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The existing intersection of social justice and nursing

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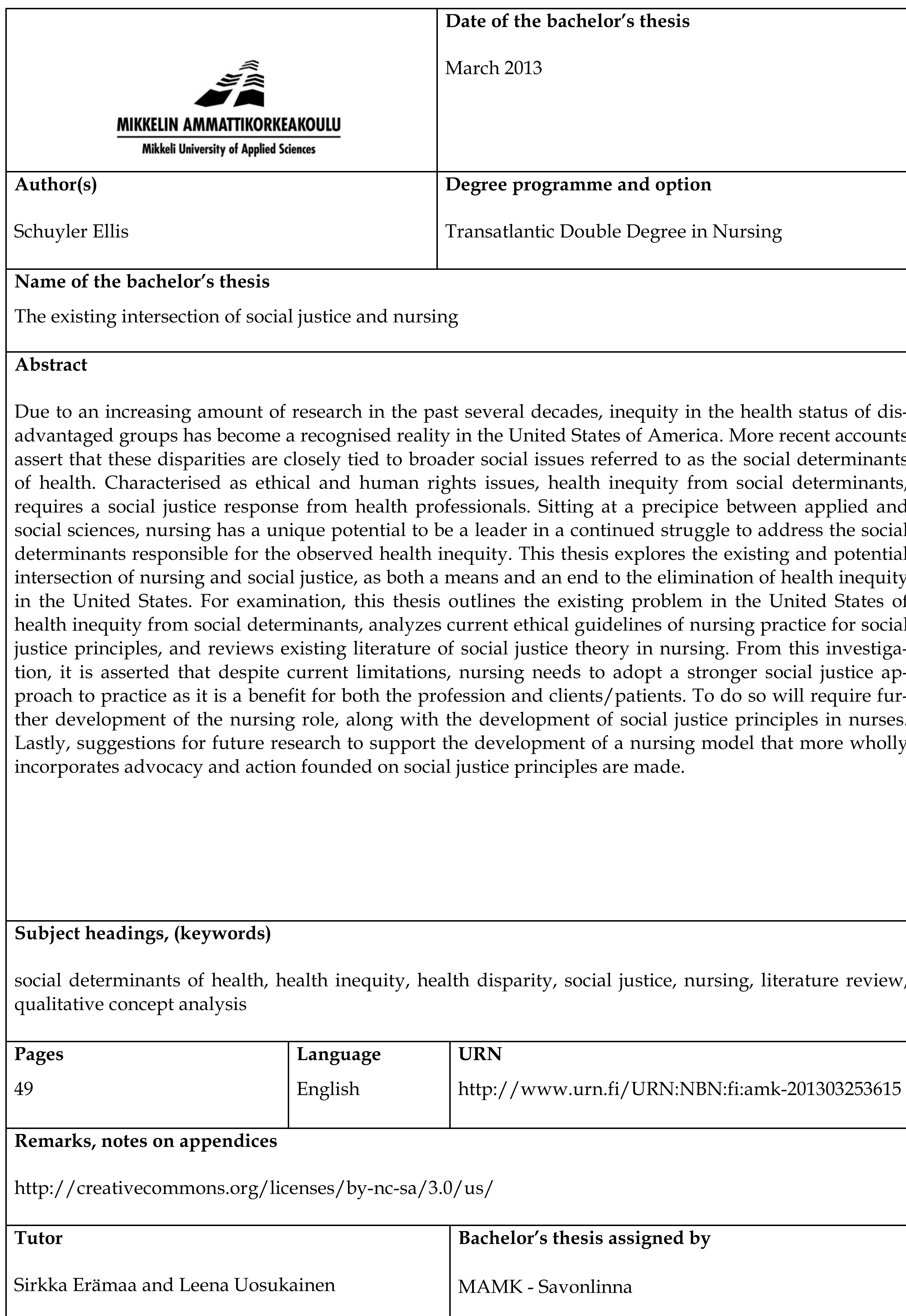

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Abstract

Due to an increasing amount of research in the past several decades, inequity in the health status of disadvantaged groups has become a recognised reality in the United States of America. More recent accounts assert that these disparities are closely tied to broader social issues referred to as the social determinants of health. Characterised as ethical and human rights issues, health inequity from social determinants, requires a social justice response from health professionals. Sitting at a precipice between applied and social sciences, nursing has a unique potential to be a leader in a continued struggle to address the social determinants responsible for the observed health inequity. This thesis explores the existing and potential intersection of nursing and social justice, as both a means and an end to the elimination of health inequity in the United States. For examination, this thesis outlines the existing problem in the United States of health inequity from social determinants, analyzes current ethical guidelines of nursing practice for social justice principles, and reviews existing literature of social justice theory in nursing. From this investigation, it is asserted that despite current limitations, nursing needs to adopt a stronger social justice approach to practice as it is a benefit for both the profession and clients/patients. To do so will require further development of the nursing role, along with the development of social justice principles in nurses. Lastly, suggestions for future research to support the development of a nursing model that more wholly incorporates advocacy and action founded on social justice principles are made.

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social determinants of health, health inequity, health disparity, social justice, nursing, literature review, qualitative concept analysis

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1 INTRODUCTION

The purpose of this thesis is to understand the current and potential intersections of social justice practice and theory in the nursing profession. Influenced by recent experiences in nursing and past experiences in social justice movements, this document serves as a reference of my own personal development during my time studying and training in Savonlinna, Finland.

In August of 2012, I arrived in Finland as part of an international partnership in nursing education. The Trans-Atlantic Double Degree (TADD) program offered through four universities in the United States and Europe seeks to broaden nursing students international experience by giving them the opportunity to study in two additional countries outside of their home school, one for a long-stay (6 to 9 months) and one for a short-stay (3 months). The students that participate must complete the required course work from both their home university and the long-stay university abroad in order to receive a degree from both schools. Out of the options presented to me, I chose Finland for my long-stay country.

During the beginning of my studies in Finland, I was required to take a class entitled Global Health/Community Health Nursing and International Competence. It was in this class that I was exposed to ways one can take nursing out of the clinic and into the streets. The first half of the course focused on community nursing theory from a book. We were taught to assess community systems as a whole, to look for deficiencies and opportunities in a community that can have an effect on an individual's health status, and to combine our practical nursing knowledge with a community knowledge to develop action plans for patients. In addition to the class time, we completed a practical training period in which we shadowed Finnish Public Health/Community Nurses (PHN) in both the clinic and the field. Paired with several different nurses during this training, I saw an approach to health care different than what I had seen before. Finnish PHN's seemed to have more freedom (and more responsibility) than other nurses I had encountered. In some ways they worked more like primary care physicians directing patients on how to be and stay healthy, rather than simply responding post diagnosis to illness. The focus is preventative and holistic.

After studying the theory, and observing the Finnish PHN's the wheels started spinning. I began to wonder if a similar system could work in the United States. If so, what would it look like? More importantly, would such a system actually address the inequalities I had observed in the United States? Looking for answers to these questions, I began to notice other parts to the Finnish system that were lacking in the United States - namely a gigantic social safety net that caught many of those falling through the cracks. With this recognition, and given the current political climate in the United States (neoliberalism), I turned away from the Finnish PHN system as a solution, but not before recognizing Finland's belief in the collective Other - the idea being that the whole of society is only as strong as it's weakest member.

