock was “labeled a suffragist, a pacifist, and a Marxist. Her overriding concern was self determination for women, nurses, and nursing; throughout her life, she challenged nurses to fight against male dominance” (Wuest, 2006, p. 87). Sanger was a feminist who championed women’s sexual rights; she defied the Comstock Act, which prohibited the distribution of contraceptive information, devices, or abortion information, in order to advance public health. Sanger also founded the beginnings of Planned Parenthood Foundation of America and organized the first international population health conference (Falk-Rafael; Wuest).

Canadian history also includes the influences of RN activists improving the situation of the poor and vulnerable. Maguerite d’Youville founded the Sisters of Charity, also known as the Grey Nuns (Gibbon & Mathewson, 1947) who were known for providing care for the poor and sick outside of hospital settings (Paul, 1994). In the 1700s, she cared for impoverished people in her home and inspired other RNs, and later created a home for the destitute (Gibbon & Mathewson; Hardill, 2006). The Grey Nuns have been called “the practical origins of modern Canadian outreach nursing”, founding many of the first hospitals in Western Canada (Hardill, 2006). In Saskatchewan, the Grey Nuns were instrumental in delivering some of the earliest healthcare with the first recorded nursing service in 1860 with the founding of a mission at Ile-a-la-Crosse, Saskatchewan (Robinson, 1967).

Canadian public health and community nursing was also strong outside of church origins. In the late 1800s, Lady Ishbel Aberdeen worked with the National Council of Women that was

fighting the self interest of physicians (Hardill, 2006). Aberdeen also established the Victorian Order of Nurses (Gibbon & Mathewson), which provided “nursing services to isolated impoverished farm families across the prairies” (Hardill, p. 92). In 1911, Eunice Dyke

the first superintendent of public health nursing in Toronto’s Public Health Department, observed that poverty forced many women to return to work when their babies were very young...which contributed to infant mortality. Recognizing this as a social issue, Dyke used her community organization skills to mobilize social agencies and churches to coordinate work with poor families (Edwards & Smith, 2008, p. 32).

The *Survey of Nursing Education in Canada*, also known as the Weir Report, released in 1932, contained a chapter on public health nursing. It described some of the struggles of public health such as physician understanding, lower nursing wages, and advanced education (Duncan, Leipert & Mill, 1999). Despite the challenges, the value of public health nursing was recognized and the Weir Report recommended that the number of public health nurses should be doubled within a 10 year period with increased government funding (Duncan et al.). In Saskatchewan, public health services did expand through to the 1960’s continuing to address the needs of vulnerable populations (Robinson, 1967). At the 1966 Annual Meeting of the Saskatchewan Branch of the Canadian Public Health Association, Dr. Schwenger of Toronto stated, “public health could and should speak on many aspects of problems concerning poverty” (Robinson, p. 206).

Recent history shows continuity in nursing activism. In British Columbia during the mid 1900s, Grace Donald, a public health nurse, dispensed antibiotics to marginalized communities such as incarcerated clients, sex trade workers, and those who were unstably housed (Hardill, 2006). In Saskatchewan, nurses played a pivotal role in the development of healthcare and the advancement of the profession of nursing. In 1913, due to an alarming infant mortality rate, a position of Infant Welfare Nurse was developed, with a nurse working with new immigrants distributing information in multiple languages, and teaching new mothers preventative public health measures (Robinson, 1967). Jean Browne, the first president of the Saskatchewan Registered Nurses’ Association (SRNA), drafted the Bill that led to the Registered Nurses’ Act 1917, pioneered public health nursing through her work with school boards, and was the first school nurse in Saskatchewan (Robinson). Browne also contributed to nursing education through the Canadian Nurses Association and later became the National Director of the Junior Red Cross and was presented the prestigious Florence Nightingale Medal in 1939 for her outstanding

nursing service (Robinson). Other SRNA charter members contributed to the development of nursing in the province. Effie Feeny was involved with school nursing, Elizabeth Van Valkenburg, and Ruth Hicks were prominent in nursing education, Granger Campbell, Jean Wilson, and Helen Walker were Superintendants of Nurses (Robinson, 1967). Norah Armstrong, another charter member of the SRNA, worked as an Infant Welfare Nurse and began tuberculosis clinics (Robinson). Countless other RNs continued to care for people as outpost nurses and through the depression, despite massive drops in wages, “one private duty nurses reported a wage of \$313.00 for the entire year of 1932... a drop from \$1,159.00 in 1926” (Robinson, p. 64). This history informs possibilities for the future of social activism through inspiration grounded in the past.

Recent RN activists in Canada and Saskatchewan continue the legacy. Crowe (2007) stated, “I’m a nurse, a street nurse, and what I see downstream in society necessitates that I look upstream to find the root of the problem” (p. 6). Crowe is well known for her activism with the Toronto Disaster Relief Committee and at the Sherbourne Community Clinic, advocating housing as a human right (Picard, 2000). On the west coast of Canada, Liz Evans, a Community Health Nurse, works with the Portland Hotel Society on East Hastings in Vancouver, rumoured to be the poorest postal code in Canada. Evans stated, “I deal with sick and dying people every minute of every day. I provide health care in the context of where people live. And I fight and advocate on their behalf. If that’ not nursing, I don’t know what is.” (Picard, p.131). Picard stated, “Evans and Crowe are following in the footsteps of public health pioneers” (p. 120). In Saskatchewan, Jan Cibart, a homecare nurse who worked in North Central Regina, has been profiled in the *Globe and Mail* (2002), *Maclean’s Magazine* (2007). Upon receipt of a Saskatchewan Health Excellence Award in 2005, the *Regina Leader-Post* (2005) noted Cibart was, “considered an advocate for her clients, she assists them with issues that affect their health such as housing, poverty, addictions and discrimination” (¶ 6).

Registered nurses are prepared through both education and practice to act as advocates; activism is a nursing role and a responsibility. The behaviors and skills needed to be socially and politically active are embedded within the roles of nursing (Rains-Warner, 2003). Cramer (2002) found that resources and engagement were the most important factors in organized political participation among RNs. One study identified that “other oriented” activism by RNs at the community and societal level was aligned with client activism and well within the scope of

caring nursing practice (Wilson, 2002). Political activism in nursing is grounded in service, application, and empowerment (Rains & Barton-Kreise, 2001), valuing the needs and insights of clients with a goal of improving the human condition. Political activism is an extension of caring; an obligation nurses who bear witness to clients' suffering must enact to fulfill their contract with the public (Falk-Rafael, 2005).

Registered nurses work as social activists is needed more than ever. Unfortunately, the reverse appears to be happening and these efforts have seemingly decreased in recent decades (Drevdahl et al., 2001). Changes to the roles of the RN, and prescriptive contexts of practice have been argued to subdue nursing practice (Conger & Johnson, 2000). Moreover, role changes have caused RNs to conform to institutionalized nursing practice and avoid initiating actions that have the power to affect larger systems that influence health (Conger & Johnson). The institutionalization and medicalization of healthcare may have contributed to a building of silence among nurses (Reutter & Duncan, 2002; Buresh & Gordon, 2006). Registered nurses' positions in the administrative hierarchy created by the implementation of a business model may also be a causal feature (Falk-Rafael, 2005) of this dissociation of social activism. Giddings (2005a) discussed how nurses maintain the status quo by conforming to current structures and not questioning the interests of powerful groups. Ambiguity surrounding RNs' political role (Boswell et al., 2005) and heavy workload (Des Jardin, 2001) may compound these identified issues and related challenges.

2.2 Social Justice and Nursing

Nursing must engage in activities towards social justice to fulfill its social obligations as a profession (Falk-Rafael, 2005; Ballou, 2000). Social justice means addressing inequities and redistributing power, resources, and access so that all individuals have equity in the benefits, responsibilities, and consequences of society (CNA, 2006). A social contract exists between professions and the public. Social justice is the ultimate responsibility prompted by this trust (Byrne, 2006; Fawcett & Russell, 2001) and an ethical concept of high importance to nursing (CNA, 2008; Falk-Rafael). Edwards and Smith (2008) stated, "concerns about social injustice...have been at the foundation of public health services (p. 32). Scholars have envisioned social justice as a unifying theme in nursing's metaparadigm, underpinning all efforts (Schim, Benkert, Bell, Walker, & Danford, 2006). The *CNA Code of Ethics* (2008), endorsed by the SRNA, contains promotion of justice as a nursing value and ethical responsibility. The Code

further elaborates on “ethical endeavours” and aspects of social justice which ethical nursing practice addresses relating to “the need for change in systems and societal structures in order to create greater equity for all” (CNA, p. 16). These efforts translate the contract of social justice into action illuminating strategies that RNs can “advocate for and work toward eliminating social inequities” (CNA, p. 16).

Distributive justice is a component of social justice (Falk-Rafael, 2005). Distributive justice is, “an equitable distribution of goods consistent with egalitarian principles” (Drevdahl et al., 2001, p.23). Registered nurses must engage in social and distributive justice to challenge the sources of inequities and increase the health of low income populations (Drevdahl et al.). Social justice changes systems and is a proactive approach that nursing can take at the population level to assure equity in health for all people (Schim et al., 2006).

The powerful links between health and income vectors “a commitment to health [which] necessarily implies a commitment to reducing poverty” (Braveman & Gruskin, 2003, p. 539). A recent study in Saskatoon, Saskatchewan noted increased or disproportionate rates in low income neighborhoods compared to high income neighborhoods in regards to suicide attempts, mental illness, injuries, poisonings, diabetes, chronic obstructive pulmonary disease, coronary disease, chlamydia, gonorrhoea, hepatitis C, teen pregnancy, low birthrate, infant mortality, and all cause mortality (Lernstra, Neudorf, & Opondo, 2006). Dr. John Millar of the Provincial Health Services Authority of British Columbia, stated

people living in poverty and the fact that they have ill health is a causal relationship, not just a statistical association...social inequality kills. It is astounding to me, as a public health professional that we continue to accept [inequity], when we know it is creating poor health in this country (2007, ¶ 20).

The health sector can be a major contributor to reducing poverty, starting with monitoring and addressing poverty as a priority of practice (Braveman & Gruskin, 2003).

Morgan (2007) and Byrne (2006) stated that RNs need to consider the impact of poverty on a client’s health in order to provide holistic nursing care. This practice directs care away from the medical management model towards a population health perspective (Morgan). Registered nurses in all settings encounter clients who are impacted by poverty and their understanding of poverty’s influence on health shapes their actions (Ruetter, Sword, Meagher-Stewart, & Rideout, 2004). They make assessments that reveal health inequities and have a professional responsibility to address their findings (Malone, 2005). Registered nurses can improve health by

responding to these inequities both in the community setting and in acute care (Morgan). An RN must be competent in attending to economic struggles to be an effective caregiver (DeLashmutt & Rankin, 2005).

In Saskatchewan, the *Standards and Foundation Competencies for the Practice of Registered Nurses* is a document that describes the criteria that all practicing RNs competency is evaluated against (SRNA, 2007, p. 3). The document addresses population health and primary health care; specifically RNs must “[anticipate] potential health problems of issues and their consequences for clients” (SRNA, p. 8). The Foundation Competency 34 includes assessment of physical, emotional, spiritual, cognitive, developmental, environmental, and social as part of a holistic assessment (SRNA). Foundation Competency 91 addresses advocacy and social justice: the RN, “advocates for and promotes healthy public policy and social justice especially with vulnerable populations” (SRNA, p.11). These competencies show the professional commitment, in the province of Saskatchewan, for RNs to address both client and context holistically.

Advocacy, rooted in social justice, combines nursing practice with its philosophical intent. Historically, RN leaders have modeled the way showing that the necessary skills are embedded in the role of the RN. Struggles to ensure equity in vulnerable populations remain integral today for the profession of nursing as well as an expectation of practicing Saskatchewan RNs. This important work cannot be left behind at a time when its ability to have an impact remains. For nursing care to remain holistic, the praxis of socially just activism must remain paramount, fulfilling nursing’s responsibility based on its privileged position.

CHAPTER THREE

Conduct of Research

3.1 Theoretical Framework: Social Constructionist and Critical Theory

Appreciative Inquiry (AI) incorporates constructionist principles. Therefore, AI methodology aligns with the chosen framework of social constructionist inquiry that captures and values multiple perspectives constructed by participants and explores the implications of those constructions for their lives and interactions (Patton, 2002). Constructionism focuses on relationships as the foundation of knowledge or a “communal base of knowledge” (Cooperrider & Whitney, 2005, p. 50). Utilizing a constructionist framework aligns with the researcher’s worldview as constructionism allows for power issues to be addressed by recognizing that a certain perspective can be adopted by mainstream culture thus privileging it as the predominant or norm perspective (Patton, 2002). Reed (2006) stated AI and social construction share basic concepts such as a negotiated worldview. Social construction brings to inquiry an emphasis on valuing multiple perspectives, the influence of language, and the impact of the relationship between the researcher and the participants on findings (Patton).

Constructionism addresses creation of meaning attributed to phenomena within its social context. Reed (2006) saw the social constructionist framework as a useful tool for change as it focuses on the centre of an experience by looking at people’s interpretations and constructions of that phenomenon. Since it assumes that how the world is understood is based in the subjectivity of people’s perceptions there is no one truth to seek, instead the best way to learn about a phenomena is to explore it from the people who have lived it (and co created it), inclusive of their experience and their language in expressing their reality. Understanding a concept includes understanding its assumptions, explicitly the shared reality of that concept and how it is reinforced by socialization.

Consistent with constructionism, critical theory acknowledges that no knowledge is value free and separate from human consciousness (Boutain, 1999). Critical theory assumes that, while realities are constructed, situations can be constructed to be more fair and just (Fontana, 2004). In addition, critical approaches help to address the issue that some of the research participants come from places of privilege. Critical theory emphasizes that knowledge created is

liberating of oppressive notions and research does not replicate power imbalances already rampant in society (Browne, 2000) but rather takes aim at the false consciousness that sustains them (Fontana). Browne described emancipatory praxis as “the dialectical relationship among knowledge, theory, and practice that can precipitate emancipatory changes in relation to clients, nursing, and health care” (p. 44). This emancipation comes from new levels of understanding (Browne) linked to the constructionist’s assumption that new perspectives can change past realities.

Inclusion of critical theory and social constructionism brings theoretical triangulation to the study. Theoretical frameworks contribute to nursing knowledge by identifying relationships among concepts and building bodies of nursing knowledge by unifying findings of several studies within a singular context (DeMarco, Campbell, & Wuest, 1993, p. 33). The combination of these approaches helps situate this study within current scholarship, concurrently examining nursing, income status, and health inequities.

