

## **L'importance du *lieu* dans le secteur des soins infirmiers communautaires**

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Quand un emplacement géographique acquiert un sens, il devient un lieu. Les auteures examinent l'importance de ce constat du point de vue de la géographie et de l'expérience vécue. Elles étendent le concept actuel de géographie des soins infirmiers aux soins infirmiers communautaires, s'intéressant aux complexités de cette sphère d'exercice et à des travaux de recherche souvent passés inaperçus. Elles explorent la notion de lieu au sein du foyer et de la collectivité, touchant aux dimensions structurelles et spatiales qui définissent la relation thérapeutique. Les auteures recensent les travaux en géographie de la santé et proposent une analyse de leurs implications pour la pratique et la recherche en santé communautaire. Elles invitent les infirmières de ce secteur à se pencher sur ces questions en s'attardant à des dimensions comme le pouvoir de l'infirmière, le rôle des lieux marginalisés comme déterminant de la santé et les meilleures approches en matière de soins destinés aux clients de milieux sociaux diversifiés.

Mots clés : géographie de la santé, géographie des soins infirmiers, lieu, soins infirmiers communautaires, relation thérapeutique

# Considering *Place* in Community Health Nursing

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When a geographic location is assigned meaning, it becomes a *place*. The authors argue that place matters as both geographical location and lived experience. They extend the current conceptualization of nursing geography to encompass community health nursing and address intricacies of community nursing practice and research that often go unnoticed. They do so by exploring the notion of *place* in home and community, including the structural/spatial dimensions of the nurse–client relationship. The authors review the health geography literatures, then discuss the implications for practice and research in community health. They invite community health nurses to critically examine their practice and research with reference to such issues as the power of the nurse, marginalized places as determinants of health, and how best to care for clients living in diverse community settings.

Keywords: health geography, nursing geography, place, community nursing, nurse–client relationships, therapeutic landscapes, post-asylum geography

The discipline of geography has moved beyond mapping the physical earth to include social, cultural, historic, political, economic, and physical features that together create the context of human life (Cutchin, 2005). While nursing researchers have given much attention to the effects of environment on health, they have paid less attention to the places where nurse–client relationships exist and how those places shape such relationships. This article originated in conversations among the three of us as doctoral students with an interest in space and place in community nursing. We hope it will raise awareness about the complexity of relationships in community nursing practice, an area steeped in geographical implications. In terms of the dynamics between nurses and clients in community work, we argue that place matters — as geographical location and lived experience, as demarcation of space, and as site of meaning creation. Like a growing number of nursing scholars, we believe that nursing research and practice benefit from a thoughtful examination of health geography, a sub-discipline of geography. Our understanding of place in nursing has been shaped by the work of several authors, most notably Gavin Andrews (2002, 2003a, 2003b, 2004) and Joan Liaschenko (1994, 1997, 2001) and their call for an exploration of how nursing affects, and is affected by, the spaces and places in which care is provided.

Andrews and Liaschenko shed particular light on the notions of location, environment, and the moral geography of nursing.

Our aim in this article is to extend the ideas presented in nursing geography to community health nursing. We believe that when nurses think and talk about how they navigate actual geographic places, they are articulating an aspect of community practice that is important to the nature of the work but often goes unnoticed in health-care discourses. Specifically, we suggest that health geography can be used to critically examine community nursing research and practice. Such a perspective can highlight issues of marginalization and vulnerability not only in how clients belong (or are assigned) to certain diagnostic, economic, racialized, or gendered groups, but also in the places of community practice. It can also highlight issues of power and proximity in the nurse-client relationship.

We present our argument in two sections: a brief review of the health geography literature, and considerations for community health nursing provoked by the review.

### **A Brief Review of the Health Geography Literature**

The philosopher Edward Casey (2001) sets *place* apart from *space*, arguing that each addresses a different aspect of our spatial lives. He suggests that space is disembodied and abstract while place is a bodily orientation, yet both are inseparably related and ever shifting. Casey (1993) suggests that “there is no being except being in place. Put the other way around, there is no utterly placeless existing...” (p. 313). With this concept in mind, in this article we adopt the following definition of place: “an operational ‘living’ construct which ‘matters’ as opposed to being a passive ‘container’ in which things are simply recorded” (Kearns & Moon, 2002, p. 609). A geographical location matters when people attach meaning to it through their own understandings and experiences, their own social, cultural, and economic circumstances. Different people coming together in the same place at the same time will experience the place in distinct ways, and the same person can experience a place differently at different points in time.