With this realization, the wheels continued to turn and I my focus shifted toward the intersection of nursing and social justice. New questions emerged, can nursing in the USA use social justice theory in practice? If so, what does that look like? How is it applied and what are its benefits? Does health care extend beyond the clinic and medicine to other social structures?

As I sought out answers to these questions, I began to envision a nursing model that combines Public Health/Community nursing with social justice community organizing. This model would sit at the precipice between social and applied sciences seeking to erase health care disparities not by only treating individuals, but by treating communities as a whole. This model would not only focus on physical determinants of health but social determinants, as well. Founded on the belief that there is a connection between socioeconomic inequality and health inequality, this model would place nurses in the roles of health care worker and community activist. Their new fight would be against poverty, racism and sexism while continuing the battle against diabetes, cancer, and heart disease.

It is from this vision that the following thesis was born.

2 MISSION OF THESIS

Although the impetus of this thesis was a vision to create a nursing model combining nursing and social justice community organizing, certain constraints limited that op-

portunity - mainly, time and location. In consideration that the thesis is being prepared in a limited time frame for a study abroad program in Finland, it was decided that rather than embark on the creation of a model, it is best to initially investigate the themes and concepts that could feed future creation of such a model. Additionally, my current location in Finland, wrought with a language barrier, would prevent the testing of such a model or any suggestions for its creation.

Thus, using a framework of social determinants of health, this thesis explores the existing intersection of nursing and social justice - specifically as both a means and an end to the elimination of health inequity and the creation of health parity in the United States. To adequately examine this intersection, this thesis aims to outline the existing problem in the United States pertaining to health disparity and inequity from social determinants of health, examine current ethical guidelines for nursing practice for social justice principles, and review existing literature pertaining to social justice theory and practice intersecting with nursing. From this investigation, this thesis will conclude with a discussion on the results of the inquiry that highlight an understanding of the concepts with a look to future investigation that can result in the sound development of a nursing model.

3 RESEARCH METHODS

3.1 Model exploration via qualitative research

Nursing is an emerging new field of study that sits on the precipice between empirical and social sciences. Blending both abstract and concrete concepts, research into the profession for both theoretical and practical development has been met with much debate. Hinging on philosophical and methodological arguments, the debate wages on - often with the new nurse researcher, or student, lost and confused. However, it can be asserted, that each philosophy and methodology does have its place in the field. As nursing is a profession that encompasses multiple sciences, it also can encompass multiple research methodologies and philosophies. In order to choose the appropriate philosophy/methodology, prior to initiating research the nurse-researcher must identify the conceptual basis of her/his task. If the goal is to explore concrete concepts of practice, perhaps a more quantitative approach is necessary; if the goal is to develop

an abstract theory of practice, perhaps a qualitative approach is necessary. Although ultimately, there may be overlap in methodology, the researcher needs to initially determine a clear intent. From here the process can grow.

Considering that the results of this thesis will add to the abstract, theoretical concepts of the nursing profession, it is my belief that qualitative concept analysis, performed rigorously, is an appropriate starting point. By permitting the exploration of multiple perspectives while bearing in mind the multiple meanings contained within the texts and experiences, qualitative concept analysis will affirm an end product with a holistic understanding of the phenomena. As Hugh McKenna states in Nursing Theories and Models (1997, 57), "Concept analysis enables us to refine and define a concept that has originated in practice, research, or theory. It helps us differentiate it from similar and dissimilar concepts. The end result is a way of reliably checking or operationalising the existence of that concept in nursing practice. Therefore, concept analysis is a core activity in the development of theory."

These statements do not disregard the importance of quantitative research. Quantitative research has its place in theory/model assessment and/or concrete practical development. However, for this research which leans more to the social science side of nursing, theoretical exploration must begin by using a rational and/or historical lens before applying any empirical philosophy. Upon formal completion, it is possible that any concepts generated could be empirically tested as the foundation for a community health or public health nursing position; however, this research aims to clarify the need, application and make suggestions for the development of nursing practice, not to create a model, nor attest to any specific effectiveness.

3.1.1 Process, methods, and credibility in qualitative concept analysis

For clarity, Cole (1988) states that qualitative concept analysis "...is a method of analysing written, verbal or visual communication messages." (Elo and Kyngäs 2007, 107). In its most basic form, concept analysis is a research process where the data comes from communication in any form. But it is deeper than that, as its end product is what has value. As stated by Elo and Kyngäs (2007, 108), "The aim is to attain a condensed and broad description of the phenomenon, and the outcome of the analysis is concepts or categories describing the phenomenon. Usually the purpose of those

concepts or categories is to build up a model, conceptual system, conceptual map or categories." In other words, the goal is to describe phenomena, understand data, and provide new knowledge and insights that can lead to both theory and action.

On paper, that sounds simple enough. One just needs to analyse some type of communication to find meaning. But in order to give the analysis validity, its process must be methodological. As quoted by McKenna (1997, 58), "Chinn and Kramer describe the process as a technique or mental activity that requires critical approaches to uncovering the subtle elements of meaning that can be embedded in concepts. The process is a highly deliberate and disciplined activity." The research is targeted to gather all sides of a concept, and then each 'text' is read to look beyond the veneer to see its underlying constructs. Essentially, a good qualitative concept analysis process includes immense breadth and profundity. Credibility in the research process is elaborated on by U.H. Graneheim and B. Lundman. They state (2003, 110), "Credibility of research findings also deals with how well categories and themes cover data, that is, no relevant data have been inadvertently or systematically excluded or irrelevant data included." Thus, in order to complete a credible analysis, the onus is on the researcher to monotonously explore all data on the subject, and not simply select the data that supports the researchers preconceived conclusions.

Despite the intention for credibility, it must be noted that subjective interpretation will exist, which is acceptable. Therefore, as much as the researcher tries to set aside preconceived conclusions, they may jade some of the analysis completed - this not only reinforces the importance of a broad initial search on the subject, but also that of a methodological approach to the data analysis. In general, it is understood that there are two main approaches to concept analysis, inductive and deductive. Inductive reasoning "[takes] note of patterns and commonality in...phenomena...to build up a body of knowledge" while "...deductive reasoning involves moving from the general to the specific" (McKenna 1997, 52). The difference between the two is the starting point. In inductive reasoning, the researcher will gather instances of a phenomena and amalgamate them to form a theory, whereas in deductive reasoning the researcher will start at the theory and move backwards to find specific phenomena that can support the theory, also known as 'theory testing.' However McKenna puts forth a third approach, 'retroductive reasoning.' According to McKenna (1997), retroduction combines both induction and deduction for theory construction. He cites an example from Boore,

who both tested an existing theory (deduction) and used the findings to develop a new, more practical theory (induction) (McKenna 1997, 53). This third approach gives the researcher a fuller perspective on the concept. By using this third methodological approach, the researcher can add a level of credibility to her/his work, in spite of their preconceived conclusions regarding their research - in essence the ‘retroductive’ approach helps to remove bias.

