Investigating student nurses’ constructions of health promotion in nursing education

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Abstract

This article describes student nurses’ constructions of health promotion and the change of these constructions during their nursing education in two Finnish polytechnics. The data consisted of essays written by the 19 student nurses before they began their nursing education in 1997 and of stimulated recall interviews with the same students during the second year of their education in 1998. The data were analyzed by using thematic analysis. During the first study year, 13 students’ constructions of health promotion changed. Six students had initially broad constructions of health promotion and their constructions remained unchanged. Four basic changes were found in the students’ constructions: (1) the emphasis shifted from physical to multidimensional health promotion, (2) health promotion became more concrete and contextual, (3) the conception of perfect health became more permissive and relative, and (4) the interpretation of health promotion shifted from performing towards being there for the patient. These results may indicate that student nurses in Finnish polytechnics were attempting to adopt the empowerment approach to health promotion for their constructions. Moreover, the results represent a major challenge concerning nursing education and health promotion learning from the constructivistic approach to knowledge building.

Introduction

Effective health promotion presupposes a broad and internalized conception of health promotion by health professionals. White (White, 1994) defines a conception as a system of explanation. Defining a health promotion conception requires more than classifying something as health promotion or describing all knowledge associated with the concept health promotion. Defining a conception requires such deep appreciation of its meaning that it becomes possible to apply the knowledge appropriately in new situations. The conception, then, represents a functional unit of thought which includes both propositional (knowing what) and procedural (knowing how to) aspects (Hewson, 1985). In this article, we use the term construction to describe students’ continuously developing conception of health promotion in the context of learning in nursing education.

Students’ conceptions and their change during their education have been studied within various disciplines [e.g. (Chi et al., 1994; Vosniadou, 1994; Tynjälä, 1999)]. Earlier research that has explored nursing students’ understanding of health promotion, in the context of Project 2000 education (Elkan and Robinson, 1993; Robinson and Hill, 1995; Smith et al., 1995; Macleod Clark and Maben, 1998; McDonald, 1998), has yielded information on how a health promotion concept and its relationship to health education and nursing are defined by student nurses. The results of the latest studies are contradictory. Nursing students’
L. Liimatainen et al.

In order to develop broad health promotion conceptions in student nurses, the challenge is to make the students aware of their interpretations of health promotion and how they apply them in caring situations (Machintosh, 1998). Conceptual change and the change of students’ constructions can be seen as transformation of conceptions in the process of learning, where understanding the idea of health promotion implies knowing what it means. The process of meaning building begins with minimal understanding when students begin to consider the value of health promotion for their future work and begin to see some implications. With more advanced understanding, students behave like experts; they see a wide range of implications of health promotion, and apply it to new and complex situations. The highest level of understanding implies accommodation, which not only involves understanding but also personal acceptance of and commitment to health promotion (Strike and Posner, 1985). This view of learning is consistent with the constructivistic idea of knowledge building. The learner is assumed to actively build her knowledge by constructing and re-constructing her concepts of the topic to be learned and to interpret new information on the basis of existing knowledge (Vosniadou, 1994; von Glaserfeld, 1995). Johns’ (Johns, 1994) model of structured reflection can be utilized in this reflection process as a tool for developing and clarifying students’ personal knowledge base of health promotion. It has recently been suggested that a constructivistic or postmodernistic approach could be used for the development of health promotion knowledge and programme evaluation (MacDonald et al., 1996; Labonte et al., 1999), and for evaluating nursing education (Pateman and Jinks, 1999).

Latter (Latter, 1998a) has suggested that it is time to move on from education on concepts of health promotion to assessment of competence. In this process, it is essential to be aware of students’ constructions of health promotion in order to facilitate health promotion learning from the constructivistic approach to knowledge building. This also requires a shift in research methods and designs. The aim of this study was to investigate and describe the qualitative changes of students’ health promotion constructions, and to explore the procedural aspects of these constructions in clinical training during nursing education.