A closer look at places reveals things about them. Physical structures suggest underlying social structures and other invisible divisions. For example, well-maintained houses may be associated with wealth and cramped, rundown houses with poverty. However, in many cases the physical structure reveals little about the place or may lead one to draw inaccurate conclusions; for example, a person’s place of residence may not be what she or he considers home. Hence, places shape social meanings and social meanings, in part, shape places.

Health geography has emerged as an area of human geography, a sub-discipline that critiques traditional notions of geography as purely objective spatial science. Health geographers study people and places in relation to health issues. They explicitly address people *in place*, calling on the philosophical traditions of phenomenology, symbolic interactionism, and existentialism (Andrews, 2003a). They use two particular approaches to human geography: the humanist focus on individual agency in the experience of place, and the cultural focus, which examines cultural impacts on the construction of places, and, conversely, the creation of culture by places. Out of these traditions emerge questions about people's sense of place and placelessness, or the feeling of being out of place, and the structural (social, political, and economic) aspects of place (Andrews, 2004) — all of which influence health.

Next we will briefly review four subsets of health geography: infectious disease, therapeutic landscapes, post-asylum, and nursing. All of these geographic perspectives are valuable in thinking about community health nursing, particularly health-related meanings of the places in which we community nurses work and how we occupy these places with our clients.

### ***Infectious Disease Geography***

Health geography, historically known as medical geography, initially focused on infectious disease (Andrews, 2002). This primarily epidemiological concern for the mapping of disease still dominates common understandings of public health (Andrews, 2004; Frohlich, Corin, & Potvin, 2001; Rosenberg, 1998). Public health, as one avenue of community health, has origins in the connecting of geographical characteristics to disease outcomes, using prevalence and incidence rates to generate knowledge about the distribution and determinants of disease across populations in order to identify and isolate risk factors (Frohlich et al., 2001). One such disease is HIV/AIDS, which is generally studied according to rates of spread by location, underlying causes, modes of diffusion, including behaviours of risk groups, and socio-economic conditions of the locations where risk-taking occurs (Andrews, 2004; Rosenberg, 1998). Accounts of HIV infection have tended to omit the influence of cultural aspects of places on people's health choices and, conversely, the influence of individuals' choices on social and cultural norms regarding HIV. This is an important consideration given that, as pointed out by Gesler (1992), both physical environment and culture are integral dimensions of health.

The stigma of contagiousness is one social dimension of infections that has influenced their management and treatment. Examples of stig-

matized illnesses are leprosy, the plague, cholera (Gesler, 1992), and tuberculosis (Draus, 2004). Considerations of place are implicated in the goal of protecting society from such diseases. Isolation, quarantine, and colonization occur through the construction of places such as hospitals, sanatoriums, and asylums in order to contain the disease as well as its victims. People deemed “diseased” are removed from everyday life so that society is safeguarded and can continue to function (Gesler, 1992). However, these means of protecting society can serve to stigmatize those who have been removed from it.

### ***Therapeutic Landscapes***

Health geographers’ exploration of therapeutic landscapes — landscapes associated with treatment or healing (Gesler, 1992) — parallels nursing scholars’ concern for environment as one of the metaparadigms of nursing (Thorne et al., 1998). Both the natural world, such as the countryside or mineral springs, and the built environment, including the design of buildings and rooms (Gesler, 1992), have been studied in this sub-discipline of geography, not only as physical settings but as places with supposedly therapeutic effects on the people in them. The concept of therapeutic landscape suggests that places can be part of the healing process (Gesler, 1992). However, geographic landscapes may not be intrinsically therapeutic (Conradson, 2005). Although there may be landscapes of treatment, healing, or even respite, the notion of *therapeutic* remains subjective; that is, inhabitants’ experiences of and interactions with a place must be considered, and in this sense landscape has a subjective as well as a relational outcome (Conradson, 2005; Gastaldo, Khanlou, & Andrews, 2004).