3.1.2 Benefits of qualitative concept analysis in model exploration

Earlier it was mentioned that there is a great debate regarding approaches to nursing research. Although each philosophy has its place in this field, each one serves a different purpose. For theory or model development, qualitative concept analysis has the greatest benefit. As Janice Morse stated in 1995, ‘...there is a vast amount of conceptual exploration yet to be accomplished...because the theoretical base is the foundation of nursing research and practice...the most urgent need for methodological development in nursing exists in the area of conceptual inquiry” (McKenna 1997, 55). Due to the nebulous concepts that exist in nursing, the profession will benefit most from analysis that helps provide definition to these concepts for the practitioner. This definition is best found through a qualitative concept analysis with flexibility and creativity. From Elo and Kyngäs (2007, 108):

> “...content analysis has an established position in nursing research and offers researchers several major benefits. One of these is that it is a content-sensitive method (Krippendorff 1980), and another is its flexibility...(Harwood & Garry 2003). It is also much more than a naive technique that results in a simplistic description of data (Cavanagh 1997) or a counting game (Downe-Wamboldt 1992). Concept analysis can be used to develop and understanding of the meaning of communication (Cavanagh 1997) and to identify critical processes (Lederman 1991). It is concerned with meanings, intentions, consequences and context (Downe-Wamboldt 1992)”

Qualitative concept analysis changes the role of the researcher from simple “data processor” into “theorist.” In the role as theoriser, the researcher has the ability to enrich the profession by not simply verifying or subtracting existing thought through empiri-

cal testing, but adding thought through detailed study and concept clarification. McKenna further elaborated on Morse's thought by referencing Kaplan's 'paradox of conceptualisation: "He realised that good concepts are essential to formulate good theory, but you also need good theory to provide you with good concepts. Therefore, the better our concepts, the better the theory we can generate with them and in turn the better the concepts available for future theory development" (McKenna 1997, 55-56). Although McKenna alludes to a circular nature in concept analysis and theory development, it should not be viewed as circular; but rather spiral. Just as a spiral starts broadly then spins deeper into a final point, qualitative concept analysis does the same. As research is added to a particular concept, the closer we come to a more complete truth or definition, theory or model of benefit to nursing. This exploration, this benefit, exists in qualitative concept analysis.

3.2 Applying research methods

The analysis of nursing research above served as the framework for the research conducted for this thesis. In this thesis, I have applied a 'faux' form of retroduction. For the concepts such as 'health disparities' and 'social determinants of health,' I used an inductive approach, examining journal articles and other literature that described the existing observed phenomena. However, when tackling subsequent sections such as nursing ethics and social justice in nursing, I used a deductive reasoning. For these sections, I analysed existing journal articles and other texts to understand the broader concepts implied, and then thought backwards to specific phenomena (the social determinants of health and health inequity) that help define these concepts.

With the completion of both the initial inductive reasoning for the base concepts of social determinants and the deductive reasoning of the more abstract concepts, I then examined the resultant information with an additional inductive approach. This secondary analysis served as the "spiral" in this retroductive concept analysis. That is, by reexamining data, I was able to identify existent phenomena that served as suggestions for further development of nursing. Collectively, these observed phenomena form the discussion section of this thesis. Even though I was able to apply multiple research approaches, I fell short of a true retroductive analysis as defined by McKenna. Unfortunately, due to time and location restraints, I was unable to test any suggestions.

Thus, the suggestions presented remain theoretical until future work can be completed to empirically test their effectiveness.

3.2.1 Data accumulation

Practically speaking, to accumulate the data for this analysis, I began with multiple searches of electronic journal articles on EBSCO. Using English-language searches with geographic limitations of ‘North America’, ‘Developed Nations’ and ‘United States’, I searched the terms, ‘health inequity’, ‘disparity’, ‘social determinant(s)’, ‘social justice’, and ‘social advocacy’ - both individually and in combination with the terms ‘nursing’ and/or ‘public health’. The time frame was initially limited to 2010-2013 to ensure that only the most recent research was selected; however for the topic of ‘social justice’ a broader timeframe was needed and was expanded to 2006. For each search, of the results obtained, only those that had been subjected to the scrutiny of peer review were considered. The remaining articles were examined based upon subject material. Ultimately the decision to select a small handful (4 to 5) for each subject was made. For the section on social determinants of health, the selection was of those that highlighted mortality or trends in the development of the social determinant/health disparity relationship was made. For the other subjects, criteria varied, but a historical perspective was a requirement; along with a definition of the concept. This allowed for multiple perspectives and interpretations of history of the said concept, plus a varying view of the definitions put forth.

3.3 Conclusion to research methods

Nursing is a unique profession that combines a multitude of sciences into practical execution to benefit health care clients. Due to the extent of the sciences from which this profession draws, much debate exists and will continue to exist on how to best address the phenomena that exist in nursing. It is not necessary for research methods to be mutually exclusive. They can, and should intersect. But they should be applied methodologically. In terms of concept clarification, qualitative concept analysis, when ritualistically conducted, has the ability to explore vague concepts of nursing while formulating new theories or models. From inductive to deductive to retroductive reasoning, qualitative concept analysis gives freedom and creativity to research that can analyse phenomena and seek some form of truth. Although this method may not be

the end all determinant for practice, it certainly serves its purpose in making the abstract more concrete while pushing the field of nursing into broader applications.

4 HEALTH DISPARITIES AND SOCIAL DETERMINANTS IN THE USA

4.1 History, definition, and background

Much of current and historical dialogue in the United States revolves around the concept of equality. Equal rights, treatment, and opportunity across populations are constantly being sought, attained, and protected. One relatively recent addition to these discussions is health and health care. Within the past 20 years, it has become an accepted truth that among certain populations health inequality, or health disparities exist. Health inequalities, or disparities, are currently defined by the World Health Organization as, "differences in health status or in the distribution of health determinants between different population groups" (WHO 2013). Thus, as a measurement of health differences, an explosion of research has been conducted to begin identifying causes of existing disparities. Through these studies 'social determinants', or "social (including economic) factors with important direct or indirect effects on health," (Braveman et al 2010, 382) have emerged as a focus point in the discussion on health disparities.

What is to follow, is an examination of just a fraction of the hundreds of research articles on these topics that expose the connection between 'social determinants' and 'health disparities.' The sources used in this examination encompass the broad trends in the social determinant/health disparity discussion as well as focus on specific relationships between them. This examination is not meant to be entirely comprehensive, but to simply expose the relationship. Additionally, it will be asserted, that despite efforts to peg certain determinants as the cause of a particular health care disparity, larger, more fundamental social factors exist that trigger socioeconomic inequity leading to health care inequity. Differentiated as 'upstream' and 'downstream' determinants, it is the 'upstream' determinants that have the causal relationship between social factors and health disparity. Ultimately, addressing these social factors will have the greatest impact on current health care disparities. (Braveman et al 2010, 382)

All sources examined have an empirical framework with conclusions derived from quantitative and qualitative analytical methods; thus limiting their subjectivity.