The concept and ideology of health promotion shaping students’ constructions

Health promotion is a contested concept. It has been used and defined in a variety of ways and from different points of view (Tones, 1996). Still, in many countries the teaching of health promotion in nursing education is based on two WHO declarations, the Ottawa Charter (Ottawa Charter for Health Promotion, 1986) and Health for All 2000 (Health for All 2000, 1993) (Wass and Backhouse, 1996; McDonald, 1998; Sjögren et al. 2000), and on their broad and abstract definition of health promotion. Health promotion is defined as a process of enabling people to increase control over their health and to improve it (WHO, 1984). Health promotion combines the dual approaches of structural change and individual education, and encompasses a set of values (Ottawa Charter for Health Promotion, 1986). Health promotion in nursing can be viewed as an integral part of everyday practice or as a separate ‘add on’ activity (Benson and Latter, 1998). Earlier, Macleod Clark (Macleod Clark, 1993) suggested that health promotion in nursing should be viewed as health nursing or as health-promoting interaction approach to care. Then, any interaction or activity that includes certain key principles and features of health promo-
Investigating student nurses’ constructions of health promotion

...tion, such as empowerment, holism, equity, participation, collaboration, individualization, negotiation, facilitation and support, has the potential to be health promoting.

According to Rush (Rush, 1997), the existing health promotion ideology of nursing education powerfully shapes the approaches and conceptions of future health promoters. Boud and Walker (Boud and Walker, 1998) argue that everything we do is invisibly framed and situated. In a professional context, disciplines and professions define what counts as legitimate knowledge and acceptable practice. Macleod Clark and Maben (Macleod Clark and Maben, 1998) have argued that nursing education maintains and reinforces the traditional model of health promotion. This emphasizes individuals and risk factors, and aims to prevent diseases and complications through teaching, informing and controlling (Tones et al., 1990; Downie et al., 1997). In health promotion teaching, this implies a disease-centered approach (Robinson and Hill, 1995; Macleod Clark and Maben, 1998; McDonald, 1998), which leads to a bias and ineffective use of health promotion methods (Robinson and Hill, 1995, Smith et al., 1995). In the area of clinical learning, as well, research indicates that there is a shortage of new role models in health promotion since the majority of nurses share a narrow, traditional disease-centered model of health promotion (Latter et al., 1992; Smith et al., 1995; Macleod Clark and Maben, 1998).

Latter (Latter, 1998a) and Rush (Rush, 1997) have indicated that preparing student nurses for the traditional health promotion role will not be enough in the future. In order to meet the health challenges of the 21st century (WHO, 1999), nursing students will need to be equipped with a new health promotion role with broader societal, political, economic and media aspects connected with determinants of health. In addition, health nursing and the holistic, empowerment approach will be included in this new health promotion role of nurses (Rush, 1997; Benson and Latter, 1998; Macleod Clark and Maben, 1998; Tones, 1998; WHO, 1999). The empowerment approach refers to health-promoting interaction (Macleod Clark, 1993), to the need to clarify values, beliefs, health and health-related determinants of behaviour, to a need to foster empowerment through improving self-esteem and awareness, beliefs about self-efficacy and the acquisition of life skills and a partnership model of communication (Tones, 1996; Downie et al., 1997). The aim of these activities is the well-being and empowerment of individuals and/or communities (Tones, 1996).

Reflection as a method of investigating changing health promotion constructions

The learning of health promotion is often context based and situation specific, and occurs in complex circumstances. Consequently, knowledge building in health promotion requires flexibility, critical thinking and reflection. Conceptual change is not a simple linear process of replacing old conceptions with new ones (Wass and Backhouse, 1996). Vosniadou (Vosniadou, 1994) indicates that, in teaching science, the simplest form of conceptual change is enrichment, an assimilation type of change where new information is added to an existing knowledge structure without restructuring. A more difficult form of change is revision, a change where the new information is inconsistent with existing beliefs and presuppositions. It may involve changing individuals’ beliefs or it may take place at a theoretical level. The most difficult form of conceptual change is revision at the level of framework theory, causing misconceptions, inconsistency and inert knowledge. In education science, Tynjälä (Tynjälä, 1999) has established that conceptual change occurs on four different levels: on the semantic level of individuals’ concepts, at the level of the relationships between concepts, on the ontological level and at the level of framework theory, which underlies conceptions.

If we understand knowledge as a social construct of reality, it is arrived at through reflection and dialogue (Kvale, 1996). Boud and Walker (Boud and Walker, 1998) emphasize the role of the context where reflection takes place. They state that context is perhaps the single most important influence on reflection and learning. In nursing education, different clinical settings constitute a major part...
of the health promotion learning context. Training offers an opportunity to learn from experience via reflection, which can help to clarify and integrate the concept of health promotion in real working contexts. Kolb (Kolb, 1984) has argued that theoretical concepts will not become a part of students’ framework until they have been meaningfully experienced at a reflective level.