3.2 Research Design

3.2.1 Approach: Appreciative Inquiry (AI)

Appreciative Inquiry is both a research method and a philosophy; it discovers value, recognizes the best in people, and affirms past and present strengths, successes, and potentials (Cooperrider & Whitney, 2005). The “positive core” (for example best practices) is at the centre of AI; AI seeks to ask questions that illuminate this core and spread its wisdom and energy (Cooperrider & Whitney, p. 8). Appreciative Inquiry is founded on the heliotropic principle which suggests that just as plants grow towards light, people are drawn towards the positive (Bushe, 2005; Havens et al., 2006; Micheal, 2005). AI is a philosophy that encourages change through “creating meaningful dialogue, inspiring hope, and inviting action” (Havens et al., p. 464). As a research method, AI differs from problem solving methods in its focus on generating change (Bushe, 2007). Bushe (2005) emphasized AI’s grounding in real experiences as foundational to promotion of change based on actualizable goals.

The “art and practice of asking unconditionally positive questions that strengthen a system’s capacity to apprehend, anticipate, and heighten positive potential” is the core of AI (Cooperrider & Whitney, 2005, p. 8). It builds social capital by highlighting successes and “recognizes that people find ways around problems, and that no situation is without achievement” (Reed & Turner, 2005, p. 167). It provokes people to “challenge the status quo as

well as the common underlying assumptions” which shape their work (Cooperrider & Whitney, p. 29).

The positive focus of the methodology can provide an uplifting experience for the participants.

The participants stir up memories of energizing moments of success creating a new energy that is positive and synergistic. Participants walk away with a sense of commitment, confidence, and affirmation that they have been successful. They also know clearly how to make more moments of success (Hammond, 1998, p. 7).

Appreciative Inquiry creates an energy that renews commitment to change and a sense of hope towards achieving a positive future (Michael, 2005). It validates participants’ strengths, contributions, and achievements (Cooperrider & Whitney, 2005). In turn, AI enables the interviewer to “give back to their interviewees the stimulation, encouragement, and sense of momentum that their own work gains from the time and honesty invested by the people they interview” (Michael, p. 229). Participants of this study informally recounted to the researcher conversations they had after their interviews with other potential participants, friends, and family about how inspired they felt from the interview experience.

Of specific relevance to this research, is Appreciative Inquiry’s use of the 4-D cycle: Discovery, Dream, Design, and Destiny (Cooperrider & Whitney, 2005). The four main themes of the cycle can be elaborated as: Appreciating: The best of what is (Discovery); Envisioning: What might be (Dream); Dialoguing: What should be (Design); and Innovating: What will be (Destiny) (Hammond, 1998; Keefe & Pesut, 2004).

The use of AI in research, as illustrated by Figure 3.1, encapsulates underlying philosophical assumptions (multiple definitions, diverse domains, multiple relationships, and conceptual systems). Theory development incorporates assumptions along with the 4-D cycle within a context rooted in lived experiences. Theory and evidence exist within a reciprocal relationship where each strengthens and informs the other component.

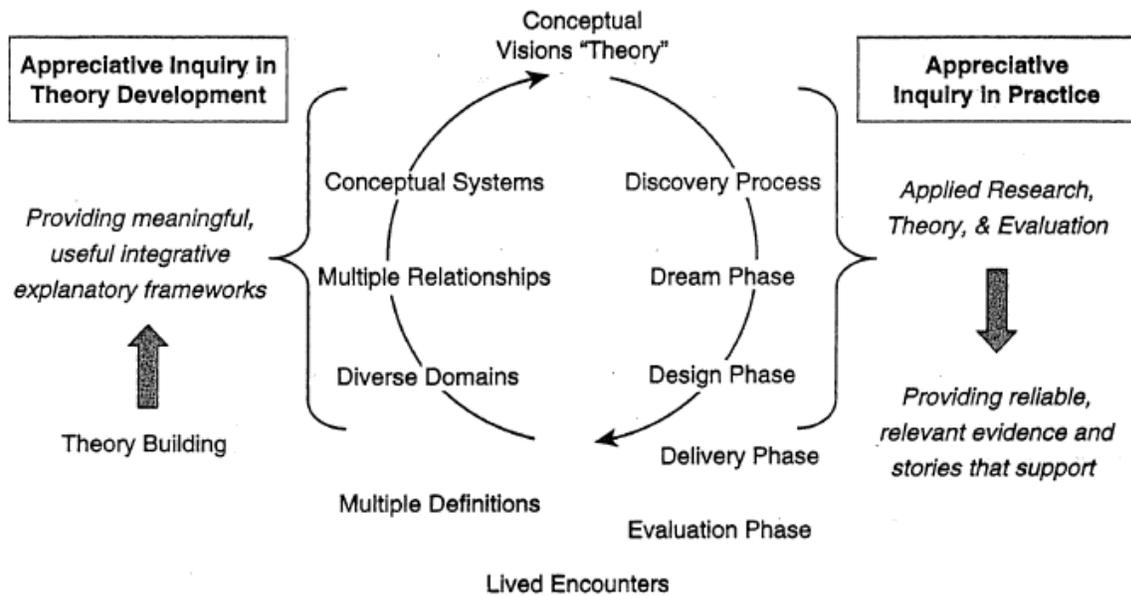


Figure 3.1 Appreciative Inquiry Diagram (Edwards as cited in Reed, 2006, p. 192)

Research on the limitations of AI is scarce because the methodology is relatively new, however, concerns have been raised based on its constructionist roots and appreciative stance (Reed, 2006). Appreciative Inquiry has been critiqued as focusing so much on the positives that it misses the negatives and therefore does not illuminate holistic understandings (Michael, 2005). However, AI can yield an understanding of the positive and negative through creating a supportive environment where people can speak freely without fear or defensiveness of their perceived weaknesses (Michael). When challenges are discussed, AI suggests reframing negatives by asking if these challenges were removed what would it look like? For example, study participants discussed the impact of workload and nursing shortages on their practice. The nursing shortage, after probing, became a source for positive potential. It offered an opportunity for participants to share the knowledge and skills they acquired through adapting to the changing circumstances. Furthermore, participants were probed about what they knew could work based on their knowledge of what wasn't working. This method embraced the concept that by focusing on what works, what doesn't work will fade away (Cooperrider & Whitney, 2005).

3.2.2 Assumptions and Implications

For AI to resonate with those involved in the knowledge creation process the underlying assumptions must be congruent for the researcher and participants. Some of the basic assumptions of AI are:

in every group, something works; what is focused on becomes reality, and there are multiple realities; asking questions begins a change; people are more comfortable to journey to the future when they carry forward parts of the past; the past that is brought forward should be the best; and the language used creates reality (Hammond, 1998, p. 20-21).

The implications of these assumptions on research are that regardless of what one is looking for it already exists. Therefore, even though it has been noted that social activism has decreased in nursing (Drevdahl, et al., 2001) there may be champions of this cause with current practicing RNs in Saskatchewan. Furthermore, the assumption that talking about something is a great way to increase its prevalence, illuminates the positive effects that this research can have on creating or catalyzing change. Such change can occur throughout the research process including translation of findings, validation, and inspiration of the study participants. The relationship between inquiry and change adds to the benefits of this research through starting a “positive revolution in change” at the inception of data collection (Cooperrider & Whitney, 2005, p. 1). Through discussing the successes of Saskatchewan RNs one begins to build a vision informed by the historical successes. Therefore, knowledge and possibilities created will be situated in real events. Exploration into the best of what has happened enabled moving beyond the event itself and getting deeper into circumstances that contributed to the achievement. It also enabled description of the possibilities they held for the future. Participant perspectives draw out what must be recreated to perpetuate more success. Keeping with the constructionist roots of AI, the words used to shape this inquiry will form a perspective. As a result, the words used in the interview guide were carefully constructed and were developed with the intent of building a positive atmosphere during the interviews. Questions foster storytelling and challenge thinking about experiences in a new way, creating a new memory based on validation and support from within the positive environment of the interview (Watkins & Mohr, 2001). Appreciative Inquiry, as both a method and a philosophy, creates a research experience that engages descriptions of the past in the creation of positive futures. The research itself contributes to a desired future through inquiry, giving the topic attention and encouragement.

3.2.3 *Setting*

This study was set in the province of Saskatchewan where, as previously described, there has been a history of pioneering social change through nursing practice. In 2005, a resolution was passed by RN members of the SRNA. This resolution regarded the active participation of individual Saskatchewan RNs in the Make Poverty History Campaign. As well, the 2007 Ends of the Saskatchewan Registered Nurses' Association include advocating for healthy public policy with an emphasis on health issues for vulnerable populations.

Registered nurses were not differentiated based on geography, location, duration of practice, educational preparation, age, or gender for the purposes of this study. Interviews were held in the researcher's home (participants known to researcher) as well as participants' homes and workplaces (at participants' discretion). Suitable locations were deemed to be conducive to audio taping and private enough to avoid breeches in confidentiality. All participants lived either in Regina or Saskatoon, or within close proximity to the researcher which enabled all interviews to be done face to face.

3.2.4 *Sample*

Currently, inclusive of practicing and non-practicing, there are over 9,000 RNs licenced in Saskatchewan. Further query into registration forms illuminates approximately 1500 RNs self report their workplaces and primary area of responsibility as homecare, public health, or community health. Even though sampling criteria did not specify RNs working in community oriented placements, it is interesting to note that despite their relative minority, all participants in this study identified corresponding areas of practice on demographic forms. This is especially intriguing as all practice settings would have clients who would meet low income criteria. However, when comparing the regulatory standards and community health nursing standards items common to both are social justice and vulnerable population, but unique to the community health nursing standards are the determinants of health, the Jakarta declaration, and societal change supporting health (Fuller, Kneeshaw, Baumann, & Deber, 2008). The additional focus on advocacy and the determinants of health may explain why recruitment collaborators recognized RNs in community health and community RNs self identified as responding to the implications of income on clients' health.

3.2.4.1 *Target/theoretical.* The target population was Saskatchewan registered nurses who respond to the economic circumstances of low income clients in their direct care practice.

Inclusion criteria was comprised of the following: a) direct care RNs in Saskatchewan who b) self identified to research collaborators or researcher as responding to the implications of income in their low income clients through their practice and c) were willing to participate in the study. Direct care included RNs working with individuals, families, and/or communities. Registered nurses involved in administrative positions, education, policy, research, or formal political employment were excluded for the purpose of this research.

3.2.4.2 Sampling process. Following ethical approval, purposive theoretical sampling was used, specifically purposive network snowballing. Snowballing is a sampling technique that utilizes networks of people who are knowledgeable about the target population and recruits them to aid the researcher in finding key potential participants (Patton, 2002). This type of sampling enabled the researcher to obtain an in depth understanding from information rich cases within a small sample (Patton). It included recruitment collaborators making initial contact with potential research participants. Recruitment collaborators were key persons within the community who did not meet the inclusion criteria (for example, RNs in formal administrative positions) but were very knowledgeable about the RN community and potential participants. The researcher had conversations with these collaborators and provided them with the invitation letter for potential participants. The collaborators then distributed this information to RNs that were seen as luminaries with valuable experiences to contribute and encouraged the participants to contact the researcher or give permission for the researcher to contact them. After they had agreed or contacted the researcher the study was explained in detail and any questions were answered. Details such as inclusion and exclusion criteria, risks, benefits, time commitment, consent, and confidentiality were discussed. If the potential participant agreed, an information letter (Appendix D) was distributed to them. A mutually convenient time was arranged for the interview. Consent forms (Appendix E) for researcher and participant were brought to the interview, reviewed, and signed prior to any data collection. Inclusion criteria were discussed and a demographic form (Appendix F) was completed prior to the interview. Participants were given the option of seeing these ahead of time and all declined.

Further recruitment of participants utilized the same snowballing technique. Initial participants were requested to identify and inform their colleagues about the study and inquire if they were also willing to be contacted by the researcher. Snowballing allowed for the identification of information rich participants through the existing networks of participants. Core

cases to be studied were illuminated as key names are repeated from knowledgeable people (Patton, 2002). The potential participants were encouraged to contact the researcher with any questions at any time throughout the research. The population was sampled until saturation was achieved at seven participants.

3.2.4.3 *Sample demographics*. Participant demographics are shown in Table 3.1, excluding categories that did not have any responses.

Table 3.1 Demographic Findings

Demographic Variable	Category	Percentage
Age	20-35	43
	36-50	43
	51-65	14
Gender	Female	100
Total number of years practicing as an RN	2-5 years	29
	6-14 years	14
	15-19 years	29
	20 years or more	29
Current Residency (of client population)	Urban	86
	Urban and Rural	14
Entry to Practice	Diploma in Nursing	43
	Bachelor's Degree in Nursing	57
Post RN Education in Nursing (highest achieved)	None	71
	Baccalaureate	29
Education in other than Nursing (highest achieved)	None	71
	Baccalaureate	29
Current Employment Status	Regular full time	71
	Regular part time basis	14
	Part time and casual	14
Current Place of work in Saskatchewan (primary employer)	Hospital (patient education)	14
	Public Health Dept. or Agency	57
	Home Care	29
Current Primary Area of Responsibility in Saskatchewan	Home Care	29
	Public Health/community health	43
	Patient Education (hospital)	14
	Infectious Disease/Street Health	14

3.2.5 Data Collection

Appreciative Inquiry does not dictate specific techniques of examination, but rather pushes for investigation from a positive stance, applying the principles, and living the assumptions. It searches for the positive core that exists within every group or situation (Cooperrider & Whitney, 2005). Participants brought in articles they had written, award biographies, and thank you letters from clients. The researcher kept copies of these documents for analysis and knowledge translation activities. Demographic data were collected at the onset of the interview and were used for descriptive purposes not comparison.

Data were collected using an adapted AI Interview focusing on the discovery phase of the AI framework as developed by Michael (2005). Discovery engaged participants on ‘what is’ from an appreciative stance (Keefe & Pesut, 2004). It was about learning the best career moments, memories, and stories of participants (Michael). The questions posed reflected on recalling excellence, while enhancing inward exploration which aided in a vision of forward achievement (Havens et al., 2006). Participants were aware that they could decline answering any interview question(s) and withdraw at anytime without penalty. This individual interview approach responded to the research aim needing intimate and detailed information from a one time meeting (as opposed to the traditional organizational development goals) (Michael). Interviews were audio taped and transcribed verbatim for analysis. The researcher took field notes on observations during and following each interview to enrich the verbal data. These notes described setting, facial expressions, and body posture. These notes were typed into the transcripts and informed the participants’ intent in certain passages (e.g. laughter implies the participant was using humor to get her point across and therefore a quote without the emotion may not be representative).