4.2 Article review

4.2.1 Health inequalities: trends, progress, and policy

As can be discerned from the title, the intent of this article is to analyze trends and advancements in health care inequalities and policy in the United States, the United Kingdom and other countries in the Organization for Economic Cooperation and Development (OECD); however for the purposes of this review, only the sections pertaining to the United States are considered.

Using data sets from 1980 to 2007, the article highlights certain health care disparity measures (mortality, behavioral risk factors, and metabolic factors) in relation to the social determinants of race and level of eduction attained among adults aged 20 or older. Beginning with mortality, the authors show that over time, mortality measures are decreasing for all races and education levels. Despite this trend, the gap, or disparity, between groups and education levels is growing for certain measures. For instance, between black males and white males infant mortality has grown; "In 1980, the infant mortality rate for black males was approximately twice that of white males (24 per 1,000 compared with 12 per 1,000). By 2007 the gap between infant mortality of white and black males increased slightly [14.5 per 1,000 compared with 6.2 per 1,000]." (Bleich et al 2012, 10) This same pattern existed among females, with black female infant mortality in 2007 more than 2.4 times higher than that of white females. Regarding education level, the infant mortality rate gap between college educated and high-school educated individuals increased, growing from a 2.5 death differential in 1980 to a 3.1 death differential in 2007. (Bleich et al 2012, 11). In essence, what the data show, is that blacks and less educated suffer from more infant deaths than their white and more educated counter parts in the United States.

Regarding behavioral risk factors, the data analyzed show a similar trend to that of infant mortality; the less the education the greater percentage of behavioral risk. For example, the gap in smoking widened over time between those with high-school diplomas and those with a college education, growing from 11.5 percent to 13.2 percent

from 1990 to 2009. This trend remained for physical activity, with the gap expanding from 11.1 percent to 14 percent. This measure was mainly determined by an increase in physical activity by those that have some college education. Thus, for the measures that focus on preventative and individual behaviors for health care wellness, the existing gap caused by education level grew. (Bleich et al 2012, 13).

Lastly, Bleich et al (2012) present findings on metabolic factors. While obesity rates increased for all education levels the growth was greatest for those with the highest level of education (18.5% to 32.1%). Despite this dramatic change, the disparity between the highest educated and those with a high school diploma still grew, albeit marginally, from 6.5% to 6.8%. For hypertension, the disparity also grew, but between the middle educated and least educated groups, moving from -1.2% to +1.3%. This trend continues for diabetes, as well. The group with the least education had an increase of 13.8%, while those with some college education saw the smallest growth of just 3.8%; resulting in a disparity growth from -2.4% to 7.6%. (Bleich et al 2012, 15).

The data presented, not only shows that a disparity still exists for mortality, behavioral risk, and metabolic factors, but that the disparities in these measures are growing. Specifically, it can be stated that race and level of education are social determinants of health, or that skin color and/or level of education impact health such that those who are black or have less of an education are at greater risk for infant mortality, smoking, obesity, diabetes, et cetera. This is a sound conclusion, as it focuses on a broader view than just individual behavior and connects 'upstream determinants' (to be clarified below) of education and race to health outcomes. This conclusion makes it fare to hypothesize that improvements in education across races would be an advancement to reduce health disparities.

4.2.2 Health status, neighborhood socioeconomic context, and premature mortality in the United States: The National Institutes of Health - AARP diet and health study Health inequalities: trends, progress, and policy

Appearing in the American Journal of Public Health in April of 2012, this study sought to determine a correlation between neighborhood socioeconomic status and the risks of premature mortality. Using data collected from three different sources (the

National Institutes of Health-AARP Diet and health study, the 2000 US Census, and the US Social Security Administration Death Master file), the authors surveyed the health status of 565679 adults between 50 and 71 years in six US states (CA, FL, LA, NJ, NC, and PA) and 2 metropolitan areas (Atlanta, GA and Detroit, MI) for an 11 year time period (1995 to 2006); and evaluated the socioeconomic deprivation of their living locations using an index created from 10 socioeconomic variables. (Doubeni et al 2012, 680-1). By using these robust data sets, the authors were able to conduct multiple statistical models to estimate all-cause mortality in relation to neighborhood socioeconomic deprivation, including models to control for additional social determinants to health, such as age, gender, race, educational achievement, behavioral health risks, and history of chronic diseases at baseline. (Doubeni et al 2012, 682). In total, the researchers were able to collect complete data on 90% of participants.

The findings are summarized as such, "Neighborhood socioeconomic inequalities lead to large disparities in risk of premature mortality among healthy US adults, but not among those in poor health." (Doubeni et al 2012, 681). Speaking specifically, among those with excellent health, the deaths per 100 persons in the most affluent neighborhoods was 5.2, while in the most deprived neighborhoods that number climbs to 8.8; resulting in a hazard ratio (HR) of 1.68. But this trend diminishes when looking at individuals with poor health as the deaths per 100 persons in the most affluent was 3.58 compared to 3.42 in the most deprived (with a HR of 1.06). (2012, 683). But straightforward detailing of the health disparity was not the only find. More telling, is the observed trend, which shows the disparity in the mortality rate from most deprived to least deprived neighborhoods was present in 1995, but has since widened for those in excellent health. (Doubeni et al 2012, 682) A trend that corresponds with the work of Bleich et al (2012) which shows widening gap in infant mortality rates in relation to educational achievement levels.

As noted by the authors, despite showing a strong correlation between neighborhood SES and risk of premature mortality, this study still has limitations. Namely, that other social determinants could be at play. Although possible (and likely), it should not be disregarded that neighborhood SES which correlates to poverty and limited health care access impacts individuals personal health behaviors and/or beliefs; thus potentially qualifying neighborhood SES as an 'upstream' determinant. With this in mind, the conclusion that "...the need for social policies and programs to mitigate health

risks posed by neighborhood socioeconomic deprivation in the United States" (Doubeni et al 2012, 686-7) should be viewed as part of a solution. However, considering that neighborhood SES is often affected by other social and economic factors such as education and economic opportunity, any health related intervention on that level, should also include intervention farther 'upstream' to address its causal factors.

4.2.3 Estimated deaths attributable to social factors in the United States

Rather than approaching the subject from the comparative perspective that pits socially advantageous factors against disadvantageous ones, Galea et al (2011) calculated mortality estimates for a variety of social determinants for adults aged 25 to 64 years. Although unstated, the intent is to identify the gravity of social determinants of health. As will be seen in their conclusions, this type of study allows social determinants to be ranked among other causes of mortality, which ultimately should result in broader recognition of their role in health status leading to more concentrated efforts to divert their impact.