Reflective practice and critical thinking are considered to be crucial elements for effective learning of health promotion (Williams, 1995; Macleod Clark and Maben, 1998; Rivers et al., 1998). Naidoo and Wills (Naidoo and Wills, 1998) have suggested reflection as a method to unite theory and practice in health promotion. Reflection can be defined as an essential phase of the learning process whereby people explore their experiences in a conscious way in order to arrive at new understandings and new behaviors (Jarvis, 1987). Reflection can produce the metacognitive or self-regulatory knowledge (e.g. attention regulation, monitoring and evaluation of ongoing processes) which has an important role in controlling and integrating the other components of professional knowledge (Bereiter and Scardamalia, 1993). Reflection may help students and professionals to unlearn much of their traditional conceptions about health promotion and to criticize the current practice (Williams, 1995). In order to link experience and theoretical conceptualization through reflection, student nurses need to practice and learn these skills in a clinical setting where they are in direct contact with clients and their problems. Johns’ (Johns, 1994) model of structured reflection is one of the theoretical aids which can be used to help students to see themselves in the context of their health promotion practice, and to clarify and develop their personal knowledge base of health promotion. Johns’ model evolves as a sequence through which students examine their experiences under supervision (Johns, 1994; Platzer et al., 1997).

Previous studies have indicated that the challenge in nursing education is to broaden the role of nurses from a traditional approach to an empowerment approach of health promotion (Benson and Latter, 1998; Macleod Clark and Maben, 1998; WHO, 1999). Clinical training is a major learning context in nursing education, but there is a shortage of new health promotion role models in health care settings (Smith et al., 1995 Macleod Clark and Maben, 1998). Reflective practice and reflection may help students and professionals to learn from working life experiences and broaden their constructions of health promotion towards the empowerment approach (Williams, 1995; Naidoo and Wills, 1998; Rivers et al., 1998). In this study, reflection has been used as a tool to investigate student nurses’ constructions of health promotion during their education.

Method

The aim of this study was to investigate student nurses’ health promotion constructions and their change from a propositional point of view during nursing education, and from a reflective and procedural point of view during clinical training. The following research questions were addressed:

- What were the students’ constructions of health promotion before they began their nursing education?
- How did the students’ constructions of health promotion change during 1 year of nursing education?

Context of this study

This study is based on a more extensive follow-up research project which investigates health promotion learning and teaching in two Finnish polytechnics of social and health care (Liimatainen et al., 1999; Poskiparta et al., 2000; Sjögren et al., 2000). This research tracks the development of health promotion constructions and skills of 19 student nurses, who began their nursing studies in August 1997 and will graduate in 2000. The curricula of the two polytechnics form the context and the basis of health promotion learning. According to the curricula, both polytechnics were committed to constructivist learning and the health promotion content of both curricula was based on the Project 2000 model of nurse education.
Investigating student nurses’ constructions of health promotion

In Polytechnic A, the content of the curriculum that the sample took was ‘Health promotion, caring and rehabilitation in nursing for different age groups’ and this module was a part of professional studies. The aims of the professional studies, according to the curriculum, were that the students would learn to promote and support health in different nursing environments as responsible individual nurses and partners in professional teams. The clinical placements during this module were in medical and surgical wards of a large hospital. In Polytechnic B, the sample was also engaged in professional studies and their module was called ‘Nursing skills and methods’. The curriculum of Polytechnic B emphasized students’ ability to learn to promote and maintain health and to prevent diseases in nursing as the aims of professional studies. The clinical placements were in geriatric and rehabilitation wards of two hospitals.

Participants
At the beginning of the research project, the researchers purposefully selected 20 voluntary students to participate in this follow-up study. In summer 1997 the newly enrolled student nurse volunteers in the two polytechnics were asked to write an essay on ‘What do you think health and health promotion is?’. The students submitted 82 essays. Ten students from each polytechnic who represented very heterogeneous (ranging from narrow to broad) constructions of health promotion were subsequently invited to participate in this follow-up research project. One of the 20 students who volunteered to participate in the project, discontinued her nursing studies at the beginning of the education. Consequently, 19 student nurses constituted the study group of this research. The students were between 18 and 23 years of age.