At the end of the interview, participants were encouraged to make a bumper sticker highlighting their vision for nursing. Participants ‘talked it out’ as they made their bumper sticker, which was also transcribed as study data. Bumper stickers were intended to incorporate the provocative component of AI, instead, participants highlighted positive aspects of what nursing is and could be from their perspective. The focus of the bumper stickers was on an ideal future, not in the format of provocative propositions which would entail shifting from the abstract future to a practical affirmative statement of what could be.

After interviews took place, the participants were again provided with the researcher's and supervisor's contact information. Participants were emailed their own interview transcript along with the transcript release form and preliminary tentative analysis. Participants were encouraged to direct questions or concerns to the researcher or the supervisor.

The AI methodology incorporates narrative roots by encouraging storytelling (Bushe, 2005; Michael, 2005, Watkins & Mohr, 2001). Stories are easily remembered and retrieved contributing to the success of this methodology (Sugarman, 2002). Michael found that participants were excited to share and offered "dynamic and unrehearsed information without fear of reprisal" (p. 226). All positive successes (large or small) are explored as the past is seen as a possibility for future change, not historical data to be forgotten. Participants in this study told their experiences through stories captured during the interviews.

Appreciative Inquiry places high importance on positive questioning, "basing the power of dialogue on the power of the questions we ask" (Sugarman, 2002, p. 3). The researcher acts as a change agent and "the major thing a change agent can do that makes a difference is to craft and ask unconditionally positive questions" (Cooperrider & Whitney, p. 53). Well crafted questions enable a successful interview through building rapport and creating energized relationships (Bushe, 2007). The interview guide was adapted from questions previously used by Michael (2005) and Keefe & Pesut (2004) (Appendix G). These questions were assessed against Bushe's criteria for generative questions that challenge the status quo. This criterion builds on the purpose of AI that is "to generate a new and better future" (Bushe, p. 4). Questions must be surprising, engage peoples' heart and spirits', build relationships, and illuminate a new perspective on reality (Bushe). Consistent with AI, participants were asked to clarify key values during and following the interview and after (i.e., during member checking when reviewing the preliminary analysis).

The interviews provided an experience of AI prioritizing Discovery while incorporating Dream and Design. Destiny was not addressed in the interviews. Destiny, can also be thought of as Delivery, it is where planning what will be happens, specifically the actions, commitments needed to make the provocative propositions a reality (Reed, 2006). It was not within the scope of this research to fully include Design and Destiny as neither the researcher nor participants have the authority to implement system wide change. The current research cannot feasibly engage the whole system to accomplish such an end. It was felt, however, that focusing on the

foundational Ds was useful to inform these latter components of AI. Design and Destiny build on Discovery and Dream; therefore this research can offer information for future researchers wanting to look at Design and Destiny in more depth.

Data were reviewed by the researcher and supervisor during the data collection. Preliminary analysis was discussed and the number of interviews was based on the richness of data leading to saturation. Additional interviews were added after saturation was reached because of potentially unique contributions aligned with diverse practice settings. It was found that despite these presumed distinctions, the findings merely validated preliminary analysis and saturation was re-confirmed.

Data triangulation was also used as a way to capture multiple perspectives and thus remained consistent with the constructionist theoretical framework. Multiple data sources were integrated to formulate findings. However, archival data and observations were primarily used to strengthen interview data. This was purposeful to avoid compromising the power of AI and participant's personal perspective of the positive core. Observations were limited to the actual interview interaction. As well, archival data were varied (articles, thank you cards, etc.) and not available for all participants however this data source was supportive not primary to the research. Archival data were combined with the primary data collection technique (the appreciative interview) for data triangulation and validation. Interviews captured the perspective of the participant, observations from field notes were added, and archival data provided historical validation and addressed confidence in findings through the inclusion of diverse viewpoints. Triangulation of multiple data sources increased the credibility of inquiry (Patton, 2002). Patton stated, "a common misunderstanding about triangulation is that the point is to demonstrate that different data sources or inquiry yield the same result. But the point is really to test for consistency" (p. 248).

3.2.6 Analysis

The researcher in consultation with the thesis supervisor conducted data analysis. Digital files were transcribed verbatim. Next, text was checked for accuracy by listening to the audio file and simultaneously reading the transcripts. The researcher added emotions or observations to this text from field notes and taped intonations/variability (shown in transcript example - Appendix K). Participants were encouraged to bring in any archival data such as newspaper articles, award bios, or other sources that highlighted their achievements over their career. Data triangulation

provided a pragmatic way to ensure consistency with participants' stories and addressed any weaknesses of the interviews such as recall error, self serving responses, and/or impact of participants' mind frame during the interview (Patton, 2002). The availability of field observations, archival data, and transcripts allowed for the inclusion of multiple data sources to inform analysis.

Analysis followed the components of Discovery, Dream, and Design from the AI process. WeftQDA software was used for data management, (for examples of codes see Appendix J). This tool allowed for a large amount of data to be sorted into categories and then sorted into themes within categories. The researcher searched out sections of the data that fit within the framework of the delimited AI components (i.e. Discovery, Dream and Design). Interview data were examined and when participants spoke about best practices, these passages were highlighted and classified as Discovery. Similarly, when participants moved towards visions of the future these passages were classified as Dream, and when passages were consistent with the Design component they were classified as such. Once data was organized into its corresponding AI component, data passages were examined for themes. Sixteen thematic codes were co-created; some were evident in more than one AI component. Themes were then organized for similarity and collapsed into five overarching themes with sub themes. At this point, thematic categories, themes, and sub themes, were reviewed again and rich data passages were separated for inclusion in the thesis document. These themes were also explored for values underlying them by examining passages within thematic categories for words or passages explicitly stating or implying values.

Questions from each covered 'D' cycle were compared to the other 'D' cycles for consistency of themes and values underlying cycle components. Explicitly stating the positive core, building provocative propositions, and outlining a charter of relationships, roles, and responsibilities represented the culmination of addressed AI components.

Member checking was utilized to ensure that stories, themes, and values were congruent with the participants' expressed meaning. Validation was in the form of transcript and preliminary tentative analysis reviews that included participants signing a transcript release form. Five of the seven participants responded. The only concern raised by participants was in regards to the grammar in statements. Participants expressed gratitude for the opportunity to share their stories and stated the research experience was positive. Using a validation approach was

consistent with AI methodology which looks to share stories, develop themes, and link to the values underlying those themes. The themes then become a shared image among the participants for a preferred future (Watkins & Mohr, 2001).

3.3 Ethical Considerations

3.3.1 Confidentiality

Confidentiality was addressed by using code numbers on all data collected. Confidentiality was maintained throughout the research through coding any notes, audio files, demographic forms, and consent forms with identification numbers. The consent forms were stored separately from other data with identification coding. Participants were given the opportunity to review transcripts of interviews and tentative analysis that may be used for publication. Identity of participants remained anonymous in research reporting. Most data were reported in group format, with quotes not including any personally distinguishable factors, thereby minimizing the risk of identification. Data will be stored in a locked cabinet at the University of Saskatchewan for five years upon completion of study, under the responsibility of Dr. Petrucka, thesis supervisor. Original raw data are only available to the primary researcher and thesis supervisor.

3.3.2 Risks

Ethical approval was obtained through the University of Saskatchewan's Behavioral Ethics Board on April 23, 2008 and remained valid throughout the study. No deception was used in this study. Participants were informed of all aspects of the study and encouraged to ask questions at any point. Informed written and verbal consent were obtained prior to participation in the study. Initial contact with participants was made by a research collaborator on behalf of the researcher. Participants were made aware that they could withdraw at any time. Process consent was re-established when member checking occurred, including reminding them that they could withdraw at any point. No participants decided to remove themselves or their data from the study. No participants reported any emotional upset as a result of their participation in the study, therefore no external counseling referrals were needed. An opportunity to debrief the research experience was made available after the conclusion of the interview and offered when contact was made for member checking/transcript review.

There were no conflicts of interest identified during the study. No financial benefits were associated with the research for participants or researcher, nor were monetary incentives used to

recruit potential participants. There were no professional relationships between the researcher and the potential study participants as the researcher worked in an administrative role thus her direct colleagues were within the exclusion criteria.

3.3.3 Benefits

This study addressed current research gaps by building the knowledge base on the role of RNs who respond to the economic implications of low income clients by highlighting the participants' strengths, skills, and capacities. Researching social issues through the accomplishments of health care providers working for social justice can contribute to a broad social impact by including another perspective to the current literature. Study information can help bridge the current philosophical and practice divide in the area of socio-political activity by registered nurses. It can also help inspire RNs who want to expand the social activism part of their practice but are unaware of what such advocacy work entails.

Participants were able to share their stories, have their experiences validated, and see their knowledge translated to other health care professionals and the public. The AI method encouraged participants to look at their experiences in a new light contributing to a greater sense of accomplishment and empowerment. The research process is a validating experience that gave something back to the participants as they contributed to new understandings of the roles of registered nurses in responding to the needs of low income clients.

3.4 Rigor

Patton's social construction and constructivist criteria (2002, p. 545) are complementary to the methodology as AI embraces the "constructionist principle" (Cooperrider & Whitney, 2005, p. 49). The criterion includes acknowledging subjectivity, trustworthiness, authenticity, triangulation (capturing and respecting multiple perspectives), reflexivity, praxis, particularity (doing justice to the integrity of unique cases), enhanced and deepened understanding, and contributions to dialogue (Patton). As outlined in the theoretical framework, an assumption of constructionism is that there is no single truth to seek. The credibility of research lies in knowledge creation through exploring the perspectives of participants and addressing to how their constructions of reality shape understanding.

Appreciative Inquiry views human systems as constructions of the human imagination (Watkins & Mohr, 2001). Constructivist trustworthiness is informed by the researcher's own perspective, experiences, understandings, and place within a world that is constructed socially,

politically, and psychologically (Patton, 2002). Therefore, the researcher also completed the study's appreciative interview personally to highlight her own perspective. This interview allowed the researcher to be aware of her own influence on the direction of the interviews through probing and reflective comments. As well, the self interview helped situate the researcher's own experiences in relation to the experiences of research participants. The researcher's experiences and awareness of the topic helped to build rapport with participants and enabled deeper probing to gather rich data. Member checking was used to ensure the data collected were congruent with the participants' intended meaning.

Members of the thesis committee reviewed the research process and provided valuable feedback and suggestions. The thesis supervisor provided debriefing for the researcher as well as helped the researcher identify biases that might have been incurred. The researcher maintained an audit trail for all methodological decisions and conclusions, and kept a reflective journal during the study to be aware of how the researcher's own biases influenced the study (Appendix I). Throughout the study, the researcher continued to reference back to the literature on AI, ensuring congruence between method, analysis, discussion, and conclusions.

3.5 Knowledge Dissemination

A final report in the form of a thesis has been formulated for the University of Saskatchewan as per requirements in the curriculum of the Graduate Program of the College of Nursing. Copies of the findings were distributed to study participants. Findings from the study and components of the report will be utilized for the formulation of journal articles for publishing and presentations at conferences such as the Canadian Public Health Association Annual Conference, the Canadian Nurses Association Biennium, and other conferences that have themes congruent with this research. Findings from this research have been presented at the *New Directions in Population Health Research: Linking Theory, Ethics and Practice* Conference in Regina, November 2008. As well, findings have also been accepted to be presented at the *Canadian Association of Nurses in AIDS Care 2009 Conference: The Spirit of HIV/AIDS Care: Culture and Caring* in Saskatoon, April 2009.

Nurse researchers can impact knowledge through "breaching the boundary between nursing research and health policy" (West & Scott, 2000, p. 823). Knowledge that is created can also be translated into grey literature, (such as community organization's bulletin, anti-poverty coalition, and popular literature such as *Maclean's*) to cultivate new understandings that

encourage social change. Keeping policy in mind at all stages of research includes clearly stated policy implications and flagging publications as pertinent to health policy through strategic use of key words (Shamain, Skelton-Green, & Villeneuve, 2003). Broadening the dissemination of activist research encourages effective use of knowledge production for social change. Negotiations between practitioners, researchers, policy analysts, and decision makers enhance the translation of research into effective policy creation (Shamain et al.). The provocative propositions serve as policy recommendations from this research.

CHAPTER FOUR

4.1 An Area of Nursing Where I Can Make a Difference

Analysis followed AI philosophy and method. The purpose of sense-making is to organize the data in a way that “helps researchers understand what people feel they have achieved and how this might be helped to happen again” (Reed, 2006, p.139). Stories were distinguished as building blocks for positive future growth (Reed). The constructionist principle was illuminated through the stories participants told as they constructed their pictures of the future (Watkins & Mohr, 2001). This analysis, rather than finding the norm or best, seeks to create synergy as opposed to consensus by reacting to the messages and meaning in a way that promotes forward movement (Watkins & Mohr, 2001).

The appreciative interviews explored the best of what is through a focus on Discovery. Themes built upon the discover cycle component, illuminated and informed the Dream and Design components based on participant data, the underlying core values, and the positive core. Michaels (2005) demonstrated a similar outcome, “In my work, the Discovery stage of the appreciative framework was isolated from the ‘Dreaming’, ‘Designing’, and ‘Destiny’ phases... Yet across the interviews, it was as if the participants were somehow being drawn towards the Dreaming stage as their interviews progressed” (p. 229). The dream piece was also explicitly elicited through specific questions in the interview, while design components were peripherally addressed. Themes became a foundation for a vision based on the reality of the uncovered exceptional moments which become the norm (Watkins & Mohr). Data were organized according to themes within each cycle component after a brief description of the corresponding theory. Themes were triangulated within their respective cycle components for consistency, while sub themes used participants’ own words. The outcome of data interpretation is a focus on a constructed future reflective of diversity rather than overarching abstract themes based on norms.

The limitations of the appreciative interview versus the summit approach are apparent in the lack of fulfillment of the full four D cycle. Destiny was not explored as it looks at what will be and sustaining the change which is outside the scope of this research. This study did not have the purpose or the capacity to implement the findings within the identified system.

4.1 Discovery- What Works?

Discovery, the first phase of AI, is “the best of what has been and what is” (Cooperrider & Whitney, 2005, p. 16). In Discovery, themes are understood as “what do we hear people describing as life giving forces” (Watkins & Mohr, 2001, p. 115). Discovery uncovers diverse stakeholder strengths and aligns them for the achievement of collective potential. It inquires into the stories of best practices (Watkins & Mohr). The Discovery phase illuminates “exceptional accomplishments, and historical aspects that participants value” (Watkins & Mohr, p. 43).