Targeting both individual-level and area-level social factors, a comprehensive list of social factors, including education, poverty, social support, area-level poverty, income inequality, and racial segregation, was determined based upon available data on each factor. To calculate their estimates, the authors initially estimated the relative risk (RR) of mortality associated with each social factor by using a meta-analysis on articles selected from a MEDLINE search of the relation of social factors and adult all-cause mortality from 1980 to 2007. Using the 2000 US Census, prevalence estimates for all but one of the social factors (social support) were obtained (prevalence estimates for social support came from the National Health and Nutrition Examination Survey). By employing a statistical formula that uses the RR and prevalence data as variables, it was possible to derive a population-attributable fraction (PAF) of mortality for each social factor. (In simpler terms, the PAF is the proportion of deaths that would not occur in absence of the social factor.) This fraction was then multiplied by the total number of deaths in the United States in 2000 (obtained from the National Vital Statistics Report) to estimate the total number of deaths attributable to each social factor. (Galea et al 2011, 1456-7 & 1461)

Looking at the results, the initial attention is drawn to the numbers of deaths attributable to social factors. Adding up the numbers reveals that approximately 540000 people died from individual-level preventable social factors; while another 334000 people died from addressable area-level social factors. In total, roughly 875000 people died in 2000 from social determinants of health! As the authors note, "these mortality estimates are comparable to deaths from the leading pathophysiological causes. For example, the number of deaths attributable to low education [244526] is comparable to the number caused by acute myocardial infarction [192898]...the number of deaths attributable to racial segregation [175520] is comparable to the number from cerebrovascular disease [167661]...and the number attributable to low social support [161522] is comparable to deaths from lung cancer." (Galea et al 2011, 1462).

Outside of the total numbers of deaths attributed to the social factors, other observable data is worth noting, specifically the prevalence of certain social factors and the population-attributable fraction. For instance, income inequality has a prevalence of 31.7%, the highest prevalence of any social factor, for this particular age group. Additionally, the highest PAF percentage was for that of low education for those 25-64 years, at 11.5%. This suggests that instead of any economic factor, education has the largest effect on health status. (Galea et al 2011, 1462)

Clearly and concisely displayed through this research is the gravity at which social determinants affect health status. With death numbers eclipsing that of the leading pathophysiological causes of death, it is easy to see that attention must be focused on the social impediments of health. With that said, the approaches to these problems need to be broad and focused systematically. As will be explained below, 'upstream' determinants cause 'downstream' determinants which effect a populations health resulting in disparities; in this case, mortality. Thus, working to mitigate 'downstream' consequences, although valuable, does not and can not eliminate disparities. For that, it is important to continue to flesh out more 'upstream' determinants, such as low education and poverty, and attenuate those factors primarily.

4.2.4 Social determinants of health: coming of age

As has been seen, studies of health disparities make a compelling case for the link between social inequity and health inequity, especially among more systematic social

factors such as education level, income, race, and neighborhood SES. Defined as 'upstream determinants' of health, these factors are the "fundamental causes that set in motion causal pathways leading to (often temporally and spatially distant) health effects through downstream factors," while the 'downstream' determinants of health are "factors that are temporally and spatially close to health effects (and hence relatively apparent) but are influenced by upstream factors" (Braveman et al 2011, 383), such as individual behaviors or health care services received. To exemplify this difference one can imagine a case of diet and nutrition, where despite knowledge of proper nutrition, a factor such as income or neighborhood status leads to routine consumption of fast food which is more accessible/affordable than fresh food from a market. Here, the diet is the 'downstream' determinant that leads to obesity, high cholesterol or diabetes while the lack of income or neighborhood status is the 'upstream' determinant limiting the accessibility of healthier diet options. Summarily, downstream determinants directly effect health, while upstream determinants trigger downstream determinants.

Braveman et al (2011) continue their observations with the identification of a visible pattern to help better understand these upstream social determinants. From a collection of evidence tying health disparity to social factors, the research team saw a stepped gradient pattern to health among upstream social determinants. This pattern shows that a social factor is not just a participant, or a by-product of poor health, but that it is a cause of poorer health - where the most socially disadvantaged suffer the most and the least socially disadvantaged suffer the least, while those with intermediate social advantage fall, as expected, in the middle. Thus, when attempting to alleviate health disparities this pattern has applicability:

> "Although other research is needed to clarify the underlying pathways, the dose-response relationship suggested by the gradient patterns supports the biological plausibility of a fundamental causal role for one or more upstream SDOH. Gradients by income, education, or occupational grade could reflect relatively direct health benefits of having more economic resources (e.g. healthier nutrition, housing, or neighborhood conditions, or less stress due to more resources to cope with daily challenges), unmeasured socioeconomic factors, and/or associated psychosocial/behavioral factors, such as health-related behaviors, self-

> perceived social status, or perceived control." (Braveman et al 2011, 384)

So as one moves up socially, so do they move up in health care status as well. This pattern lends itself to the notion that the upstream determinants of health, "...play a more fundamental causal role and represent the most important opportunities for improving health and reducing disparities." (Braveman et al 2011, 383)

This understanding about social determinants of health (SDOH) is key to a deeper look at the subject of 'upstream' determinants and a weaving together of causal pathways amongst factors. In a discussion about several individual 'upstream' social factors on health (neighborhood conditions, working conditions, education, income and wealth, race and racism, and stress), the researchers begin to make suggestions on the causal pathways that link 'upstream' determinants to health. Most notably, are their suggestions regarding neighborhood status, working conditions, education, and race.

Starting with neighborhood conditions, the authors note that physical, service, and environmental characteristics can "create and reinforce socioeconomic and racial/ethnic disparities in health." (Braveman et al 2011, 385) Thus, the insinuation is that our neighborhoods can cause health problems from poor air or water quality, or reinforce them by limiting our access to education or health services. On working conditions, the authors note that "Different pathways linking work and health may interact to exacerbate social disparities in health: Socially disadvantaged groups are more likely to have health-harming physical and psychosocial working conditions, along with disadvantaged living conditions associated with lower pay." (Braveman et al 2011, 385-6) This observation notes the connections among multiple upstream determinants of health, where inequity in one may lead to inequity in another, and jointly that may lead to inequity in health.

Regarding education, it is implied that it is a factor with the most variability as it may have the greatest impact on other upstream determinants. Initially the authors cite the link between sheer literacy and being better informed to make better health decisions, but they elaborate on this and expose how education lends itself to employment opportunities, higher income, and psychosocial factors such as self-confidence, social status and social support which all help to decrease stress. (Braveman et al 2011, 386-

7). Thus, according to the authors it appears that education may be one of the key social determinants in ameliorated health disparities. Although this is just a sample of the observations made, the important point of this analysis surfaces: that ‘upstream’ social determinants are interrelated, such that one inequity will affect another which will trigger another, which will trigger another, resulting in an affected health behavior harmful to health and leading to a disparity across a population or group.

4.3 Collective analysis and main findings

Even with the limitations of the above article review several themes become clear between health disparities and their social determinants. First, the connection is clear: socially disadvantaged populations suffer from greater health risks than their advantaged counterparts. Across multiple social factors it was shown that a disparity exists among mortality rates depending on the position of a group on a social factor scale. Second, it was shown that the trend regarding the effects of these social factors and their resulting health disparities is growing across spectrums; meaning that a greater gap in health equality is prevailing. This trend was particularly observable in the factors of education and neighborhood SES deprivation. Third, the issue presented by social determinants of health is grave. As was estimated, in 2000 nearly 875000 people died in the United States as a result of preventable social factors. (Galea et al 2011) When broken down by the social factor cause, these deaths rival those of most pathophysiological causes of mortality. Thus, broader recognition of this issue, coupled with action is needed, now. This action must come with a more complete understanding of social determinants of health.