Beyond the *therapeutic* landscape, there are ordinary, everyday places that contribute to or detract from healthy living (Andrews & Kearns, 2005; Wilson, 2003). For example, Wakefield and McMullan (2005) present a case study of Hamilton, Ontario, a steel-manufacturing city, as an everyday geography. They point out that while there are places that are typically understood as healthy, there are also those that are deemed unhealthy, unpopular, on the margins of society, and therefore stigmatized, and that these places also affect one’s well-being.

Therapeutic landscapes have power, and so does the published research about them. This research tends to be conducted in Western countries and based on biomedical understandings of health (Gesler, 1992) that have ethnic and racialized underpinnings (Delaney, 2002; Wilson, 2003). Furthermore, therapeutic landscape research tends to be focused on extraordinary events in people’s lives (e.g., visiting a spa or

summer camp), to the exclusion of everyday geographies and non-Western conceptualizations of place (Wilson, 2003). Wilson's study of the relationship of Aboriginal people with the land addresses this gap, highlighting the complex link between the land and health and between the spiritual and social aspects of place.

### ***Post-Asylum Geography***

Gone are the days of the asylum in the sense of problematic long-term mass housing and custodial care of people with mental illness. In its long shadow has come a movement towards deinstitutionalization, a phenomenon marked by a significant shift of psychiatric care from the hospital to the community (Dear & Wolch, 1987; Philo, 2000). This is the focus of inquiry for post-asylum geographers, who examine places other than hospitals as settings for mental health care. Questions addressed can include how those living with mental health problems occupy places; how they are sheltered, cared for, and assisted in such "post-asylum" locations (Philo). Pinfold (2000), for example, looks at how deinstitutionalized groups are supported in the community; she explores the roles, positions, and therapeutic benefits resulting from "socio-spatial networking in the community" (p. 201). The places inhabited and described by Pinfold's research participants tend to be marginalized — places that keep them separated from society even outside of the hospital's physical walls.

### ***Nursing Geography***

The growing body of what is characterized as *nursing geography* literature informs our understanding of the interplay between nursing, space, and place (Andrews, 2004; Carolan, Andrews, & Hodnett, 2006). In the general nursing literature, the term *place* is ambiguous. It is often used metaphorically, but metaphors for place do not incorporate geographic elements (Andrews & Moon, 2005). In nursing geography, place and space constitute and are constituted by the everyday world of nursing, and there are multiple ways in which questions of place and space are taken up in nursing scholarship: the importance of health-care settings and how they are socially constructed; the relationship between moral agency and place in nursing care; and the spatial dynamics between nurses and their clients in the health-care places of hospital and, to some extent, home (Andrews, 2003a; Ekman, Skott, & Norberg, 2001; Liaschenko, 1997, 2000; Malone, 2003; Peter, 2002). Carolan et al. (2006) identify the nurse-client relationship as an important element in nursing geography in terms of the healing nature of places, questions of situatedness, and nurses' social location in the context of gender and power.

### **Community Health Nursing and Place**

The areas of health geography reviewed above have particular relevance for community health nursing. The infectious disease perspective calls to mind the work of present-day TB nurses, who provide care in a range of physical locations such as homes, workplaces, coffee shops, parks, and shelters. Although they no longer work in sanatoriums, the obligation to protect society from infectious disease remains central to their practice. This obligation is complicated by the need to navigate multiple places of care.

The concept of therapeutic landscape fits well into discussions of the concept of community. We may ask, for example, how a sense of community affects clients' healing processes. Critiques in this area of health geography that move away from "therapeutic" language are also useful. "Street nursing," a sub-specialty of community nursing, is one example of a practice in which nurses and their clients occupy everyday geographies that are unpopular, considered unhealthy, and stigmatized by their association with homelessness and poverty. Additionally, community nurses often provide care to Aboriginal and other racialized people, and are therefore challenged to understand multiple cultural meanings of the relationship between health and place, beyond Western notions of what is therapeutic.