The root core of RN practices at its best occurred when the personal, relational, and social aspects of nursing aligned. The theme of personal describes how participants saw their role as being intertwined with their individual identity. Personal motivation was important to participants as they described their own motivation as being foundational to their desire to make a difference. The relational theme shows how the relationship between their personal selves and their clients was fundamental to their ability to practice as they did. Connecting to, and understanding clients, was an area where RNs felt they had the greatest impact in accordance to their role. Participants described times when the clients let them in to more personal aspects of their lives. It was then they knew they had made a difference because of the trust the RNs were receiving from their clients. The learning that took place for participants as a result of these relationships was one which fostered advocacy. Advocacy was based on their increased awareness of how their own practice and the realities of clients fit into the world. This activism highlights the social theme that situates the personal and relational in a larger context of a society. For example, in the social context, advocacy directed at changing society’s attitudes and awareness was facilitated by RNs using knowledge acquired during client interactions.

The theme of personal motivation for making a difference came through in participants’ desire to effect change and feel impassioned about their work. For many of the participants, their nursing role was integrated with their personal identity. Nursing with low income clients contributed to their personal understanding of themselves and society as well as enabled them to take action and feel involved. Sub theme quotes highlighted these underlying currents in the larger theme (Tables 4.1).

Connecting and understanding was the relational theme that came through as a life giving force at the positive core in this practice context. Participants built on their own personal motivation to facilitate connection. The connection and understanding of clients catalyzed an

increasing depth of personal understanding. The inter-dependant nature of client and personal understanding contributes to the synergy found as these RNs came to know clients, developed a connection, became a part of their stories, created their together stories, and were non judgmental (see Table 4.2 for examples of themes and sub themes quotes). The nurse client relationship, combined with the RNs' personal motivations, contributed to movement towards social interface for the participants.

The third Discovery theme encompasses the social aspect(s) of care (see Table 4.3 for supporting participant quotes). The socially situated theme was informed by the personal and relational themes; these themes were the motivations for the best practice of advocacy and awareness activities. Participants identified the client contexts within the socially situated contexts looking at where they were at inclusive of multiple factors such as housing, social supports, addictions, and personal readiness. Meeting clients where they were at helped these RNs facilitate access to appropriate care. The foundation of the personal and the social contributed to advocacy aimed at improving social justice.

4.1.1 Discovery Theme One: Personal Motivation

Table 4.1 Discovery Theme One

Sub Theme	Data Quotes
4.1.1.1 To affect some change	<ul style="list-style-type: none"><li data-bbox="432 420 1902 665">• Wanting to affect some change for those people. To sort of try to support them, and show them that people do care about them. That they are not alone and isolated. That, there are a group of us who are really working hard to, not necessarily try to extricate them from their life, because I don't think that's realistic, but to show them that there are people out there who can support them and give them a hand and, that this doesn't have to be their life.<li data-bbox="432 695 1902 886">• Knowing that for a lot of people, they have had historically very little reason to trust anybody outside of that community. Especially if it's somebody who's educated and employed with opportunity and privilege, so knowing that and having the opportunity to maybe change that barrier that many people have, that keeps me doing it.
4.1.1.2 To have passion for something	<ul style="list-style-type: none"><li data-bbox="432 977 1902 1162">• If you're going to do it, jump with both feet. You know, try any of the ideas that you have, and if they do come in with a strong passion, definitely support that passion they have. I think just totally supporting their passion, and saying, yeah this is what you kind of want, this is what may work really well for you, try this, and do this, here's some stuff.<li data-bbox="432 1192 1902 1393">• I still want to be passionate about whatever it is I'm doing as I am now. I mean, there are days that sometimes I hate my job, but I love the client group I work for. I love getting on my soap box and really advocating for this client group, and teaching people about this client group, that they're not all criminals and scary people and this and that. I still want to have that fire in five years.

Sub Theme	Data Quote
4.1.1.3 I can make a difference.	<ul style="list-style-type: none"> <li data-bbox="428 285 1915 383">• The power of what we can do for somebody...The fact that you play a big part in somebody's life and in their well-being. I was going to say their health, not their health, but their well-being. <li data-bbox="428 399 1915 496">• What I think is great about it is that it's an area of nursing where I feel that I can make a difference and I can see something positive come out of what I do. <li data-bbox="428 513 1915 711">• I do feel like I make a difference with them. And much of it, the actual nursing care or the actual task that you're doing, but also becoming a part of their lives, if you advocate for anything, if you can figure out a way that something can be better for them. Also knowing when to step back because maybe things don't need to be better, maybe everything's fine the way it is, there's a lot of levels of better.

4.1.2 Discovery Theme Two: Connection and Understanding

Table 4.2 Discovery Theme Two

Sub Theme	Data Quotes
4.1.2.1 It's connecting	<ul style="list-style-type: none"><li data-bbox="432 420 1906 667">• You have to look into that person's life and you have to work with that... it's connecting... It doesn't work all the time, you know...and you have to be okay with that, but when it does, it is an amazing feeling. It could be just... saying "hello" or smiling at them, or whatever it may be... because if you don't have that, then you're not in the right place... Here you need to connect with the people. If you can't connect with them, you won't be able to understand.<li data-bbox="432 695 1906 941">• Sometimes it's simple... for example, a client who died, having our names on that funeral card, he knew and his family knew someone gave a crap. Someone tried. Someone didn't care who he was or what he was but made him a priority... you can't necessarily keep them alive longer. They're going to choose their life path. But if you can develop that relationship where if they choose to make some changes, they're going to come to you to find where to go from there.

Sub Theme	Data Quote
4.1.2.2 To truly get to know [clients]	<ul style="list-style-type: none"> <li data-bbox="428 289 1902 542">• Residents from the community come in... the ones who always just want to use the phone in the front. Eventually, the ones who want to use the phone, if you say hi enough, and if you reach out and just how you doin' enough, then eventually [they] start accessing your services because it's comfortable...when you walk in, that's who you are, and we try to find out who you are vs. what you have. I think that's what makes it special. It's very comfortable. We don't judge. <li data-bbox="428 570 1902 709">• We want to know who you are as a person, where you come from, what's on your mind, what are you thinking, instead of if they're diagnosed or something. If they say they're coming in for a reason, usually it's not the reason that they're coming in for. <li data-bbox="428 737 1902 987">• It's kind of a lost population. It's population that not a lot of people care about. It gives you an opportunity to truly get to know that population, rather than just see them in their crisis mode you actually get to know their family you get to know a little about them rather than just seeing the outward shell. It's very dynamic, it's on the fly... It gets you out in the community, too. You're out and about and it gives you a chance to really advocate for a population that doesn't really have a voice of its own. Especially in healthcare.

Sub Theme	Data Quote
4.1.2.3 Being non-judgmental	<ul style="list-style-type: none"><li data-bbox="428 277 1923 545">• I'll hear lots of the clients say, 'thanks for not treating me like a prick' ...Because people see the needle marks in their arms and make judgments right off the bat. I've honestly seen it in hospital... They know I don't do that...I've done blood work in community, in their homes because they don't like going to the labs because the lab techs will look at them funny or whatever. They know they can tell me stuff and I'm not going to go to the cops. I'm not going to judge them for that. They know I'm going to listen.<li data-bbox="428 561 1923 984">• I think a lot of it is just being there, and being non-judgmental is one of the biggest things. Going to where they are, going to their homes, making a joke. Not always being 100% medical all the time... Of course that's important, but so is that relationship. Giving them a hug, those sorts of things that make them feel human and cared about and not just rushed in and out of some office and poked and prodded and this and that. Creating an environment where they feel that they can talk to me or ask me stuff or get other help. And letting them know, because a lot of it is, they've never had anyone really care...I guess just providing them somewhere safe. And knowing that, and giving them that idea that they are worth it. And that they are beautiful people and they've got tons to contribute.

4.1.3 Discovery Theme Three: Advocacy and Awareness

Table 4.3 Discovery Theme Three

Sub Theme	Data Quote
4.1.3.1 Trying to find out where [clients] are at	<ul style="list-style-type: none"> <li data-bbox="428 383 1902 854"> <p>• I might specifically go to someone’s home to talk about their [illness] and what they need to do, and, or what their options are, rather than dictating what they need to do. You know, I might have my agenda as this is what I want to teach them today. However, they could be in crisis. They’ve got no food, someone robbed them, they just found out they’re getting kicked out of their place next week, so really learning about their illness wouldn’t be top priority for them. I have to switch gears in order to maintain a trusting relationship, who’s going to trust that person who’s going yeah, I know you’re going to be homeless, but I need to talk about this. Instead, I’m going, okay, what are our options... I start to help them in that sense because too many times they come in with a problem, but too many people focus on what they think the problem is. And then that person never comes back again.</p> <li data-bbox="428 878 1902 1130"> <p>• We’re really doing overall patient management so you’re helping them access the resources they need, and you’re helping them with their whole life. You’re not just helping them learn how to deal with [their illness] it’s so much broader than that... it’s life skills, and how to, how to find the right foods to eat, for instance... Listening to them and trying to find out where they are at, and what they’re actually able to do. I mean, sometimes, good management isn’t even your goal. Just getting them fed is your goal.</p> <li data-bbox="428 1154 1902 1406"> <p>• Every nurse nurses a different way... there’s my personal role the way I connect with people is different from the way other nurses connect with people. So when they come in, you have your roles and your duties, your [Child Health Clinics], your immunization clinics, your parenting, outreach, presentations. And I use those as just tools to connect with people. So you have your duties and they’re great, but my role is actually to understand and to see what they actually need, not what they’re coming in for but what they actually need.</p>

Sub Theme	Data Quote
4.1.3.2 Help [clients] try to access	<ul style="list-style-type: none">• Things like helping them make phone calls...they've got one quarter in their pocket and they don't have a phone and it's minus 30. It's hard to kind of maneuver the system because sometimes I've gotta make eight phone calls, so they struggle even worse with that.• A story that sticks out in my mind in terms of how difficult it was for that family to cope and things like, not even having a winter jacket. You know, some very, very basic necessities of life were things that we had to sort of help them try to access. We worked very closely with a school resource person who was able to help get some of those things going, and get some decent breakfast and lunches going for this kid, and that kind of stuff.• It's grassroots, right? It's taking care of the ones that don't have access to a lot of things. I mean there's simple health determinants, right? Housing, food security, education. I guess it's almost like if you can, I compare it to nursing in third-world countries. I mean, every city has its own third world.
4.1.3.3 Advocating for someone	<ul style="list-style-type: none">• I really like the idea of advocating for someone who doesn't have a voice, Nurses are trusted people in the community, and I think that this is a client population that needs someone backing them rather than keeping them down.• Being advocates for those individuals and for that environment that they come from and saying well, but what if this and this happened to you? Where would you be, and sort of just giving them some frame of reference. I think it does make people think, and so if I can just give them one little tidbit to sort of think about. That those people aren't really that different from us.

Sub Theme	Data Quote
4.1.3.4 [Our care] could be better	<ul style="list-style-type: none"> <li data-bbox="428 277 1923 383">• You might be having a particularly difficult time with somebody or with a particular situation, and someone else can either make a comment to you or take over the situation and it just changes the perspective totally. <li data-bbox="428 391 1923 711">• Sometimes I think you lose perspective. When you do it over and over and over and sometimes I hate to admit it, but I know it happens, that things become okay that I wouldn't normally that wouldn't normally become okay. Sometimes it takes a different pair of eyes or a different mind to go in and say hey, you know what, this could be better, we could do better here. I know where I experience that most often is when I have student nurses with me and they and they have some great innovative ideas that I think, yeah you're right, that I kinda just got used to it but yeah we could we could do that better.

4.2 Dream- What Might Be?

The dream cycle component was focused on searching for themes that appeared in the stories and inquiring further, which then transitioned into the design component where themes become shared images for a preferred future (Watkins & Mohr, 2001). Dream is creating a clear results-oriented vision in relation to discovered potential, and in relation to questions of a higher purpose such as “what is the world calling us to become” (Cooperrider & Whitney, 2005, p. 28). Dream moves beyond the status quo to envision futures, values, and images of a better world (Watkins & Mohr). What would success look like if it was built around strengths? Dream looks at the potential and impact that can be made based on the positive core. Dream is characterized by creative unrestricted ideas built on the outcomes from Discovery (Reed, 2006).

The images of the future that participants constructed follow Discovery with a blending of relational and social aspects of nursing. They envisioned a strong link to connection and understanding merged with increased awareness and advocacy. This theme is described as connection and advocacy. Participants saw more connections between RNs and clients in their images of a client centered care. In the ideal future, care would shift away from institutions and towards meeting clients in a context shaped by their reality. Elaboration using data quotes from interviews are included in Table 4.4.

4.2.1 Dream Theme: Connection and Advocacy

Table 4.4 Dream Theme

Sub Theme	Data Quote
4.2.1.1 More client based	<ul style="list-style-type: none"><li data-bbox="415 412 1908 613">• I would love to see nursing be more accepting. More client-based than nurse-based because too much I see a nurse say, you need to do this, you need to do that. I think nurses need to explore what are you capable of. What do you want to do, what do you want, we need to be a little bit more understanding of culture, of lifestyle, it's not all on our agenda.<li data-bbox="415 634 1908 727">• The great nurses that are out there put the client first. Put their needs secondary to the clients; realize that they are the patient; they give choice. It's not about ultimately what needs to happen.<li data-bbox="415 748 1908 950">• I think of really good nurses, I think those are the ones that figure out what the client's needs are. They figure out the client's capabilities. You know, work with what the client has. Okay, so you have to rely on the food bank and you're diabetic. Okay. What do you get at the food bank. Instead of saying, oh, you need to buy this, this, this, and this, when it's not feasible for them.<li data-bbox="415 971 1908 1060">• Client-centered, client-driven and giving the client more empowerment to make their own choices and recognizing that. Not only recognizing it, but I think embracing that opportunity and how important that is.

Sub Theme	Data Quote
4.2.1.2 Knowing [clients] on their turf	<ul style="list-style-type: none"> <li data-bbox="411 285 1913 651">• Knowing them on their turf makes a big difference. Because people sometimes can be on their best behaviour at the hospital, or don't feel like they can share or disclose. I do like getting to know somebody in their own place. And sometimes that's not always comfortable because sometimes people are too much at home in their own place, which they should be, but there has to be a bit of a line where there's some professionalism too. I think you get a better feel for who the person is and how maybe you can help them if they're at home. And you do see other things at work. like the play of family dynamics and the community, and the issues. The environmental issues, the poverty issues, whatever it is wouldn't become apparent necessarily in a hospital. <li data-bbox="411 675 1913 927">• I see a lot of it getting more and more community based... I would love to see a lot more prevention stuff... If we can keep them out of hospital, wouldn't that be great? ...we're in schools a lot, but I don't know if we're in schools enough. Based out of lots of non-government agencies... I see a lot of partnerships in the future. Where nurses may... [partner, not actually working in the facility] being that community person for them, working on their behalf. Trying to reach a client population that aren't going to them.