As was also presented above, there is a growing understanding of social determinants. Based on the work of Braveman et al (2011), it is possible to differentiate between types of social factors, the upstream and the downstream. However, the two are not exclusive. Rather, there is a linear correlation between the upstream and downstream and the observed health disparities. Upstream determinants flow into downstream determinants which are exhibited as behaviors, beliefs and health practices that result in decreasing health status and the emergence of health disparities. (Braveman et al, 2011) With this understanding, it can be stated that the true causal relationship between social determinants of health and health disparities exists between the upstream determinants and the health disparities.

This understanding, that societal structures of upstream determinants are actual causal pathways to health disparities, requires the adoption of a different definition of health disparity than originally proposed. Earlier, health disparities were defined simply as difference in health status or distribution of health determinants among population groups. (WHO 2013) Although this is still true, we now have a more complete understanding of their causes, which should be taken into consideration. Thus, with this revelation, health disparities, or perhaps more appropriately termed, health inequities, can take a more politically charged definition: "...systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups" (Braveman et al 2011, S149). "This definition...[is] grounded in ethical and human rights principles...reflecting social injustice, distinguishing health disparities from other health differences..." (Braveman et al 2011, S149). So, it is now seen that health disparities, and their social determinants, are ethical issues of social justice; or rather injustice. This definition gives health professions a starting point for understanding and exploring solutions to the observed trends of social determinants - the pursuit of a more socially just, or equitable society in all contexts, be they political, economic, historical, environmental, or social.

5 NURSING ETHICS

As stated above, the issues of health disparities and social determinants of health should be seen as ethical and human rights issues. Inherently, this means that they have political ties, with solutions that can be found using political approaches. With this in mind, in consideration of the nursing practice, it is behooving to ask the following questions: do nurses have an ethical obligation to address social determinants of health? And does current nursing practice permit nurses to take action to address social determinants of health? In other words, is political action and social justice an inherent part of the ethical practice of nursing?

The following section will attempt to answer those questions.

5.1 Review of nursing codes of ethics

Foundational to the practice of nursing is its distinctive ethical tradition. This tradition has developed over time, yet it is consistently based on the values of autonomy, benefice, non-maleficence, justice, fidelity, advocacy, responsibility, accountability, and confidentiality. (Potter 2013, 286-7) Collectively, and through additional nurse scholarship, these principles have been expanded upon to create two key professional nursing documents to define ethical practice: the American Nurses Association (ANA) Code of Ethics with Interpretive Statements (2003) and the International Council of Nurses (ICN) Code of Ethics for Nurses (2012). Viewed separately, or together, these two documents are the premiere ethical guides for nursing practice. Thus, in consideration of ethical obligations of the nursing profession, these must be consulted.

5.1.1 The International Council of Nurses code of ethics for nurses

The analysis begins with the ICN Code of Ethics. From the start of the code, there is an acknowledgement of the nurses role in social justice causes. As the preamble states:

> "Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal.
>
> Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.
>
> Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups."
> (ICN 2012, 2)

By acknowledging a responsibility of alleviating suffering and the inherency of respecting human rights, the ICN Code promotes a perspective of nursing that includes

social justice. In essence, it states that nurses have a responsibility to alleviate suffering and that this can and should be accomplished with action beyond the medical or health care field. Nurses should consider action within a political arena to ensure human rights; such as the right to health. These propositions are elaborated on in additional parts of the code.

In the first of four “Elements of the Code”, entitled “Nurses and people”, The ICN makes two statements in support of action in a social justice capacity; and potentially in regards to social determinants of health and health disparities. First, the ICN states, “The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.” (ICN 2012, 3) Second, the ICN states, “The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services.” (ICN 2012, 3) As can be read, in addition to the basic responsibilities of nurses outlined in the preamble (above), nurses must ‘initiate’ and ‘support’ action to ensure health needs are met by all. Additionally, it is part of the ethical responsibility of the nurse to advocate for ‘equity and social justice’, not just in relation to health care, but in other services that may effect health as well; such as social determinants and health disparities. Essentially, the ICN, through these statements, has made it clear that the ethical purview of nursing extends beyond the standard medical model of health care, and reaches into other life contexts, a la political action and social justice.

5.1.2 American Nurses Association code of ethics

Although the ICN Code of Ethics establishes an ethical foundation for social justice and political action, considering the geographical scope of this thesis is that of the United States, it is important to examine the ANA Code of Ethics as well. Similar to the ICN Code of Ethics, the ANA Code of Ethics immediately makes reference to social justice, the alleviation of suffering, and the required actions of nurses.

> “Nursing has a distinguished history of concern for the welfare of the sick, injured, and vulnerable and for social justice...nursing encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individu-

> als, families, groups, and communities...Nurses act to change those aspects of social structures that detract from health and well-being." (ANA 2003, 2)

So, similar to the way the ICN Code acknowledges a concern for suffering, the vulnerable, and social justice, so does the ANA Code. The main difference in the preface/preamble sections of the Codes is that the ANA does not recognize human rights directly, although it is implied; thus leaving room to refute that health and health care are human rights. However, the ANA Code does, in it's preface, state that nurses *currently* act for change, specifically changes to social structures that affect health. This last statement is important, especially in regards to social determinants of health, health disparities, and social justice. By claiming that nurses *are* working to address social causes of ill-health, it reinforces the ethical mandate that nurses do have to address social determinants of health. Thus, regardless of the belief of health and health care as a right, nurses still have an ethical obligation to take action to address social determinants of health and health disparity in the United States.

These obligations are further elaborated on in the provisions of the ANA Code. Although, insinuations to social justice and political action occur throughout the code, it is Provisions 3, 7, and 8 that speak most directly about the actions of nurses in these realms. For instance, Provision 3 states, "The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patients." (ANA 2003, 6) By incorporating the word 'advocacy' into this provision, the ANA gives credence to action with a more political nature. This is enumerated in provision 3.5, Acting on questionable practice:

> "The nurse's primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which health care needs are addressed. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system or any action on the part of others that places the rights or best interests of the patient in jeopardy. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profes-

> sion, relevant federal, state, and local laws and regulations, and the employing organization's policies and procedures." (ANA 2003, 7)

The primary insinuation in this statement is that nurses should take action within the confines of their own institution or organization of practice. However, it does extend beyond by incorporating the term "others" as having potential for violating a patients health. Thus, it is appropriate to believe that this statement adds to the ethical obligation that nurses have to their patients (be they individuals, groups, families, or communities) to take action in defense of social justice, as it is social injustices that pose a jeopardy to patients health.