Data
The data were drawn from two sources. First, the students’ (n = 19) initial conceptions of health promotion were investigated through their essays, submitted at the beginning of their nursing studies in 1997. Second, these students’ health promotion conceptions and their change after 1 year of nursing studies were explored via stimulated recall interviews (Cleary and Groer, 1994) during their clinical training in 1998. This method was selected because it enabled us to observe health promotion from a realistic point of view in the actual complex environment of health care.

Procedure
The stimulated recall interviews were conducted during clinical training in three different hospitals in Finland where the student nurses were training, as required by their curricula. During the interviews, the students were given two stimuli for reflection. The first stimulus, for investigating the changes of the students’ propositional aspect of health promotion construction, was their essay written in 1997. The students were asked to read their essay and reflect on their present construction of health promotion. The second stimulus, for investigating the procedural aspects of the students’ health promotion constructions, was a videotaped health promotion situation, which first involved making a videotape of the students’ individual health promotion practice with a patient. The patients participated in the videotaping on a voluntary basis and gave their consent to the researcher. The student nurses themselves selected the health promotion settings for videotaping, including counseling, teaching or conversational situations (n = 6) and nursing interventions (n = 13). After the videotaping, the stimulated recall interviews were conducted in private. The interview questions were open-ended and based on Johns’ (Johns, 1994) model of structured reflection. This model was adopted in this study as a research tool in order to explore the student nurses’ (1) descriptions of health promotion in the videotaped situation, (2) reflections on what they were trying to achieve and (3) explanations of the outcome of their health promotion actions. The interviews took between 1.5 and 2 h. All interview sessions were audiotaped and transcribed verbatim into computer text files.

Analysis
The data were analyzed by using thematic analysis described by Polit and Hungler (Polit and Hungler...
<table>
<thead>
<tr>
<th>Health promotion</th>
<th>Connecting category</th>
<th>Main categories</th>
<th>Subcategories</th>
<th>Content/example</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>2. Individuals’ responsibility and action for their health, that of other people and the environment</td>
<td>2. Healthy lifestyle (13)</td>
<td>‘Health promotion means that people themselves take care of their own health and think how it is reasonable to live in order to stay as fit as possible, as long as possible. A regular life and daily rhythm, enough sleep, fresh air every day, a diet, no smoking and a reasonable amount of alcohol. Not to mention sports and exercise.’ (Student 2)</td>
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<td>3. Health awareness and empowerment (8)</td>
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<td>4. Relationships (3)</td>
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## Table I. Continued