4.3 Design- What Should Be?

In the design phase, provocative propositions can be created. They are statements of the ideal future which articulate a design based on the positive core. The positive core always remains at the foundation of other AI components. It is the positive core in which the dream and design components are rooted. Because the other AI cycle components are rooted in reality, it is possible to draw on the historical examples as a way to optimize and realize the full potential of these examples in a vision of the future. The design is the social architecture, the processes and structures that need to be in place for the dream to be actualized (Havens et al., 2006; Watkins & Mohr, 2001). Design makes explicit the qualities and behaviors that will move towards the higher vision (Watkins & Mohr). This cycle component displays data in a way that is confident and assertive; it challenges the system by setting out unequivocal aims (Reed, 2006).

Participants saw the actualization of their dreams through coming together as nurses. Moving through the personal, relational, and social aspects of nursing practice, participants saw this research as a professional opportunity for nursing's potential to affect change. This study moves into endless possibilities, to a place where the sky is the limit. Registered nurses can achieve client centered care through embracing different roles and then joining together to collectively increase the potential of the nursing profession. Table 4.5 expands on the proposed approaches for realizing the potential inherent in the positive core of participants' practices.

4.3.1 Design Theme: Coming Together As RNs

Table 4.5 Design Theme

Sub Theme	Data Quote
4.3.1.1 Sky's the limit	<ul style="list-style-type: none"> <li data-bbox="428 410 1906 565">• I think the thing about nursing is that the sky's the limit... there's just so many opportunities out there, and nurses can be involved in so many more aspects of healthcare, and not just direct health care, but in public situations, policy situations, government, whatever. You're just seeing nurses in all those roles. <li data-bbox="428 581 1906 781">• I think that part of nursing needs to be utilized better. Being able to see the whole picture, and being able to look at what's best for that person as a whole, with everything, the spiritual and the mental, all those kind of things...when they get out of the hospital, what's the best thing for them when they can, without making up their minds for them.
4.3.1.2 Understanding of different roles	<ul style="list-style-type: none"> <li data-bbox="428 857 1906 1011">• If there were some way to sort of foster more sharing of information or more understanding of different roles. I've worked in a variety of different roles, so I know about acute care, I know about community, I see the differences. And I know when I worked in acute care, I had no clue about community <li data-bbox="428 1027 1906 1341">• We learn a lot about people and about I guess our society. I was never a very political person but I see a lot more now about what I think needs to be done or want to speak up and say, you aren't looking after all the people... I think it really opens your eyes to community, I worked hospital before, and you don't see outside your ward, or outside the hospital – you get really closed in, they leave your doors, what happens to them outside, I never really knew. Never really thought about it, not once. Now I'm seeing the after, like they don't really have an address to go to, or that sort of thing. So it opens your eyes to the world.

Sub Theme	Data Quote
4.3.1.3 Collectively [nursing] can do that	<ul style="list-style-type: none"> <li data-bbox="443 285 1703 597">• Look to the front-line workers for their opinions on what needs to be done different, the front-line grassroots workers get the opportunity to say, you know what, we've been doing this way for this long, it doesn't work, this is what we need to do different. They don't have the opportunity to have a very strong voice at all... I think were slowly maybe kinda sorta dabbling in the idea that if you take it up with the front-line workers you might find out what really needs to change. <li data-bbox="443 621 1703 987">• I could go do something else and know at the end of the day that I've made a difference a lot easier then I can see that happening here. When you're working against the grain of society, societal attitudes, you're working against the grain of government policy, you're working against the grain of history, so you've got a lot of things you're working against that you're just there, to set the precedent. I would tell them to not give up and the more of us that want to make that difference, there's strength in numbers and collectively we can do that and I think we can organize and make change. <li data-bbox="443 1011 1703 1260">• We're making some advances to addressing some of the specific needs of the vulnerable population and the health determinants of health that go along with being part of a vulnerable population. I think we're recognizing that there are needs and we're recognizing that we need to address those needs by thinking outside the box of how health care has historically run and provided a service.

Sub Theme	Data Quote
4.3.1.4 Potential is way out there	<ul style="list-style-type: none"> <li data-bbox="428 285 1898 545">• I've been involved a little bit in primary healthcare, so far with working with a couple of areas in the area where I come from, but it's just beginning. It's barely off the ground in terms of where we can go. In terms of good health care, I think it's the only way to go. I mean, physicians can't keep up, and the cost of healthcare, won't permit us to keep doing things the way we've been doing them. And so I think it is the only way to go, I think that the real potential... it's way out there, somewhere. <li data-bbox="428 565 1898 711">• If it was all ideal, we would be able to do prevention work. We could teach, we constantly get people asking for us to come out and be able to do talks. And we try to fit them in, but it's a real big struggle, because it takes out of your workload. And it would be really nice to be able to do a lot more of that.

CHAPTER FIVE

Discussion

Qualitative descriptions incorporate the complex cultural and contextual issues surrounding health disparities. These descriptions are a way to move beyond traditional analytic methods by providing rich descriptions which are transferable to successful clinical interventions (Sullivan-Bolyai, Bova, & Harper, 2005).

Qualitative description has the potential to provide clear descriptions of factors that promote access and use of health services... Qualitative descriptive research provides a vehicle for establishing interventions that are acceptable and understandable to persons experiencing health disparities, as well as to clinicians who ultimately must translate findings into practice (Sullivan-Bolyai et al., p. 132).

This research moved from the personal, relational, and social aspects of nursing to find professional possibilities within the context of social justice. The context will be discussed in detail with integrated theory to illuminate the overarching enabling concept that permeated participants' stories. AI focuses on building synergy to expand the positive core to create positive change (as shown through the arrow in figure 1). The discussion showcased and built on the positive core which informed the discussion around the provocative propositions derived from the data. Finally, discussion of 'the how' framed the implications for nursing research, practice, education, administration, and policy. The current study provided descriptions of the factors which culminate in RNs feeling that they are at their best while working with low income clients.

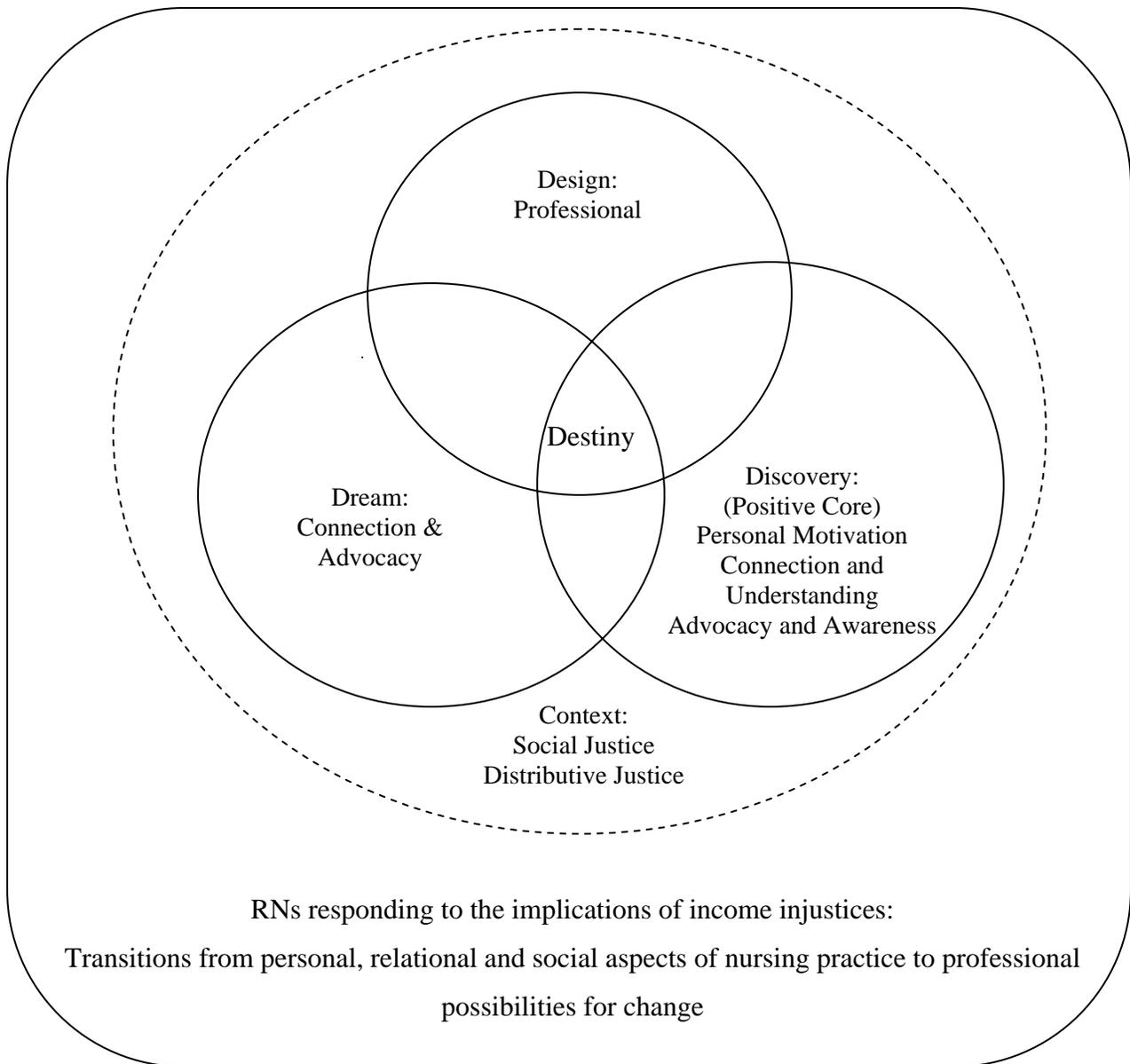


Figure 5.1 Conceptual Diagram of Data Findings

The conceptual diagram (Figure 5.1) shows the data themes organized in AI components. The positive core illuminated in the Discovery component serves as a foundation for the Dream and Design components. The overlap between the Discovery, Dream, and Design is meant to convey that the positive core is the foundation of all AI cycle components. Destiny, which builds on the positive core to work towards the vision raised in Dream, with the ‘how to guide’ as outlined in Design, is at the centre. Though Destiny was not the focus of this study, the

information provided by the other cycle components could be used to inform destiny activities. Social and distributive justice were synergistic environmental factors which enabled RN practice to be at its best while working with low income clients.

5.1 Context of Social Justice

Many types of justice, social, distributive, and market are at play within society and all impact the roles of RNs when working with low income clients. Defining these concepts and highlighting their influences on the data allows an explicit view of the context which is desirable for nursing practice to be at its best. Through a shared understanding, the dialogue on this subject can be grown towards an understanding of how such a system can be nurtured where RNs and their low income clients thrive.

A common language of justice enables RNs to broaden their understanding of how injustice impacts health and service delivery (Boutain, 2008). Social justice can be understood to mean an equal distribution of both the benefits and burdens on all members of society (Fahrenwald, 2003; Kneipp & Snider, 2001). The differentiation between equality and equity is central to social justice, as Liaschenko (1999) paraphrased Young (1990) "justice requires recognition of group differences because to recognize them is to make a place for them in social life in which they can enhance their skills and have their perspective heard and listened to" (p.45). Balance and equity were foundational to the approaches of RNs in this study. Participants looked at how they were key players in navigating the client's equilibrium between rights and responsibilities. It was often discussed that they may not change the client's situation, nor did the client always want change, but ensuring services were available to address client needs was an essential role of these RNs. One participant noted that to help a client, she used her knowledge of the healthcare system to navigate a course of action. Even with her knowledge, she had to make numerous phone calls. For a client who already had limited access to a phone this would have exacerbated 'burden' and impeded obtaining 'benefit'. The RNs played the role as social justice agents balancing benefit and burden by using their own privilege of knowledge, access, and resources.

This study highlighted that distributive justice in healthcare services was not enough to provide social justice to clients who combat a variety of impeding contextual factors in order to qualify and sustain services. The masquerade of equal access as a solution to vulnerability continues to perpetuate the power imbalance because a gradient still exists with those who are

privileged having power (to provide or deny access) over those in need. Social justice addresses the underlying issue “even when health care services are distributed more equitably, inequalities in health remain” (Marmot & Wilkinson as cited in Drevdahl et al., 2001, p. 24). Study participants called for primary health care which would level out this field by increasing self sufficiency through the creation of environments conducive to increasing capacity and assets; “nurses need to explore what [clients are] capable of” (Participant). Distributive and social justice can coexist but cannot be assumed to provide parallel pathways towards the same goal. The end goal of social justice is equity: “Social justice asserts that vulnerable persons should be protected from harm and promoted to achieve full status in society” (Boutain, 2008, p. 45). Distributive justice speaks to the equal access of goods and services among all groups as opposed to the focus on social justice, which acknowledges that equal does not translate into equitable (Boutain, 2008; Kirkham & Browne, 2006). The focus must not be on managing marginalization through equalization of access rather it should be on equal access as one tool in a toolbox used to promote equity in achievement of health.

Beyond social and distributive justice, participants felt that they work “against the grain” where overarching political and economic structures impact their clients’ health and the contexts in which they provided care. The desired practice context of social justice coexists with contrasting societal climate of market justice. In market justice, inequity is tolerated as long as the market processes remain fair; people earn what they receive (Boutain, 2008). Market justice holds health not as a right but as a commodity which can be bought and sold (Kneipp & Snider, 2001). Participants indicated there were constraints on their activities often citing funding as a major barrier.

Social justice discourses have proposed “social justice as a framework for professional nursing” which “[addresses] health concerns related to how societies are structured (Boutain, 2005, p. 404). The CNA (2006) has designed a social justice document which can be used as a lens through which nursing can frame its work. The competing pressures of social justice and market justice demand that RNs recognize “the role power, politics and economic forces play in determining health status and access to health care services” (Drevdahl, 2002, p.167). Kneipp & Snider (2001) discussed the struggle to embrace social justice while practicing in a society that values market justice. They highlighted the need for nursing to use its societal position to call for nursing’s social justice qualities and not to be oppressed by market frameworks but valued

because its tenants are inherently good. For nursing science to promote social justice, and challenge the status quo, “critiques, inquiries, and theory development informed by political theory are required” (Browne, 2001, p. 127). Political ideology influenced the way in which participants and clients interact in the world and is worth exploring, “I was never a very political person, but I see a lot more now”(Participant).