Under Provision 7 exists 7.1, or "Advancing the profession through active involvement in nursing and health care policy." Contained within this provision is the following statement, "Nurses should advance their profession by contributing in some way to the leadership, activities, and the visibility of their professional organization. Nurses can also advance the profession through participation in civic activities related to health care through local, state, national or international initiatives." (ANA 2003, 11). Nursing, like any profession, is not stagnant, it is evolving and changing, and part of this change is due to the ethical obligation espoused above. The key aspect of this statement, though, is the encouragement of nurses to expand their practice to one that is civically engaged, thus one that adopts a political approach to address health care concerns. This idea is further established in Provision 8.

Provision 8 states, "The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs." (ANA 2003, 12) Like Provision 3, this statement is advocating collaboration to address health needs; but it is the additional sub-provisions that link nursing to social justice and political action. For instance, Provision 8.1 Health needs and concerns:

> "The nursing profession is committed to promoting the health, welfare, and safety of all people. The nurse has a responsibility to be aware not only of specific health needs of individual patients but also of broader health concerns such as world hunger, environmental pollution, lack of access to health care, violations of human rights, and inequitable distribution of nursing and health care resources." (ANA 2003, 12)

And Provision 8.2 Responsibilities to the public:

> "Nurses, individually and collectively, have a responsibility to be knowledgeable about the health status of the community and existing threats to health and safety. Through support of and participation in community organizations and groups, the nurse assists in efforts to educate the public, facilitates informed choice, identifies conditions and circumstances that contribute to illness, injury, and disease, fosters healthy life styles, and participates in institutional and legislative efforts to promote health and meet national health objectives. In addition, the nurse supports initiatives to address barriers to health, such as poverty, homelessness, unsafe living conditions, abuse and violence, and lack of access to health services." (ANA 2003, 13)

Both sub-provisions, working collectively, clarify the deeper ethical responsibilities of nursing - to be aware of social justice issues as they pertain to health and take political action to address those issues - such as social determinants of health and inequities.

5.2 Summary of both codes

Although the ICN Code and the ANA Code are separate documents, both serve as the ethical guidelines of nursing practice. From review of their preface/preamble and elements/provisions, it is clear that nursing has an ethical mandate to acknowledge social justice issues, such as social determinants of health and health disparities. Furthermore, it is clear that the foundational documents of the nursing profession obligate nursing to take action beyond clinical practice to address these social issues that impact health. More specifically, the actions encouraged, are those that create social change, which often, is executed through political activism and work on policy to affect change. Yet, health disparity still exists and the trend shows inequity widening.

Understanding why inequity in social structures and health persists is complicated. There are no simple or straightforward explanations. However, despite the analysis of the Codes above, one factor is the decreasing involvement of nurses in social justices causes. Steadily, nurses have been ignoring their ethical mandate and potential role in

broader society to affect change. Health parity among populations, specifically the disadvantaged and advantaged populations, is going to require broad social change. This change is going to require more participation from nursing to fulfill the role they have neglected. To do so, nursing needs to adapt a revitalized perspective of social justice in their practice.

The following section is going to explore the intersection of nursing practice and social justice - both how and why this perspective is needed to address the health inequity seen, as caused by upstream social determinants of health.

6 NURSING AND SOCIAL JUSTICE

The concept of social justice in nursing can have two meanings. First, it can be a goal pursued or obtained, just as equity can be pursued or obtained. Second, it can be applied, through theory, such that nursing perception and actions use social justice as a tool in their practice to change societal structures that cause the absence of social justice, or inequity. This latter form of the social justice concept is what constitutes the ethical mandate of the profession (as shown above) and it has been recognized historically as the great potential of the profession to broader society. In February of 1930, Dr. Haven Emerson, then professor of public health administration at Columbia University made a speech espousing the power of nurses to affect social change; excerpts of this speech were published in 2011 in the journal, Public Health Nursing:

> "I have often felt that there is among the nursing group the largest potential power for the correction of social ills that exists within the country, because nobody else knows what the horror is, the fear that hangs over people from unemployment, as the nurse does. Nobody sees what it means to be politically hounded, the way the nurse does of the home which is subject to political catastrophe. The nurse knows well what it means for a family bread winner to suffer a reduction of wages. The nurse is the eyes and the conscience of the community in seeing and judging those matters which adversely affect the health and life and the survival of babies, children, and parents in the home...This is a power-

> ful social instrument that we are dealing with. We can't afford to allow it to be crudely used." (Emerson 2011, 569-571)

Back in 1930, the potential power of nurses for social change was recognized. Today, over 80 years later, the concept and role of nurses in evoking social change is present, but diminished. Although progress has been made, and some nurses do take action, overall the profession is still failing to live up to the ethical mandate and recommendation characterized by those of Emerson and the professions own Codes of Ethics.

Much has already been written about the intersection of nursing and social justice. Most of the literature centers on public health nurses and/or community health nurses. However, considering that the ethical obligation is not limited to segments of the profession, I have chosen to ignore a differentiation in nursing roles, and apply the following review to the profession as a whole. Thus, the following section is an examination of literature critiquing the current involvement, or lack thereof, of social justice practices in nursing as they pertain to the alleviation of inequities in health that stem from upstream social determinants.

Similar to the structure used above to review health disparities and social determinants, the following structure examines each article individually and then concludes with a presentation of findings. It should be noted that this review reflects only a fraction of the research that has been conducted on the topic.

6.1 Article review

6.1.1 Witnessing social injustice downstream and advocating for health equity upstream - "The Trombone Slide" of nursing

In line with the thoughts by Dr. Haven Emerson (above), Adeline Falk-Rafael, PhD, RN, FAAN and Claire Betker, MN, RN, CCHN(C) conducted a study of Canadian Public Health Nurses to determine the current use and impact of social justice and critical caring theory on current practice. Even though this study geographically focuses on Canada, it has implications for all nursing practice, including the USA.

The authors begin by explaining ‘critical caring theory’ as, “...a nursing theory that is informed by ethics of caring and social justice.” (Falk-Rafael and Betker 2012, 99) Or as they continue, “...critical caring is positioned as a hybrid midrange nursing theory, grounded in nursing through Watson’s caring science and Nightingale’s legacy of social activism, as well as in feminist, critical theory.” (Falk-Rafael and Betker 2012, 101). Using this theory as the framework, the authors undertook a qualitative research process to examine the topic, and did so in two phases. The first phase interviewed 11 public health nurses in 3 different cities in Southern Ontario, Canada; the second phase consisted of 2 focus groups of a total of 16 public health nurses from differing Canadian provinces. After the collection of data from the interviews and focus groups, a systematic qualitative data analysis was completed to ‘code’ the participants responses about their practice. These responses were then compared to the fundamentals of the critical caring theory and processes. (Falk-Rafael and Betker 2012, 101-102).