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<tr>
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<tbody>
<tr>
<td><strong>Goals</strong> Health</td>
<td>1. Positive health</td>
<td>1. Well-being, feeling good (11)</td>
<td>‘To improve our lives and the environment where we live.’ (Student 8)</td>
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<td>2. To support and help holistically (1)</td>
<td>‘My role in this work will be to support and assist people who need help. The most important thing is to remember the principle of holism’. (Student 1)</td>
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<td>3. Prevention of diseases (8)</td>
<td>‘To prevent diseases and problems.’ (Student 16)</td>
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<td>2. Negative health</td>
<td>4. To increase the health knowledge (1)</td>
<td>‘The goal should be to inform every citizen about correct, healthy lifestyle and fashion.’ (Student 8)</td>
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<td><strong>Results</strong> Good life</td>
<td>1. Improved quality of life</td>
<td>1. Well-being, feeling good (5)</td>
<td>‘Simply losing a little weight can make people feel much better.’ (Student 6)</td>
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<td>2. Lower incidence of diseases and accidents (3)</td>
<td>‘To prevent accidents and create safe working conditions in many ways.’ (Student 1)</td>
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<td>3. Improved functioning and management of everyday life (2)</td>
<td>‘People can cope better and manage their day-to-day chores at home, school and work.’ (Student 7)</td>
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<td>2. Longer life</td>
<td>4 Health awareness (3)</td>
<td>‘People pay a lot more attention than they used to what they eat and how much they exercise. They know what’s healthy and what’s not.’ (Student 10)</td>
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<td>5. Healthier environment (1)</td>
<td>‘Our future would seem to be easier in a healthier environment.’ (Student 8)</td>
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<tr>
<td>Clinical placements</td>
<td>Health promotion subcategories with examples</td>
<td>Manifestation</td>
<td>Goals</td>
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<td>Students (1–10) from Polytechnic B on geriatric wards (n = 10)</td>
<td>1. Interaction and emotional health promotion (10) ‘Living alongside the patient.’ (Student 4) 2. Facilitation of patients’ self-realization, participation and encouragement of individual initiative (6) ‘Helping patients to do all they can.’ (Student 2) 3. Physical health promotion (6) ‘Motivating and helping patients to do exercises.’ (Student 5) 4. Health education (1) ‘Instructions for self-care at home.’ (Student 7)</td>
<td>1. To cheer patients up and be ready to listen to them (5) ‘Well, something different to do during the day so that they wouldn’t be listening to the radio all the time, the news and such. Someone to talk to since the nurses there don’t have so much time for talking anyway.’ (Student 3) 2. To activate patients (4) ‘Supporting independent initiatives, and you wouldn’t be dependent on the nurses. An important goal would be that you could manage day-to-day chores on your own.’ (Student 2) 3. Learning and understanding for patients (1) ‘She is learning how to use a medication dispenser. And understands what things mean.’ (Student 7)</td>
<td>1. Emotional and physical well-being (10) ‘The patient was happy and satisfied.’ (Student 8) 2. Feelings of control, empowerment and independence (5) ‘The patient felt respected and important.’ (Student 6) 3. Maintaining or improving functioning (4) ‘He became so actively involved in playing.’ (Student 1) 4. Learning and independence for patients (1) ‘The patient was informed.’ (Student 7)</td>
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<th>Health promotion subcategories with examples</th>
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<tr>
<td><strong>Clinical placements</strong></td>
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<td>Students (11–19) from Polytechnic A on acute wards (n = 9)</td>
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A thematic analysis process is employed when documents are analyzed systematically with an aim to provide an overall structure to the entire body of data. The analysis began with a search for themes or recurring regularities [(Polit and Hungler, 1995), p. 527]. The analysis process of the essays was begun by defining the analytical unit as ‘a discrete phrase, sentence or series of sentences which covers a student’s single perception’ (Table I). The analysis was continued by reading the essays several times and exploring in the data (1) how the students described health promotion, (2) what was its aim and (3) what were its consequences. The semantic units were then coded from the data under the three questions described above. Next, the semantic units were reduced to simplified expressions that addressed the research questions, using the students’ own words and formulations if possible. These simplified expressions were then compared and grouped into subcategories or themes according to similar features. Finally, the analysis was concluded by connecting the subcategories at a more abstract level, and by forming main categories and connecting categories, if possible (see Table I).

The interview data was analyzed according to the same principles as the essays and the generated categories are presented in Table II. First, the categories that described the students’ constructions of health promotion, as reflected in their essays and their health promotion practice, were formed. The categories were then compared in order to identify the change in students’ constructions. The changes that were initially identified in the students’ reflections on their essays were then confirmed with the data from their health promotion practice. The validity of the chosen concepts and categories depends on logical and systematic analysis, and on the degree to which the categories serve as an accurate description of the students’ reality. The researchers’ personal experience of the phenomena being described, the videotaped situations which provided realistic, common and shared phenomena for the basis of the interviews, and the careful analytical procedure guaranteed the credibility of the findings (Kvale, 1996). The results are presented below according to the research questions.

**Results**

**Students’ initial constructions of health promotion in their essays**

Before beginning their nursing studies, the students described health promotion largely through its manifestation. The essays revealed an adolescent outlook, but the health promotion of children and older people was also described. Health promotion was predominantly described through the students’ personal experiences, such as how they had promoted their own health and what they knew as clients of health promotion. Health promotion was manifested via four broad subcategories presented with examples in Table I: (1) health-promoting services, (2) healthy lifestyle, (3) health awareness and empowerment and (4) relationships. In the category of health-promoting services, education was an important service that mediated health knowledge. Health knowledge was transmitted through the media, at school, through health professionals, campaigns and projects. Nearly all students described health promotion in action within social and health services, such as prevention, nursing, rehabilitation, children’s day care, services for older people, children’s clinics, school health care, occupational health care and dental care. Some students mentioned the services of alternative medicine. They also described how health professionals carried out health promotion: observing, vaccinating, controlling, guiding, supporting and helping individuals. The services of a healthy society were connected with the environment, healthy building practices and housing, leisure time, and hobbies. Healthy lifestyle formed a broad category which was based on physical health promotion and individuals’ responsibility for their own health. The category of health awareness
Investigating student nurses’ constructions of health promotion

and empowerment was manifested in the area of emotional health, on the one hand, as self-knowledge and, on the other hand, as an ability to utilize health promotion services and to participate in making decisions on health issues. The students also mentioned having a critical attitude and paying attention early enough to prevent problems. In the category of relationships, the students described social and emotional health promotion from their own perspective. The integrated description is provided at the level of the main categories. The manifestation of health promotion was seen from two different points of view. It was individuals’ responsibility and action for their own health, for that of other people and the environment; and it was the society’s responsibility to look after its citizens. The connecting idea was responsibility at the individual level and at the societal level.