Neo-liberal influences on the market insist that people engage in the markets as individuals, this exacerbates class differences and perpetuates poverty through weakening the power of social institutions to act as a buffer for those vulnerable to economic inequities (Coburn, 2004). It is an increasing movement towards neo-liberalism which undermines community empowerment and promotes market justice. Novak (1991) identified a change from nursing’s origins of a public health movement to subsequently increasing shifts towards the care of individuals. This research explored many aspects of individuals and the system to provide opportunity to clarify the complex factors at play in nursing with vulnerable clients. Liberal influences on nursing can impede the development of emancipatory knowledge by ignoring the implications of individualism in a free market economy where structural constraints such as race, class, or gender are seen within a context secondary to egalitarian values and individual freedoms (Browne, 2001). A focus on individualism makes it difficult to surpass self interest and address the role of social equity in health; the ultimate influences on health which nurses must target are political and social justice interventions (Sistrom & Hale, 2006). Drevdahl et al. (2001) saw continued achievement in the challenge of RNs advancing social justice in current antithetical political contexts because nursing practice itself has endured since the imposition of a medical model based in a capitalist economy.

Participants situated themselves within a liberal context by focusing on their individual strengths rather than identifying with a collective of nursing or healthcare workers. The contradiction of personal and social was not problematic for the participants. Instead, they saw their personal motivation as congruent with a socially just outcome. The emphasis of the role of the individual within a social movement may illuminate how the prevailing political ideology has influenced nursing science. Furthermore, it can contribute to an explanation of why the social activism aspect of nursing has decreased and a focus on both nurse and client as individual has increased. In a socially oriented society, governments and regulation are seen as ways to distribute goods and RNs as a public service would be a part of ensuring that system fostered

health. Conversely, in a society of neo-liberalism government interventions are often seen as perverting the market, and favor lies in deregulation, privatization and trade liberalism. The response to inequity in this type of a society is not through a fairer distribution of goods and social programming that encourages social justice, rather efforts focus on how to increase participation of the vulnerable in the market. Therefore, RNs now may feel that issues around justice are the product of an individual's relationship with the market as opposed to a social problem resulting from unjust policies.

Liaschenko (1999) explored the relationship between justice and personal values in nursing practice. The universal and the particular accounts of justice can be perceived as contradictory. However, in reconceptualizing justice "personal values of a certain kind need not conflict with the universal tendency of justice if those personal values are informed by emotions that keep one open to the suffering and distress of oppression and domination that prevent full participation in social life" (Liaschenko, p. 46). Data from participants supported this notion highlighting their individual passion for making a difference within the social justice context. Furthermore, "those personal values that work in such a way so as to include previously marginalized others in the group of those who have access to the goods of social life are the personal values that are compatible with an enablement account of justice" (Liaschenko, p. 46). The RNs in this study recounted stories where they used their own places of privilege to help navigate the system along side the client, acting as a partner and guide.

A call has been made for nursing to consider an "ethic of just care" (Liaschenko, 1999, p. 47). Boersma (2006) also called for just care as an ethical value, stating that integration will acknowledge that caring enriches understanding of justice. Just care incorporates the passion and personal motivations of clients within the individual nurse-client relationship as well as a larger movement concerning the societal context of that care. Variables such as the relationship between societal-structural components like access, poverty, and social/political status are intrinsic to health disparities (Flaskerud & Nyamathi, 2002). For nursing to move beyond describing and actually reducing health disparities the focus must include income, access, social/political power, and human rights (Flaskerud & Nyamathi). This research moved beyond specific situations to look at life giving forces, thus not limiting any responses but rather encompassing the whole system of health with a focus on how to grow more of the good that is already in existence. Participants worked through the levels of personal, relational, and social

aspects of nursing to come to the conclusion that there was a collective opportunity for change based on the contributions of passionate individuals.

Those who have expertise in working with vulnerable populations can work to communicate their stories, thus advocating within the profession for redress of the social issues and the identification of individual roles associated with being an effective caregiver. Nightingale's historical legacy of justice making (Boykin & Dunphy, 2002) is connected with nursing practice that takes experiences from individual focused care, and translates them for advocacy. This practice, while diverse in detail, remains "rich in caring, laden with compassion, and manifested through justice-making, it is especially through caring that we bring intimacy, nearness, feelings to our work of justice" (Boykin & Dunphy, p.18). One RN described an experience where she felt a client was instructed to provide self care without adequate tools or training. Her long standing relationship with him informed her assessment that this client was unable to provide that type of care for himself, which inspired her to engage in multi level advocacy. Through this RN's actions, the client received the appropriate tools and support to enable an appropriate level of self care. These positive core elements of connection and advocacy can remain true in many areas of nursing practice, looking at a social level goal through a focus on the responsibility of the individual.

By explicitly working through the AI methodology, the positive core is revealed. Provocative propositions, and a charter of relationships, roles, and responsibilities show how these RNs are already reducing health disparities in a complex system. Concepts of justice are pervasive throughout the findings and key components can be used to highlight and expand nursing's role in just care. The following sections move through the positive core, provocative propositions, and a charter of relationships, roles, and responsibilities as a way to highlight this research's contribution to improving the health equity of low income populations.

5.2 Positive Core

The positive core is an internalized resource for change (Reed, 2007). Discovering and enhancing the positive core showcases the strengths, aspirations, and purposes of a system in a way that promotes positive growth. Table 5.1 displays words of the participants to describe the underlying values, strengths, and resources at play when their work is at its best. Columns were differentiated based on how they were described by participants. The values column highlights underlying ideals accepted by this group whereas the strengths column highlights ways of

relating. The resources column presents assets available for the RN to use, such as power (as a professional in regards to the health system), passion (to motivate and sustain themselves through adversity) or trust (formed in the nurse-client relationship). Resources were also items accessible to RNs that could be used to meet client needs, such as knowledge of opportunities (like a job, or a shelter bed). Other resources were the ability to provide comfort (someone to talk to, an emergency contact), or somewhere safe to stay (such as a women's shelter). Partnerships with services that could accommodate client needs (such as immediate testing or counseling) were also valuable resources RNs accessed. The work environment was an asset. The dynamic qualities of the community helped the RNs meet clients in their own spaces as well as provided information for nursing assessments and understanding the context of the care they were providing.

Table 5.1 Positive Core of RNs Working with Low Income Clients

Values	Strengths	Resources
Social Justice	Caring	Trust
Making a Difference	Connecting	Power
Positive Change	Understanding	Education
Sharing	Relating	Intuition
Engaging	Listening	Passion
Choice	Advocating	Innovation
Honesty	Supporting	Knowledge of Community
Non Judgmental/Openness	Communicating	Collective Strength
Acceptance	Facilitating	Comfort and Safety
Respect	Maneuvering the System	Opportunities
Access	Being There	Somewhere Safe
Empowering		Dynamic Environments
Holistic Care		Partnerships

The bumper sticker (Figure 5.2) by a participant summarizes what it is “To Nurse”, which highlights one participant’s view of the positive core. The participant made this bumper sticker using a quote from Hobbins (2004, p. 495), and adapted an image retrieved from URL www.greeleygov.com/CommunityDevelopment/WebImages/NRO%20Images/hands_sand.jpg The placement of the quote and the words overtop of the image were added by the participant.

It is a privilege for us as nurses, to enter eminently private and personal places & spaces of valiant, courageous



Figure 5.2 To Nurse Sticker

The foundational positive core included personal factors. Participants did not discuss components related to the profession of nursing as their base in this area of work, rather the profession of nursing came later. The very core of what motivated and sustained them was intrinsically related to who they were and their personal values. Their role in connecting, supporting, and advocating differentiated them from other types of service providers and privileged them to gain entry into low income populations. Although not specifically unique roles of nursing, connecting, supporting, and advocating were very important to participants. They were contextually situated within a relational context of a specific nurse and a particular client. This role was reflected in comments such as:

- “The fact that you play a big part in somebody’s life”
- “I do feel like I make a difference with them”
- “To be a part of that and to know that maybe I can help in some way”

The differentiation from professional and personal was reflected by Giddings (2005b), who stated “nurses’ personal awareness of social injustice in their lives and in the lives of others -

their social consciousness - influences whether or not they are able to challenge the status quo” (p. 224). Giddings specifically looked at intra-professional violence and its mainstream implications within the healthcare system. However, she saw the vulnerability of some health professionals as a tool for social justice: “people acknowledge the limitations placed on them by their marginal identity and/or their commitment to social justice, and develop creative ways to challenge the dominant power base while remaining within it” (p. 233). Giddings’ concept was reinforced in this study’s findings as participants found motivation within themselves rather than within the profession, and persevered when they felt isolated from other RNs. Registered nurses, who examine their own places of privilege and vulnerability, are better able to identify their place in relation to social injustice and current health disparities. Giddings stated “a person who becomes aware of the contradictions involved in oppressive relationships and structures within professions and organizations expands the possibilities open to him or her for social action” (p. 234). Participants described confrontations with other health professionals as opportunities for them to inform their colleagues about what they learned through their own practice with vulnerable clients. People who reach expanded social consciousness are committed to challenging client health inequities even if this means being relegated to the margins of professional nursing (Giddings).

Within this research, the personal role was differentiated from the professional role, participant comments which highlighted this was: “my personal role, like the way I connect with people is different from the way other nurses connect with people. When they come in, you have your roles and your duties...And I use those as just tools to connect with people. So you have your duties and they’re great, but my role is actually to understand and to see what they actually need”. Another participant comment described how the avenues used to interact and connect with client’s showed a differentiation between the professional nursing role and the personal connection they felt with clients “much of it, the actual nursing care or the actual task that you’re doing, but also becoming a part of their lives”. Lastly, one participant stated that moving from the biomedical to the psychosocial was an important part of their role “Making a joke. I mean, not always being 100% medical all the time... Of course that’s important, but so is that relationship. Giving them a hug, those sorts of things that make them feel human”. While psychosocial is incorporated in holistic nursing practice the above comments show how these

RNs felt these aspects were more related to who they were personally than their professional designation.

5.3 *Provocative Propositions*

The provocative proposition “describe[s] an ideal state of circumstances that will foster the climate that creates the possibilities to do more of what works” (Hammond, 1998, p. 39). These are “symbolic statements because they have meaning well beyond words, reminding us of what is best about the organization and how everyone can participate in creating more of the best” (Hammond, p. 39). The statements bring together the best of what is and what might be to challenge the status quo with affirmative guidance (Watkins & Mohr, 2001). To write Provocative Propositions one finds examples of the best, determines what circumstances made that possible, and envision what might be by applying “what ifs” to common themes, in an affirmative statement set in present tense (Hammond).

A number of these Provocative Propositions (Table 5.2) were generated from participants’ data as practical recommendations and serve as both a vision of nursing excellence and policy recommendations for work towards excellence in the field of registered nursing with low income populations. Reed (2006) stated that research often “stopped at the presenting of findings for others to take up and respond too, because of this observation...the recommendation to develop provocative propositions, then was a useful way... to move from the abstract to the practical” (p. 11). The provocative propositions provide an opportunity to synthesize data in a way that builds on experiences to inspire change.

Table 5.2 Provocative Propositions

Provocative Proposition	Validating Data
<p>RNs are social justice agents who connect, support, and advocate for their clients to provide them with comfort, safety, and access.</p>	<p>The context which translated across all participants was a paradigm of social justice. The clients were “a lost population” and the conditions that care was delivered in were not reflective of societal standards. One participant commented that “I compare it to nursing in third world countries; every city has its own third world”. The realities of a vulnerable population living in the margins of society situated the RNs experiences at the intersection of social justice and health care.</p> <ul style="list-style-type: none"> • “Everyone’s entitled to good health, people are entitled to have good food, and good housing.” • “I see a lot more now about what I think needs to be done or want to say, speak up and say, you aren’t looking after all the people.” • “You’re working against the grain of society, societal attitudes...the grain of government policy, you’re working against the grain of history, so you’ve got a lot of things your working against that... set the precedent.”

Provocative Proposition

Validating Data

Nursing is a client centered profession that builds relationships with clients based on mutual acceptance and respect using knowledge of the community and an understanding of environmental dynamics.

The visions of the future moved from the personal to focus on the professional. From the perspective of the participants, relational and social aspects were seen as needing improvement and needing to shift away from being nurse centered to being client centered. The nurse was seen in relation to the prominence of the client in care.

- “The great nurses that are out there put the client first”
- “[Nurses try] to reach a client population that aren’t going to them”

3

Nurses use engagement and empowerment to facilitate community based partnerships that reach the client where they are at.

The relationship with both clients and the community was key to success stories. Innovative thinking regarding typical nursing functions was fostered when RNs worked from the client’s context to empower and engage clients.

- “Making a difference is that they trust me enough to phone me up and ask for a ride.”
 - “You look in a person’s life and you have to work with that.”
 - Knowing them on their turf makes a big difference. If they’re at home you do see other things at work... the environmental issues, the poverty issues... that wouldn’t be apparent necessarily in a hospital.”
-

Provocative Proposition

Validating Data

Nurses build on their intuition and passion for making a difference collectively to educate decision makers about what works.

Participants saw both their own passion and the collaborative strength of nursing as life giving forces.

- I [learned] to be more comfortable with my own intuition and that automatically makes me more comfortable in understanding communication that isn't necessarily overt.
- "I would tell them to not give up and the more of us that want to make that difference, there's strength in numbers and collectively we can do that and I think we can organize and make change."

Nursing uses a holistic perspective to provide comprehensive care across all aspects of healthcare within a primary health care framework.

Participants saw strength in their holistic view of client care. Through the components of primary health care that were already incorporated into their practice they saw immense potential. They wanted to be able to invest more time in such aspects.

- "Nurses can be involved in so many more aspects of healthcare."
 - "You're helping them with their whole life."
-

5.4 Charter Roles, Relationships, & Responsibilities

The research question provides stimulus for reflection of the roles, relationships, and responsibilities for the nursing profession in pursuing health equity for low income clients. What are the possibilities for the nursing profession to reduce the implications of poverty on health successfully, based on the achievements of direct care registered nurses who respond to low income circumstances of clients in Saskatchewan? Through combining the positive core and provocative propositions, a charter of roles, relationships, and responsibilities was developed. This charter can inform RNs to be at their best practice when working with low income clients in Saskatchewan. Based on experiences shared by participants, the possibilities through synergy from life giving forces, those aspects that are present when a system is performing at its best (Watkins & Mohr, 2001), are illuminated.