Debates surrounding post-institutional mental health care in post-asylum geography resemble those found in community health. For example, the social-structural concerns in mental health care centre on risk assessment, coercion versus civil liberties, resource limitations, and development of appropriate supports throughout the course of illness and health (Pinfold, 2000). These concerns are shared by nurses working in other areas of community health such as communicable diseases or healthy-baby programs. In writing about community health nursing, Chalmers, Bramadat, and Andrusyszyn (1998) argue that simply moving clients from hospitals to community settings does little to address health needs unless the structure of the health-care system becomes more community-focused. Post-asylum geographers raise questions about not only the places where care is provided but how those places shape care. Moreover, post-asylum geographers highlight the troublesome question of place for community nurses who work with marginalized people in marginalized places.

Ideas from nursing geography are explored here with particular attention to place, space, and the nurse-client relationship in community work. Community health nursing takes various forms: home care, public health, outpost, street, or parish nursing. Differences in location of care and clientele define the type of care provided within these forms, and the

nurse-client relationship varies across a range of job descriptions, tasks, and program mandates. The Canadian Home Care Association (2003) defines home care as a range of services that help clients to live at home and that often prevent, delay, or substitute for hospital care. Public health nursing is distinct from home care in that it is directed towards population-health promotion in “diverse settings...and with diverse partners, to meet the health needs of specific populations” (Community Health Nurses Association of Canada, 2003, p. 3). While home care and public health nursing, along with other nursing specialties, are organizationally distinct, their values and care situations often overlap. Community nurses integrate personal and clinical understandings of people’s health and illness into their care. Care begins with the general assumption that the nurse is a guest in the client’s place, whereas the hospital is often perceived, by both health professionals and clients, as the health professional’s place. Home is “a place offering a wider view of the patient’s life, disease, illness and suffering” (Liaschenko, 1997, p. 50). It is a private place, a haven of physical and emotional well-being that shelters individuals from public scrutiny and surveillance, a place from which they can prohibit unwanted outsiders. Even in situations where home is a site of fear, abuse, exploitation, and/or isolation, it is understood by many as a personal and private domain.

Nurses’ work in the home is usually organized by, and in the direct interest of, the client, not the nurse. Yet once the nurse enters, the home’s privacy is challenged and the client’s ability to restrict public surveillance is compromised. Clients may feel uncomfortable acquiescing to a stranger, albeit a professional one, in their homes. Likewise, the nurse’s sense of a controlled workspace is altered, along with her/his sense of power, authority, and control. This altering of positions serves to blur the boundaries between the personal and the professional and therefore can create spaces that engender more egalitarian partnerships between nurses and their clients (McGarry, 2003; Peter, 2002; Spiers, 2002). Liaschenko (1994) makes three points about nurse-client relationships in the home that allude to this personal/professional blurring: nurses have the authority to perform regulated acts in places other than the hospital, the nurse’s role in the home involves surveillance, and the private versus public spaces of the home must be considered.

Care in community health nursing is not restricted to the home but also occurs in places such as schools, community centres, and drop-in clinics. Unlike hospital and home-care nurses, community health nurses observe and engage with people in the broader community context of their daily lives. *Context* implies not only the physical setting but also social, political, and cultural settings that entail moral ambiguities and responsibilities for nurses. For example, a community’s physical bound-



aries are usually defined for a specific public purpose, often to separate one subpopulation from another. Areas of different social, economic, and ethnic groups often have more subtle boundaries, expressed colloquially as “the other side of the tracks,” “a neighbourhood too rich for my blood,” “gay village,” “subsidized housing,” “inner city,” “Chinatown,” or “Little Italy.” Such labels often determine how the inhabitants of an area are perceived and judged. Nurses working in these neighbourhoods may see their clients through these generalized and often stigmatizing labels. Certainly these dimensions of place complicate the nature and quality of nurse–client relationships in community settings, relationships in which nurses must deal with issues of stigma and prejudice about their clients as well as the location of their care, and even themselves. We believe that addressing such problematic attitudes about marginalized people *and places* is part of the responsibility of community nurses.