The aims of health promotion were seen as well-being or feeling good and the prevention of diseases; in lesser degrees, to holistically support and help or promote health knowledge. The aims of health promotion, at the level of the main categories, were positive health, concentrating on well-being, without mentioning diseases, and negative health, emphasizing the prevention of diseases. The connecting category was health, the ultimate aim of health promotion. The results of health promotion were well-being, less disease and fewer accidents, a healthier environment, and improved functioning and management of daily life. The students saw that, at the level of the main categories, a longer life and better quality of life were the results of health promotion.

The change of students’ health promotion constructions via stimulated recall interviews

In the following, the change of the students’ health promotion constructions will be described from two perspectives. First, the students’ reflections on the changes in their health promotion constructions, when comparing their thoughts to their essays from 1997, i.e. before they begun their nursing education. Second, comparing and validating conceptual change with the aid of the students’ reflections on their own videotaped health promotion practice in the clinical setting. The categories of the students’ health promotion constructions that were based on their reflected practice during the stimulated recall interviews are presented in Table II.

Reflecting on their essays, six students stated that their constructions of health promotion were unchanged while the remaining students identified changes in their constructions. Health promotion education, practical training, and changes in the students’ personal lives and their thinking and reflection had caused the changes. More specifically, the six students who reported no change stated that clinical training, especially on chronic nursing wards, had strengthened their initial views on the importance of holism, the patient-centered approach and rehabilitation in health promotion. A student who was training on a geriatric ward reflected during the interview:

I think it [construction] hasn’t changed, maybe it has become even stronger. That you should take the patient into account, that you shouldn’t make the same plan for everybody. Empowerment is what’s very important in our work. [Student 1, 1998]

Exploration of the qualitative aspects of the changes in the students’ health promotion constructions revealed four types of change.

Change from physical health promotion to emotional and social health promotion

During the interview, while reflecting on their essays, the students described how they had come to understand that health promotion was much more than mere physical health promotion. They saw it as more humane and holistic:

In this essay, I only thought that health is nothing more than physical health, that if you can run... But of course, this is different now that we studied it in school last autumn. Other elements of health have been added to the list. [Student 2, 1998]
The change from the physical to the emotional and social was observed also at the level of health promotion practice (see Table II). Interaction was the most frequently reflected element of health promotion practice by the student nurses. The students saw that health promotion included psychological aspects that influence the health and well-being of individuals. In particular, the students from Polytechnic B who were training with aged people on chronic wards emphasized the patient-centered approach, the health and wellness-oriented approach, where listening, talking and spending time together with patients were important. These students experienced the results of their actions as their patients’ feelings of emotional well-being, control and independence as described in Table II.

Abstract health promotion construction becoming more concrete and contextual

During the interviews, the students further defined the concepts that they had mentioned in their essays on a more general level. The clinical context and the students’ own experiences were important aspects in this type of change. During clinical training, concepts had become more concrete and they had been renamed, as in the following example. In her original essay, this student wrote:

“All the time we see around us vivid examples of sick people. These examples teach us to value our own health and, in addition, they strengthen the will to learn how to help the ‘sick’ people in order to improve their lives. [Student 16, 1997]

During the interview, in 1998, she stated that, initially, she thought that helping in nursing meant doing things for people and that she had subsequently realized otherwise:

Maybe I thought that helping means doing things for people but now my idea is more like how you can get people themselves to be inspired to take care of themselves and their health. Self-care. I have more time than the nurses here do and, in a way, I sometimes wanted to help too much. I didn’t understand that it wasn’t necessarily helpful any longer. Now I’ve had this insight. [Student 16, 1998]

In clinical training, this change was realized when students linked new and more specific concepts to health promotion. Participation, facilitation, negotiation and empowerment were the new concepts that the students who were practicing on geriatric wards used for describing their practice in the interview. The concept of health education was only realized during a single student’s videotaped medication counseling situation on a geriatric ward. The health education was traditional in nature. The student acted as a knowledgeable expert who instructed the patient and dominated the situation. The balanced interaction, typical of other settings on geriatric wards, was not functional in this health education context.