The design for achieving equity was seen as a professional opportunity based on a foundation of individual factors (as opposed to nursing skills, education, image, or identity) and images of connection. These nurses saw their passion and personal motivations combined with an understanding of the clients' realities as what enabled them to impact change. All of these factors frame the quest for social justice through the individual. While not explicitly contradictory, the underlying philosophical arguments are ones of collectivism versus individuality. The overall goal and current context are social but the process and components are individual. The oxymoron that results is collective individualism. These RNs, at the end of the day, saw each RN working individually within her own respective passion to enact an overall movement that would collectively become a social movement. Through their efforts in their own communities raising awareness, as well as the advocacy they did with, and on behalf of, their clients, these nurses were taking action to increase an understanding about their clients' reality as well as influencing policy to change the social conditions that perpetuated the poverty their clients faced.

Two 'bumper stickers' (Figures 5.3 and 5.4) that participants made show the individual piece within nursing: "Embrace the Diversity of Nursing" and "Be the Nurse You Want to Be". A third bumper sticker (Figure 5.5) encapsulated the complex layers of individual collectivism by framing the context of nursing as holistic caring underscored by values premised on a knowledge of self and letting everyone live their life. Permission was granted to the researcher for the use of these bumper stickers.



Figure 5.3 Embrace Sticker



Figure 5.4 Nurse Sticker



Figure 5.5 Wholistic Sticker

A key piece to this argument is resonance of the personal within the professional. The professional design is based on each individual RN's positive core of personal motivation, awareness, connection, and understanding. Individual autonomy remains paramount throughout overarching concepts such as client centered care. These themes such as public health are enabled through a context of personal freedoms premised on human rights. All persons are seen as part of a system, but with a purpose based on their own way of being in the world.

A description of the roles, relationships, and responsibilities as illuminated by this the research is included in Table 5.3 as a starting point for future dialogue and research.

Table 5.3 Roles, Relationships, and Responsibilities

Role	Relationship	Responsibility
Supporter	Open	Advocate
Facilitator	Responsive	Maintain Trust
Change Agent	Flexible	Promote Safety
Listener	Accessible	Address Specific Needs
Engager	Accepting	Highlight Client's Capabilities
Educator	Comfortable	Influence Positive Change
Provider of Choices	Empowering	
Partner		

5.5 Implications

Nursing must take into consideration the effects of the political and social environment on clients' health. The current climate of social justice is limited to developing awareness but falls short of focusing on engaging in a direct professional address to the root causes of social injustice. Participants in this study envisioned the actualization of a socially just context in which to practice as a professional ideal. This can be realized through engendering a responsibility in

individual nurses. Building on individual strengths towards a collective vision of activism enables an upstream approach to targeting the foundations of inequity.

5.5.1 Research

Further research is needed to confirm and elaborate on concepts discussed throughout this research. A critical review of the positive core, specifically examining the role of evidence in the formation of these behaviours, could help knowledge translation activities that seek to transplant this knowledge into external systems. Exploration into the individualism versus collectivism within nursing practice could inform activities around nursing practice in low income communities by inquiring into the efficiency of fostering personal capacity in individual nurses versus a focus on professional collective activism. Additionally, further research would also be valuable to explore the roles, relationships, and responsibilities of nurses as defined in this research. For example, are there situations that currently exist that evidence these and live out the proposed provocative propositions? Would this data resonate with RNs in other contexts?

This research used AI as a means to move from research as knowledge creation to research as the impetus for change (Reed, 2007). Furthermore, through the application of AI on equity issues, this research has highlighted its potential to create a research movement for social change. Similar research around equity issues utilizing the AI summit approach would potentially contribute to the dialogue and understanding of social justice and nursing practice. For example, community based nursing practice could utilize this method to look at a specific issue inclusive of the affected populations and examine the role of AI in creating and maintaining positive change. Exploration from an appreciative stance into nursing practice concepts such as community development and population health could contribute to knowledge about the capabilities of the research methodology as well as application of the AI organizational development principles to community settings.

5.5.2 Practice

Appreciative Inquiry addresses the theory practice gap in nursing by creating knowledge from nursing practice and the perspective of RNs. By starting a dialogue at the grassroots level that recognizes the expertise of RNs, validation and dissemination happen concurrently. Recommendations are not imposed from deductive logic, they are built through an inductive process that realizes the potential for change rooted in the positive core of the involved RNs. The application of AI to issues around equity can inform burn out issues such as acknowledging

when RNs and other professionals working in the field of social justice and health equity feel a crisis of relevance. This research shows that there are success stories, best practices that do make a difference at the individual, relational, social, and professional level. Through the creation of provocative propositions, a vision can inspire and transform nursing practice by articulating the possibility of an ideal future built from historical successes.

Nursing practice can work towards making the provocative propositions a reality through increased communication among nurses in diverse areas of practice and increasing community partnerships. For example, the change of shift handover report could be replicated when clients transfer between acute care and community services so that nursing care providers have an opportunity to ensure continuity. Registered nurses can focus on connecting with their clients, and move their focus from an agenda which is task based to one which uses a holistic approach to meet clients' where they are at, in terms of physical location as well as lifestyle and behaviors. The integration of justice and caring combined into the ethical principle of just care may strengthen nursing practice through the synergy of each concept enriching the other. Social activism is not embraced to the extent that it once was "it has become increasingly difficult for [nurses] to justify socially oriented activities ... in the face of pressure to produce measurable deliverables" (Kirkham & Browne, 2006, p. 330). This cannot continue to be the case if RNs are to fulfill the destiny of their passion as described in this study.

5.5.3 Administration

Hiring RNs for their passion is a key point coming out of this research. Consideration for the passion of the RN in that area could also be seen as problematic with potential for subjectivity resulting in discrimination, however, given the results of this research exploration into possibilities of helping RNs work in areas they feel passionately about would be valuable.

Administrators could apply the findings of this research in a number of areas, such as considering a staffing model based not only on tasks that needed to be completed but also considering aspects such as time to develop a therapeutic relationship and time for engagement in advocacy activities and participate in program development discussions. Study participants had immense knowledge of how the system of care could be designed to be more effective. One example is the expansion of primary health care services. Through including the population involved and the RNs in program development administrators could ensure that their program capitalized on the positive core of RNs. Utilizing RNs for primary health care activities enables

RNs to engage in prevention and promotion activities that are satisfying for the individual, building on their understanding of holistic care to maintain health rather than only address illness. An administrative focus on primary health care service delivery would also address the implications of income on health by incorporating the social determinants of health through a population health approach.

5.5.4 Education

A deep understanding of the context that shapes RNs' practice will prepare students to realize their social mandate by illuminating the root causes of illness and the ethical obligation to address such factors that perpetuate vulnerability. A sound understanding of the theory surrounding income, health, and justice can provide them with foundational knowledge in addressing those issues when they present in clinical practice. Explicit clinical experiences concerning low income clients can help to create transformative experiences which may lead to development of the social consciousness discussed by Giddings (2005b) and evidenced by this study's participants. Undergraduate and continuing nursing education could further develop awareness in students on the types of justice, political ideologies, and the historical role of nursing in activism. Curricula should highlight the contributions of nursing to health equity as well as the legacy of historical RN activists.

This study showed the passion of RNs as motivating and sustaining professional practice, nursing education could ensure emphasis on students developing and understanding their own passion. Ensuring time for students and RNs to explore their own personal values will help them develop their intuition and understand their unique contribution to nursing. These ends could be met by building reflective techniques such as journaling or peer debriefing into core curricula. For example, within the Nursing Education Program of Saskatchewan there is a course entitled: Development of Self which incorporates such strategies. Encouraging introspective activities to increase one's self awareness and be in touch with one's reactions as a professional behaviour may nurture personal development as an asset for professional development. Nurse educators can be role models of this, communicating their own strategies and the benefits of this on their practice. Through fostering personal development as a routine process in education, RNs may continue this upon graduation and throughout their career.

5.5.5 Policy

Nursing policy can explore its potential role in actualizing the vision these RNs saw for the profession of nursing, including an increasing prominence of primary health care and expanded scope. In addition to developing consistent nursing policy programming, this research illuminated a call for increased involvement of RNs in public policy to shape a more conducive context for equity in health. Creating venues where RNs and their clients can share their experiences would strengthen policy by providing information that could increase the relevance and responsiveness of policy to the needs of low income clients. One way to increase participation of RNs in policy could be to apply the appreciative lens and highlight how RNs have already shaped policies in the past. Moreover, looking at how positive changes in policy have resulted in increased equity in vulnerable populations can highlight the potential contributions of policy level change, encouraging more RNs to get involved in influencing policy changes towards more equitable outcomes.

5.6 Limitations

5.6.1 Generalizability

Limitations of this research include a lack of generalizability. Due to the nature of qualitative research this study cannot be assumed ‘true’ for other populations or contexts. This study did not include any RNs who identified their role as acute care, nor were there any RNs who worked in a strictly rural setting. This occurrence was not due to the sampling methodology but nonetheless RNs from these areas were not included and therefore their perspective is lacking in the data.

5.6.2 Sample

Purposefully no advanced practice RNs were included, and, for pragmatic reasons, the voices of the clients are also absent. Future research could explore the views of low income clients on the role of the direct care RN. Through engaging clients in research nursing can further an understanding of its role validated by the public the profession serves.

5.6.3 Methodology

The proposed limits of AI as a methodology that favors the positive at the exclusion of the negative did not turn out to be the case for this study. Participants disclosed information about issues and areas of concern, which was included in the data. As a way to encourage the participants to go deeper when negative experiences were mentioned the researcher probed

“what would it look like if that wasn’t an issue, if you could change that what would be the result you would see?” The questioning enabled all aspects to be incorporated but within an appreciative lens. Another limitation is the lack of fulfillment of the 4 D cycle, a larger study which would have sufficient time and resources could target a health region or area of practice and apply the AI Summit to address this issue. Because a diverse perspective was desired for this exploratory research, an AI Summit and limiting of RNs from one setting/area was not appropriate for this study. Because AI is in its infancy, being used as a research method as opposed to an organizational development technique produces issues surrounding the purity of methodological application which can be a concern. Currently some feel that a summit approach (e.g. Bushe) is the gold standard, while others (e.g. Reed) feel that AI does not actually dictate a specific data collection or analysis technique. This research followed the principles of AI throughout data collection, analysis, and discussion. The researcher found this adherence to the philosophical principles of AI to be beneficial. However, some may still feel the research is limited because of the limited use and awareness of AI as a research method.

CHAPTER SIX

Conclusion

Appreciative Inquiry as a research methodology and philosophy provides a positive look into what at times can be an often ignored topic: nursing with low income clients. Many scholars have cited the effects of income inequity. As the number one social determinant of health, with a broad array of effects, income inequity is irrefutably a topic that nursing must address. Saskatchewan poverty rates show that this is a very real problem. Furthermore, the poor suffer disproportionately from disease; therefore, RNs in all practice settings will encounter clients who suffer because of socioeconomic disparities. This research combats the crisis of relevance by documenting RN's first-hand experiences successfully working toward equity and justice for low income clients in Saskatchewan. Appreciative Inquiry inspires hope by focusing on what is working. As a method and a philosophy, it moves knowledge creation forward based on historical experiences, inspiring nursing to see the potential within itself for social change. By highlighting current best practices in pursuing equity for low income clients this study offers insight into how nursing can alleviate suffering and promote health, especially in vulnerable populations.

Data collection involved appreciative interviews that encouraged storytelling enabled rich data while simultaneously igniting the potential for AI to create change by starting a dialogue about the positive. Through the interviews, participants experienced a positive style of questioning that captured and relayed their stories as they had happened, rather than reconstructing their stories to fit the status quo. Because of this supportive approach, participants contributed rich data that explicated workable solutions to persistent problems. Analysis then built synergy by pulling together the experiences, possibilities for the future, and knowledge of how it should be from participant's stories regarding the role of nursing in building equity. Through examples of innovation, this research challenges nursing to take this knowledge and communicate its relevance so that the profession can begin to capitalize on the expertise offered through the voices of these RNs. The innovations offered are rooted in examples from nurse client interactions. These examples take into account the complexities of nursing, environmental dynamics, and contexts in which clients are situated. These factors are important transitions from

theoretical discussions towards implications and action for RN practice. By translating participants' direct care experiences into further research, broader policy development, and education, nursing can build social capital, which is a proponent of social justice.

How do the experiences of these RNs shed light on the ways nursing can reduce the implications of income inequity? By revealing the ways that participants addressed the impacts of poverty in shaping their clients' health, this research reinforced that RNs must take a comprehensive view of health. Participants saw an overall context of social justice as a necessary factor in increasing population health. Individual RNs work within their own passions and create momentum for collective action. "Our connectedness is integral to comprehending and implementing social justice" (Drevdahl, et al., 2001 p. 29). Aligning personal and professional strengths with a social justice context creates a synergy that allows RNs to develop meaningful client interactions and create sustainable positive change.

Participants described their own personal journey as part of reaching the collective vision for the nursing profession to bring about social change. Advocacy was central to the participants' stories, as well as in their design for reducing health disparities. Registered nurses situated themselves as individuals with the privilege of intimate client interactions. This enabled a distinct perspective on the social context of their overall practice and profession. Participants demonstrated an expanded social consciousness, in which connecting and understanding led to the achievement of just care. In order to embrace this expanded consciousness, nursing must nurture and positively reinforce it until it becomes a social norm for the profession. Registered nurses must each find their own passion as a tool for building collective synergy to make a difference. The focus must remain on clients; by anchoring nursing practice in clients' reality, RNs become partners in a collaborative mission to achieve social justice.

Furthermore, what are the possibilities for the profession of nursing when working with low income clients? Further research is necessary to explore the implications of the provocative propositions illuminated in this research. This research revealed that these RNs saw passion and connection as central to their care of low income clients. Through risk taking and being in tune with their own intuition, they discovered a way to create meaning in their practice. Rather than focusing on overarching ideas of professional nursing practice, this research diversifies nursing knowledge, contributing the concept that every RN brings an essential life giving force. Nursing "must take risks if we want to expose and change how the economy, the state, and civil society-

with particular emphasis on the overpowering dominance of market philosophies and policies-generate health inequalities” (Drevdhal et al., 2001, p. 28). These RNs practice activism through providing care inclusive of multiple contextual factors. Participants bring who they are to their practice as well as bringing their practice to others through advocacy. This research illuminates possibilities for positive change in the nursing profession. By bringing their personal passions to their client interactions, and connecting with a broader social justice context, RNs create a unique opportunity for responding to the implications of income injustice and building equity within nursing practice.