The discourse on community health nursing has popularized the notion of community as a “plurality of persons” (Smith–Campbell, 1999) rather than a physical setting. In the concept of community-as-client, the whole community, rather than individuals, is seen as the recipient of care. Community-as-client has been used as a theoretical framework for studies of caring in public health (Rafael, 2000; Smith–Campbell, 1999), nurses’ perceptions of their work (Reutter & Ford, 1996), and client competence and empowerment (Courtney, Ballard, Fauver, Gariota, & Holland, 1996; Reutter & Ford, 1996). Community-as-client, however, has not gone without critical analysis. Attributing client characteristics to a community serves to remove the physical geography of communities from theory, although it remains a pragmatic aspect of practice. St. John (1998) found that community-as-client may not be useful for community nurses. Her research participants did not describe the community as an entity receiving nursing care; they used the language of geography, networking, resources, and target groups, most often describing community as a place. Schroeder and Gadow (2002) reached similar conclusions; they point out that community-as-client ignores obvious, significant differences between an individual and a community. Community-as-client has been pivotal in reorienting community nursing practice towards the broader social-determinants-of-health perspective. But abandoning the geographic aspects of community may contribute to a homogenized view of clients, where they are grouped into general categories such as “high risk,” which often have negative connotations. In viewing community as a geographical setting, we seek to understand the nurse–client relationships that exist therein and the ethical questions that arise out of such relationships.

Non-institutional places of care affect the moral agency of the individuals involved — from nurses and clients to family members and other health-care workers — in similar yet distinct ways. Liaschenko (1994,

2000) invokes ethical issues of place and space in her articulation of the moral geography of home care, which refers to the nature and quality of the nurse-client relationship in sustaining clients in the setting of their choice, such as the home. Whether it be hospital, home, or other location, the place itself can enhance or diminish the power of the individual (Peter, 2002), which in turn can positively or negatively affect the care provided. McGarry (2003) discusses the balancing of power between nurse and client, which can be partially understood by viewing the nurse as a guest in the client's home. In McGarry's study of community nursing, the location, as well as the longevity and structure of relationships, was a source of both satisfaction and tension for nurses. This raises the question of how close to or distant from (both spatial conditions) one another nurses and clients feel.

The spatio-structural dimensions of nursing relationships have been explored, implicating them as a kind of geography in themselves. Liaschenko's (1997) and Malone's (2003) moral explorations of nursing relationships focus on how spatial and structural concerns affect nurses' proximity to their clients. According to Liaschenko, the nurse-client relationship is inherently spatial, because it comprises the relative physical, social, and psycho-emotional positions of nurse and client and the practical circumstances that bring them together. Liaschenko points out that relationships have local/intimate as well as global/structural dimensions. The former involve the nurse and client in close proximity, while the latter are the social, cultural, and political aspects of a place that bear on the moral work of nurses.

Malone (2003) expands on Liaschenko's ideas by explicating proximal and distal nursing. She conceptualizes proximity as "nested proximities" — physical, narrative, and moral. Physical proximity is direct bodily contact between nurse and client and is the nest for narrative proximity, which involves the nurse listening to the client's story, engaging with the client as a person beyond the illness. Finally, moral proximity is nested within both physical and narrative proximity: being physically and narratively close to clients, nurses are in the moral position of bearing witness to distress and suffering. Malone proposes that it is more difficult to stay close to patients in hospitals; nurses are forced, by structural factors such as staff shortages and lack of time, to practise distal nursing. In fact, the practice of proximal nursing in hospitals becomes "a powerful form of spatial resistance" (p. 2324) that emphasizes the relational and context-bound situations of nursing care. Similar structural factors exist in organizations such as home-care agencies, community care access centres, and public health departments. Community nurses, too, may be pushed into distal nursing by structural factors such as the staffing policies of

community organizations, regardless of their close personal involvement with clients in the private setting of the home.

As Malpas (2003) points out, however, proximity does not disappear with distance; rather, the character of proximity shifts. Nurses adjust psychologically and emotionally according to the physical and social structures within which they work and within which their clients live. Nurses may create distance while remaining physically close to their community clients. This can happen when they witness inequity, oppression, poverty, abuse, or discrimination or where the setting of care causes anxiety about their personal safety. As Peter and Liaschenko (2004) explain, “nurses may want to flee [from such situations], but their place in the system, both geographically and politically, prevents it” (p. 222). Proximity and distance are, thus, subjectively experienced by both nurse and client. Nurses and clients must negotiate proximity, particularly in home and community settings, as part of the nurse–client relationship. This negotiation requires that nurses and clients make choices about their closeness to one another, which may become problematic when examined with an awareness of place.