Construction of perfect and absolute health becoming more permissive and relative

In particular, clinical training provided a multidimensional perspective on health. Initially, the students rigidly separated disease and illness from health, thinking that health promotion was intended for ‘healthy’ people only:

In my essay the construction of health promotion meant striving for perfection in physical, emotional and social health. That definition came from my own health, from young people’s perspective. During clinical training, another picture was added. In the essay I wrote how to promote my own health, the point of view was health. Here, illness has been added to my construction. I’ve realized that health can be promoted even if one is ill. [Student 12, 1998]

In clinical practice, the change was observed when the students described how their absolute construction of health became relative. Complete health no longer was the sole aim of health promotion. Helping patients to manage on their own and the rehabilitation of patients became aims as well. Students from Polytechnic A who were training on acute wards saw health promotion more as a disease and intervention-oriented approach
which tended to focus on the physical health and diseases of patients, and which cast patients in the role of passive health promotion recipients. A student who was practicing on a surgical ward stated:

Health promotion. Only yesterday, another student and I were thinking together how all of this is health promotion. So then, we thought that, in the end, any kind of intervention, that’s health promotion. You investigate it and try to find answers, or find out about similar things. Health promotion, that’s when you get a high fever, then antibiotics to the rescue and here, anyway, it’s disease-centered health promotion, such as preventing disease and relieving pain, that’s it. It begins with the disease. [Student 14, 1998]

**Construction of health promotion as performing shifting towards being there for the patient**

In their essays, the students described health promotion largely as performance, as in various health promotion services. In clinical training interaction, intimacy and being there for the patient became important elements of health promotion:

Well, in my essay I concentrated quite a lot on action but now I think this has begun to change. [Student 15, 1998]

This change became apparent especially practicing on chronic nursing wards. Listening to and talking with patients was not easy to accomplish on these wards. The staff, as well as the students themselves, thought that talking was not real nursing work and the students in this study had qualms about spending too much time talking with patients:

Yesterday I got stuck with my own patient here and then I still went to another room and that took me all afternoon. Then I got a feeling that I had to go and do something. But if you are a student, at least someone then has a little bit of time to listen. So, you don’t have to keep thinking that you have to be doing something all the time. [Student 5, 1998]

### Discussion and implications

The findings of this study indicate that student nurses build their constructions of health promotion, such as health nursing or empowerment approaches to health promotion (Macleod Clark, 1993; Tones, 1996; Latter, 1998b; McDonald, 1998). In addition to the formal education and curriculum delivery, there are myriads of factors, e.g. the hidden curriculum, clinical culture, staff attitudes, peers and the media, that might have influenced the students’ health promotion learning. The fact that clinical placements share, in writing, a common philosophy of care that establishes the patient-centered approach and endorses the values of health promotion seems to help the students to adopt the constructions of the empowerment approach to health promotion. Latter’s (Latter, 1998b) research also supports this interpretation. The value of clinical placements and the contextual factors that facilitate or constrain the development of a broad construction of health promotion was confirmed. The students modified their health promotion approaches and adapted them to the clinical setting where they were practicing. On the other hand, the students who were training on acute wards and exposed to the traditional role models of health promotion were confused about the meaning of health promotion, as were the students in the study of Macleod Clark and Maben (Macleod Clark and Maben, 1998). The health promotion concept that was taught in the polytechnics was a broad and abstract one, at the structural level of society rather than a part of individual nurses’ daily work. In this study, the students’ constructions of health promotion mostly referred to the level of minimal understanding. They could apply the principles of health promotion in some situations but failed to apply these ideas in more complex situations, e.g. on surgical wards or in health education. Some implications are presented here for promoting a fuller understanding, or accommodation (Strike and Posner, 1985), in health promotion during nursing education. The complex concept of health promotion needs to be supported with more discussion and contextual redefinition.
in different health care settings during nursing education and, especially, during clinical training. It is also a challenge to educators to critically evaluate how clinical placements can help students to develop a broad role of health promotion during nursing education.

Facilitation of a deeper and broader understanding of health promotion by students will be the challenge of nursing education in the future. Reflection is a crucial tool for the process of meaning building in health promotion. Teachers, mentors, and peers need to participate in the discussion. Reflection as a method helps students to think critically and avoid uncritical model learning in clinical placements. It can also help student nurses and nurses to empower themselves (Williams, 1995). Latter (Latter, 1998b) has argued that nurses need to be empowered themselves in order to empower others. Empowered nurses might also adopt a broader health promotion role, including social and political action and working at the structural level of health promotion. Johns’ (Johns, 1994) model of structured reflection can be used as a frame of reference to reflect on current practice in order to build a broader understanding of health promotion in different contexts.