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Appendix A: Timeline

Timeframe	Action
March, 2008	Proposal Defense Edits
April 2008	Ethical Approval
May 2008- June 2008	Participant Recruitment and Data Collection
July 2008	Member checking and Data Analysis
August 2008	Final Analysis, Synthesis of Results and Preparation of Final Report
September 2008- February 2009	Draft Reviews with Committee and Edits
February 2009-April 2009	Thesis Defense

Appendix B: Budget

Item	Cost	Comment
Room for Interviews	00.00	Setting did not incur any costs
Long Distance Phone Charges	00.00	All interviews were conducive to face to face interviews
Counseling Contingency	00.00	No participants identified a need for assistance due to the research process
Refreshments for Participants	40.00	Coffee, Juices, Cookies, Muffins
Ipod Adapter	0.00	Digital recording device borrowed for free
Travel	200.00	To Saskatoon (one return trip needed)
Transcription	\$500	For Interviews \$15/hr for 6 of the interviews (first interview 150.00)
2 Printer Cartridges	50.00	2 cartridges
Package of Paper for: <ul style="list-style-type: none"> ▪ Information Letter ▪ Consent forms 	36.00	1 box= 5,000 sheets
Colored Pens	0.00	Pens Borrowed For Bumper stickers
Sticker Paper	20.00	
Total	796.00	

Appendix C: Resources, Supports, and Environment

The research environment was the College of Nursing at the University of Saskatchewan. The University of Saskatchewan provided access to computers, printers, library services, and experienced researchers. This study occurred under the supervision of Dr. Pammla Petrucka.

Appendix D: Information Letter and Inclusion Criteria



Researcher: Sarah Liberman
Graduate Student, College of Nursing,
University of Saskatchewan,
Telephone: (306) 798-1082
Email: srl745@mail.usask.ca

One of your colleagues has identified you as a nurse who responds to the needs of low income clients. This referral has resulted in an invitation for you to participate in a research study entitled ***Responding to Implications of Income Injustice: The Role of the Direct Care Registered Nurse Activist.***

Sarah Liberman, a Graduate Student from the College of Nursing, University of Saskatchewan, will be conducting the research. Her contact number is (306) 798-1082, or her email is srl745@mail.usask.ca.

The purpose of the study is to describe and explore the success stories of direct care registered nurses in Saskatchewan who are responding to low income clients' economic circumstances as part of their practice. Informed written and verbal consent will be gathered first if you agree to participate. You will be able to keep a copy of this form. This study will include one interview which will not exceed two hours. The researcher will contact you after this interview to check for clarification on the information you have provided. Your responses will be kept confidential and will only be reported in a summary format. A summary of the study findings can be mailed out to you when the study is completed if you request.

This study has been approved on ethical grounds by the Behavioral Ethics Review Board at the University of Saskatchewan, on April 23, 2008. If you have any questions with regard to the study or your rights as a participant you may contact the Ethics Office at (306) 966 2084. If you have any concerns about the primary researcher they can be addressed by the thesis supervisor Dr. Pammla Petrucka at (306) 798-1082.

Risks for participating are estimated to be minimal, if psychological distress becomes apparent referrals to counseling will be provided.

Benefits of the study are an increased understanding of the roles of practicing registered nurses in addressing poverty. This information could be used to develop skills training and capacity building workshops for other registered nurses. This information could be published in order to add to the knowledge base on social action of registered nurses. These benefits are not necessarily guaranteed.

Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort. If you are interested in learning more about this study, please contact Ms. Liberman and more details will be provided. Thank you for your time.

Appendix E: Consent Form



Researcher: Sarah Liberman

Graduate Student, College of Nursing,
University of Saskatchewan,
Telephone: (306) 798-1082
Email: srl745@mail.usask.ca

You are invited to participate in a research study entitled *Responding to Implications of Income Injustice: The Role of the Direct Care Registered Nurse Activist*. Please read this form carefully, and feel free to ask questions you might have.

Purpose and Procedure: To describe the successes of direct care registered nurses responding to low income circumstances in their client population as part of their practice. Demographic data will be collected to describe the population being study, but will not be used to compare participants or their data to each other. An individual interview, which will not exceed two hours in length, will be used. This interview will be recorded, but you may request to have the recorder turned off at any point without any penalty. After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.

Potential Risks: Risks are estimated to be minimal. Referrals to an external counseling agency will be provided if there is any apparent distress.

Potential Benefits: An increase in awareness and knowledge regarding the successes of registered nursing in responding to low income needs of clients. These benefits are not necessarily guaranteed. There may be no benefits to participating in this study.

Storage of Data: Data will be safeguarded and securely stored in a locked cabinet at the University of Saskatchewan under the supervision of the Faculty Advisor, Dr. Pammla Petrucka, for a minimum of five years.

Confidentiality: Data (tapes and transcripts) will be stored in a locked cupboard at the University under the supervision of the University Faculty Supervisor. The consent forms will be stored separately from the questionnaires, so that it will not be possible to associate a name with any given set of responses. Data will be used in a thesis, journal articles, and poster presentations at conferences. Although the data from this study will be published and presented at conferences, the data will be reported in summary format, so that it will not be possible to identify individuals. If quotes are used they will not include any identifiable words.

Right to Withdraw: Your participation is voluntary, and you may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request. You may also choose not to answer certain questions during the interview.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researcher, Ms. Liberman at the number provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioral Research Ethics Board on April 23, 2008. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (306-966-2084). Any questions about the primary researcher can be directed to the thesis supervisor, Dr. Pammla Petrucka at (306) 789-1082. Out of town participants may call collect. Results of the study will be made available to you at your request.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Appendix F: Demographic Data
(Not descriptive purposes)

Researcher: Sarah Liberman
Telephone: (306) 798-1082
Email: srl745@mail.usask.ca



Code Number:

Date:

Age	20-35	
	36-50	
	51-65	
	65+	
Gender	Male	
	Female	
	Transgender	
Total number of years practicing as an RN	1 year or less	
	2-5 years	
	6-14 years	
	15-19 years	
	20 years or more	
Current Residency (of Client population)	Rural	
	Urban	
Entry to Practice (check only one)	Diploma in Nursing	
	Bachelor's Degree in Nursing	
	Master's Degree in Nursing	
Post RN Education in Nursing (highest achieved)	None	
	Diploma	
	Baccalaureate	
	Masters	
	Doctorate	
Education in other than Nursing (highest achieved)	None	
	Diploma	
	Baccalaureate	
	Masters	
	Doctorate	

Current Employment Status	Regular full time	
	Regular part time basis	
	Casual	
Current Place of work in Saskatchewan (If you work in more than one place. put a 1 for primary employer, 2 for second employer, and 3 for third employer)	Hospital	
	Mental/Community Health Centre	
	Nursing Stations (outpost or clinic)	
	Public Health Dept. or Agency	
	Rehabilitation/Convalescent/Nursing Home/ Long Term Care	
	Physician's Office/Family Practice	
	Business/Industry/Occupational Health	
	Private Nursing Agency	
	Home Care	
	Association/Government/Educational Institution	
	Other (specify)	
Current Primary Area of Responsibility in Saskatchewan (If you work in more than one area place a 1 for primary area, 2 for second area, and 3 for third area)	Medical/Surgical/Critical Care/Oncology	
	Maternal/Newborn/Pediatric	
	Operating Room/Recovery Room	
	Emergency Care	
	Several Clinical Areas	
	Psychiatric/Mental Health	
	Home Care	
	Community Health	
	Public Health	
	Ambulatory Care/Rehabilitation	
	Occupational Health	
	Geriatric/Long Term Care	
	Telehealth	
	Education/Research/Administration	
	Other (specify)	

Appendix G: Appreciative Inquiry Questions:
(Adapted from Michael, 2005*; Keefe & Pesut, 2004**)

1. What's your favorite memory of nursing? *
 - a. What makes your area of nursing a good place to practice? *
 - b. What do you like best about your job? *
 - c. What first attracted you to work with vulnerable clients? *
2. Can you tell me about your role with low income clients? *
 - a. What is your favorite story about one of these clients? *
 - b. What part of this work makes you most fulfilled? *
 - c. What part of your work do you feel these clients value most? *
 - d. What are the core values that inspire and sustain you in this work? **
3. What skills are you called on to use the most with this population? *
 - a. What strengths and resources do you use to respond to economic circumstances? *
 - b. How do you know when you have made a difference? **
 - c. What made your most satisfying experience possible? **
4. Tell me about groups or people that support you in this work? *
 - a. What makes your relationship with them work? *
 - b. Tell me about a situation where you worked well together? *
5. What excites you the most about the next five years in nursing? **
 - a. If I asked you about your work in five years what would you hope to be able to tell me? *
 - b. If another nurse was hoping to make an impact on this what would be your advice to them? *
 - c. If you had to make a bumper sticker or slogan to reflect your vision of nursing what would it be? **

Appendix H: Transcript Release



TRANSCRIPT RELEASE FORM

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Email: srl745@mail.usask.ca

Study: Responding to Implications of Income Injustice:
The Role of the Direct Care Registered Nurse Activist

I, _____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Ms. Liberman. I hereby authorize the release of this transcript to Ms. Liberman to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

Name of Participant

Date

Signature of Participant

Signature of researcher

Appendix I: Sample of Audit Trail

January 2008 Theoretical Framework

- I think doing this research will help me challenge my own transitions through places of privilege and vulnerability. I used to feel my own viewpoint fit within the critical realm and now I think I am moving more towards a constructionist view. In researching my theoretical framework I found literature that I feel supports the evolution of my thinking in this area. Patton talks about how constructivists can be critical if you look at it through a lens of constructionism where certain perspectives becomes cultural norms and are accepted into mainstream society. Because of the prevalence of a concept it gains power resulting as a 'normal' concept and marginalizing other concepts in relation. You can address this in your research by deconstructing these mainstream ideologies through giving voice to the multiple perspectives relating to that one uplifted ideal. So I think I am not working within a contradiction, and it will be interesting to see how this works because I think it's the combination of critical and construction that is emancipatory.

May 2008 Data Collection

- Field notes and interviews. Oh woe is the girl who discovers a great research book once her research has already started. Methods from the margins has such a great section on field notes, and how key they can be when you have pages and pages of data, because they are often shorter and more to the point. I have noticed my transcripts are super long and my field notes could be better so I am working on those but I wish I wouldn't have been so nervous about my ability to probe and interview well and that I had spent more time remembering the rest of the research process that will follow. Oh well the interviews are super fun and its so inspiring to hear their stories. I am going back and adding to my first couple interview notes because I can still remember them so hopefully that will help when I get to my analysis.

July 2008 Analysis

- I stared with thematic analysis and it really felt like I wasn't being true to my methodology. I felt like I was missing something and that my data was remaining shapeless and unmanageable. I decided to use software to help with management and then did my first level using the AI components as a guide. This is consistent with the method. I looked at the three Ds that were apparent in the data and grouped according to this. Concurrently I

reviewed the AI literature on sense-making and used it to help clarify where key statements from the interviews should go. I felt that my own background in this area and the experiences I had in doing the interviews helped me pick out the key statements that really illuminated the rich data segments. I did a self interview so that I could check my own biases against what the data was saying to me. In the end I had sub themes within each AI component and then went back to the data to draw out larger thematic categories. It was a dark fist couple days of analysis but once I revisited my method it was pretty exciting.

July 2008 Discussion

- I chose the words for the positive core by going through the transcripts and picking out the words that linked with the categories as similar to categories identified by Hammond. I then used those along with my knowledge of the data to draft the provocative propositions. I decided to be brief in the charter of roles responsibilities and relationships because I feel like that would be mostly my insinuation and that the data wasn't focused there enough. I struggled a but at how to make this section work and then it just came through that I had to once again go to my methods and now I really feel the synergy of AI!

Appendix J: Analysis Codes

Categories

- Positive Core
- Dream
- Design

Thematic Codes

- Make a difference
- Relationship
- Client Centered/holistic caring
- Don't Fix it
- Information sharing
- Passion
- Client Centered
- Increased Utilization
- Primary Health Care
- Caring
- Change
- Non judgmental approach
- Social Justice
- Advocacy
- Intuition
- Innovations

Appendix K: Interview Excerpts

Excerpt One

1. I: The first question is just kind of a broad question about what's your favourite memory of nursing? And it doesn't have to be your favourite memory, it could just be like what's a memory that stands out in nursing?
2. P: My first patient ever. (laughter)
3. I: Okay.
4. P: A little 91-year-old lady who was on, like a long term care hospital unit thing, and she was a Ukrainian, um, lady, and they always say, all she ever spoke now was Ukrainian so you can't understand what she said. That she had contractures, bed sores, and you know, just doing bathing, you know Like they're saying she can't speak English any more. She only speaks Ukrainian, but I remember her saying "Leave me alone! Leave me alone!" when you're bathing her, and then by the end of the week, the third day, um, like she was talking to me. Like I talk, because you know, your first one patient, you're staying
5. I: Yeah.
6. P: With them, you know, and basically all day, fed her, I had to go do my little bit of charting and someone else came to feed her, and I said, "I'll be back in five minutes," and she held up her hands and said "Five minutes." It was like that. "You all think she doesn't say a thing? She does. She can talk very well. You just have to take the time to listen. (laughter) So that was, that was one of the things I'll always remember, is take the time to listen. May think they're not saying anything, but they usually are. Because you could see in her eyes, she, she was still there, but she just couldn't get it out any more.
7. I: Mmmhmm.
8. P: Mmmhmm.
9. I: Hmmm.
10. P: That's one I'll never forget.

Appendix K: Interview Excerpts

Excerpt Two

48. I Yah, um what part of your work do you feel these clients value the most?
49. P Part of my work...
50. I Mmhmmm
51. I Like what part of your role as a nurse do you feel these clients really value... do you feel sets you apart from...
52. P I think a part of it a smaller part may be my knowledge and skills but a bigger part of it I think is when they have are able to develop the trust in knowing you have a non-judgmental approach and you feel that you've got that trust from somebody I think for them that's a huge part they they don't care if I do what I'm supposed to do when I'm there but if I can come in and they feel its safe for them to be themselves and to be able to share a part of themselves whether it be there often times you know their addiction or addiction history they know they can do that they won't be judged for that, I think that's what they value the most.
53. I Yah for sure
54. P I'm just using addiction as an example it could be anything
55. I Yah
56. P Yah
57. P Could be...
58. I Tell me more about it...
59. P Gang activity, could be a history of sexual abuse when they were growing up or um dynamics that are going on in the house that may be quite negative at the time but when they know that you've figured it out or that they've shared it with you, it could be either way, and that you won't, I'm not judging them for it then that's I'm not saying well you know I don't feel comfortable knowing that or I don't you know I put barriers up for communication, if you do that then you're much more at risk for them thinking you're judgmental so for me I think that's what they value most is when they know that they can be open around me and I won't judge them for what's going on.