Purkis (1996) points out that when we move about in places we “read possibilities into space” (p. 109). She expands on the notion of proximity by suggesting that nurses choose how close to or distant from clients they will be. Their choices are based on who their clients are, their unique life circumstances, the specific health situation, and the geographical, sociopolitical, and cultural places in which nursing is carried out. The choices call for self-awareness, self-knowledge, an ability to set boundaries, and empathic understanding. Choices regarding proximity are part of nurses’ obligation to continually re-examine their power as professionals.

### **Implications and Conclusions**

Viewing *place* through the various geographical lenses we have presented raises ethical questions for community health nursing practice and research. We now offer three general reflections about such questions. First, unpopular and unhealthy community places in which care and everyday life happen raise concerns of social justice. Second, the social and cultural location of nurses as professionals, practitioners, and researchers raises questions of power. Third, community nurses can increase their awareness of their choices about proximity to clients and ask themselves whether they are practising proximal or distal nursing, through critical self, peer, and supervisory reflection and feedback.

Place is not neutral, and it must be considered in community practice and research. We invite nurses to critically examine issues such as the

power of the nurse, marginalization and oppression as profound determinants of health, and how best to care for those experiencing such conditions or how best to include them in research studies. This examination begins with the unpacking of assumptions about the places in which we work and the ways in which we take our power for granted in our relationships with clients. It includes a consideration of the places and conditions of people's lives and how we engage with them in these places. Community nursing means thinking about how place matters in our clients' lives and asking them, perhaps directly, about the meanings that particular places hold for them. It involves a questioning of our understanding of notions such as *guest* and reflecting on our presence in our clients' places. Are we simply guests in clients' homes? How do we overtly and subtly exercise our authority as we make decisions in clients' homes? How do the places in which we find ourselves working affect our choices about how close we get to clients? Do our choices about proximity contribute to healing and well-being, or do they inadvertently reinforce clients' feelings of displacement?

Peter and Liaschenko (2004) argue that nurses cannot sustain proximity without adequate resources and good working conditions. What community resources and working conditions support nurses' critical reflection on their proximity to complex and often troubling client situations? Peter and Liaschenko suggest that dialogue, a way for nurses to theorize their practice, is one avenue for such reflection and that it ought to occur among nurses, administrators, and policy-makers so that discussions of nurse-client proximity take place at all levels. How might community health organizations foster and promote this dialogue?

As nursing geography continues to develop, we need more research that explicitly addresses place and its relationship to community nursing. Such research ought to begin with the explicit assumption that place is not neutral, particularly in community work. We need not only research *on* places, but also research *in* places, in order to incorporate more interpretive, embodied understandings of place in the community setting of nursing care (Parr, 1998). This includes a critical examination of nursing relationships (including researcher-participant relationships) *with* and *in* places.

By reflecting on community nursing *in* place, we will view our relationships as care providers and researchers in new ways. Nurses can tend to become comfortable with and complacent about our benevolent power. We like to think that we are good listeners who respect boundaries, that we are compassionate and caring people who communicate effectively. However, through such complacency we may inadvertently be resigning ourselves to distal nursing. By examining the places of our rela-

tionships with clients, we are forced to also examine our participation in them. We need to become aware of our prejudices about the places in which we work, of the value judgements we make about, for example, supposedly high-risk neighbourhoods or the cleanliness, noisiness, comfort, and even tidiness of our clients' homes. It is our responsibility, as practitioners and researchers, to be aware of aspects of place and how they may play out in the situations and concerns of each of our clients or research participants.

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## *Considering Place in Community Health Nursing*

2009 update: *Amy Bender is to undertake postdoctoral work addressing the intersections of infectious diseases, mental health, and global health, while continuing to teach in the Faculty of Nursing, University of Toronto. Laurie Clune is Professor, Daphne Cockwell School of Nursing, Ryerson University, and is set to begin postdoctoral work at the Institute for Work and Health, Toronto. Sepali Gurige is Associate Professor and CIHR New Investigator, Daphne Cockwell School of Nursing; her research focuses on immigrant women's health and violence against women throughout the migration process.*