This study illustrates how student nurses’ understanding of health promotion developed during their first year of nursing education. The four types of change in the students’ health promotion constructions, identified at the level of propositional knowledge, are congruent with the common sense findings of the students when they reflected on their own videotaped health promotion practice. When the results are interpreted on the basis of conceptual change theory (Chi et al., 1994; Vosniadou, 1994; Tynjälä, 1999), it can be seen that enrichment occurred as the students added new concepts, and redefined and specified the concepts that explain health promotion (changes 1 and 2 in the data). Revision was evident when the students produced, during the interviews, new relational frameworks parallel to their previous ones (changes 3 and 4 in the data). The results indicate that the conceptual changes that were discovered in this study took place at least on four of the levels that Tynjälä (Tynjälä, 1999) demonstrated in her study. Changes on the semantic level were demonstrated by how students learnt new concepts and new meanings for old concepts, e.g. by shifting ‘helping’ towards ‘facilitation of self-care’. Changes in the relationships between concepts were manifested when the students integrated the concepts of physical, emotional, spiritual, ecological, and social health, which had earlier been separate. Shifts between ontological categories occurred when the students understood health promotion not only as performing but also as being there for the patient. Changes at the level of framework theory might be indicated by the transition from the framework of the students’ personal health promotion to that of professional health promotion. Likewise, the shift from a narrow model of disease prevention to a more complex and multidimensional approach to health promotion was identified.

The basic assumptions of constructivism underlie the development of health promotion knowledge: relativistic ontology, subjectivistic epistemology and a naturalistic set of methodological procedures (Denzin and Lincoln, 1994). From that perspective, using reflection and stimulated recall interviews was a highly appropriate method for investigating changes in students’ health promotion constructions. The understanding of health promotion that the student nurses created in interview settings was a social construction built through reflection and dialogue. On the one hand, the method made it possible to study health promotion from the point of view of interacting individuals in the real world. On the other hand, the method was time consuming and hard on the researchers. The validation of the results depends on pragmatic validation where ‘actions speak louder than words’ (Kvale, 1996). In this study, the effectiveness of the knowledge was demonstrated by the effectiveness of the related actions when the student nurses reflected on how health promotion was manifested in their thinking and practice. Reliability refers to the consistency of the findings (Kvale, 1996). Reliability was ensured in this study throughout the research process. Two
pilot interviews were conducted and videotaped. Videotaping the health promotion situations improved recall during the interviews and made the actions explicit while discouraging stock explanations. The recall sessions, conducted immediately after the videotaping, reinforced recall of the videotaped health promotion situations. The transcripts were done verbatim and checked separately by two persons. Triangulation of the data, through acquiring data that consisted of essays and interviews, enhanced the credibility of the findings. The accuracy of the data interpretation was ensured by investigator triangulation [(Polit and Hungler, 1995), p. 527] with debriefing sessions in which the themes and categories were reviewed by three researchers.

The interpretation of the results was contextual. For the two student groups, their clinical training was a part of a nursing skills course, which may have led the students to opt for numerous interventions. Yet, health promotion objectives were embedded in the goals of their more general professional studies. The students in this study were in the initial stages of their education, and many of them felt that they did not yet have enough knowledge and skills to teach patients. Teaching and counseling patients seemed quite difficult for the students. We concur with McDonald (McDonald, 1998) who suggests that teaching clients should be more clearly incorporated in the health promotion and education component of nursing curricula.

In this study, we analyzed the data on a small number of students (n = 19) in two Finnish polytechnics, gathered twice at the beginning of their education. We may, nevertheless, assume that these results provide information for developing health promotion teaching within nursing education. The challenge in the future is to support the students in constructing their own views of health promotion and the broad roles of new health promoters demanded in the 21st century (WHO, 1999). This goal requires systematic investigation and organization of health promotion knowledge in curricula (Sjögren et al., 1999), educating the staff of clinical placements in order to broaden their current health promotion approach, clarifying and contextualizing the concept of health promotion in various health care settings, and training the skills needed in health promotion by using reflective methods, which can teach students to evaluate and learn from practice.

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