Overall, the results from their findings indicate that, despite a lack of conscious knowing of critical caring theory, “...caring and social justice figured in participants’ practice and often led to social activist actions that were consistent with the carative health promoting process...” (Falk-Rafael and Betker 2012, 103) With further analysis, this finding led to the emergence of three themes regarding nurse caring, social justice theory, and social activism: 1. The existence of a moral imperative; 2. The pursuit of social justice; and 3. The existence of barriers to moral agency. (Falk-Rafael and Betker 2012, 103-107)

The majority of the article’s analysis explains the first theme of ‘The moral imperative’, noting that, “...participants readily identify values such as respect, autonomy/self-determination, honesty, fairness/justice, and social justice as underpinning their nursing practice.” (Falk-Rafael and Betker 2012, 103). Included in these underpinnings, the study participants noted that these ethics link “...directly to their efforts to ameliorate social injustices that eroded human dignity.” (Falk-Rafael and Betker 2012, 103). When speaking directly about rights of clients and caring, the nurses often noted the ethical imperative to extend their caring beyond ‘one-on-one’ to deal with the ‘bigger picture issues’ that are ailing their clients. For instance, one nurse stated, “I believe it would be unethical for me to keep pulling bodies out of the river without trying to fix the bridge...You can’t care for poor people without understanding that you have to work for social justice.” (Falk-Rafael and Betker 2012, 103). Thus, it is

clear that in certain situations, nurses see their role extending beyond individual client treatments to addressing societal injustices that perpetuate the observed health inequity. In other words, nurses can see the 'moral imperative' of addressing upstream social determinants of health.

Continuing with the moral imperative, Falk-Rafael and Betker (2012) document that the nurses knowledge of the 'bigger picture' stems from nurses witnessing the social injustices of their clients. One example comes from a nurse that stated, "[M]y thinking about social justice has evolved as I have matured in my practice...now my perspective is more at a systems level of social justice or population perspective." (Falk-Rafael and Betker 2012, 104). Part of this maturing process is caused by what is described as 'situational or relational ethics' - where a nurse encounters an ethical dilemma caused by the system of health care in which they are practicing. The authors include stories from the nurses that include 'intentional subversion' of the system to award clients more money to feed their children regardless if they actually qualify for the assistance, or purchasing cigarrettes for 'detox' clients to keep them from relapsing due to a lack of social resources for those patients. (Falk-Rafael and Betker 2012, 105). Overall, the data show that these ethical dilemmas experienced by nurses prompt the belief in the need for a social justice response. This is most clearly evidenced by the following report from a study participant:

> "We should be focused on primary prevention. We should be focused on social justice. We should be focusing on the determinants of health but we're funded in a completely different way than that and we don't have the capacity to move to where we want to so we are constantly compromising...And I think that erodes our ethical practice. Don't get me wrong. I don't think we go in and make decisions that are unethical but I think that we, in some ways need to say louder, 'We're not going in that direction because it isn't the right way for us to be spending our resources. And yes, you're giving us this program that we're mandated to carry out but that's going to compromise our ability to let nurses work in a way that focuses on social justice and that focuses on dealing with social exclusion and all those things." (Falk-Rafael and Betker 2012, 105-106)

Just as nurses came to understand that the use of a critical caring and/or social justice approach is a moral imperative, the second theme - the pursuit of social justice - arose from nurses witnessing injustice in their clients lives:

> "Nurses spoke of organizing protests, meeting with politicians, writing letters, and sitting on committees to influence current policy and believes [like Dr. Haven Emerson] that is was their unique ability to bear witness to the situated realities of their clients, which...gave them credibility in the political arena. Their actions, in turn, gave them credibility with their clients." (Falk-Rafael and Betker 2012, 106-107)

For nurses, witnessing actual injustices among their clients led to action that pursues social justice. These actions were supported by knowledge of their clients situations, and taking action gave support to their work with their clients. Thus, the pursuit of social justice via a critical caring theory had a double benefit for nursing - and ultimately for the clients themselves. In essence, both upstream and downstream determinants of health were being addressed as action upstream supported action downstream and vice-versa. As Falk-Rafael and Betker put it, "[Nurses] fought for the policies that would provide equitable opportunities for health...they engaged in an intricate dance of meeting basic needs downstream...through linking people with existing resources and moving upstream to advocate for health public policy." (Falk-Rafael and Betker 2012, 107)

Presenting the third theme from their research (Barriers to moral agency), Falk-Rafael and Betker (2012) note that, "...the barriers identified...created ethical dilemmas by hindering participants' ability to exercise an ethic of caring [and] hindered the expression of caring through activities to promote social justice." (Falk-Rafael and Betker 2012, 107) Such barriers included financial and administrative constraints, a feeling a powerlessness, technological advances that limited the time spent with the community/clients, and a refocus on individual and family health promotion rather than communities and/or advocacy work. (Falk-Rafael and Betker 2012, 108) Thus, these barriers affected nursing ethics and decreased potential activism by nurses. Additionally, they led to distress among nurses, as they struggled with 'what is versus what should be.' (Falk-Rafael and Betker 2012, 108). However, in general, these barriers recon-

firm the suggestion that nursing can benefit from the application and pursuit of social justice.

In conclusion of the study, it is found that nursing has some guidance from critical caring and social justice theory - even if it is not consciously known by nurses. This finding supports the idea that social justice action is within the purview of the nursing profession as it is an expression of caring. (Falk-Rafel and Betker 2012, 108). This finding continues to support the claim that nursing practice is vital to the movement towards social justice and that social justice is vital to nursing practice. “The importance of social justice to participants’ practice is consistent with the argument that because both public health and nursing are rooted in social justice, PHNs are best suited to address health inequities. In addition...social justice [is] both an end - the societal ideal of a just society - and a means toward that end - the nursing actions taken toward achieving a just society.” (Falk-Rafael and Betker 2012, 109) These supported statements lead to the logical conclusion by the authors that, “...ensuring that nurses’ capacity for caring - including though advocacy for social justice - is healthy and intact is not only a personal matter for individual nurses but also of vital importance to the nursing profession and the society we serve.” (Falk-Rafael 2012, 111). So, in the same vain as Dr. Haven Emerson in 1930, nursing today offers great opportunity to address social ills, but that power must be fostered and applied appropriately to acquire the inequitable society sought and end health inequity.

6.1.2 ‘Health equity through action on the social determinants of health’: taking up the challenge in nursing

Gleaned from the title, this article puts forth a notion, identical to that of this thesis, that nursing has an obligation to ‘take up the challenge’ of addressing social determinants of health. Specifically, this article argues that the action required by nursing must be one that empowers those experiencing inequities, while working to change the social conditions that perpetuate observed health inequities. To do so, the authors argue for the ‘critical caring approach’ defined by Falk-Rafael and Betker (2012) above. The authors believe such an approach, “...will assist nurses to understand the social, political, economic and historical context of health inequities and to tackle these inequities through policy advocacy.” (Reutter and Kushner 2010, 269). In addition, the authors, “...offer recommendations related to nursing practice, education and

research to move forward the agenda of reducing health inequities through action on the social determinants of health." (Reutter and Kushner 2010, 269).

To start, the authors 'unpack' the concepts behind health disparities, inequalities, and social inequities. Ultimately, they recognize the importance of distinguishing the term 'health inequity' from 'health disparity', as health inequity "...most clearly reflects a value orientation of social justice and most explicitly exposes the 'cause' of health disparities as rooted in societal structures." (Reutter and Kushner 2010, 270). This is crucial as the authors move forward in their discourse to state, "For the most part, health professionals including nurses, have focused interventions on health-care accessibility and acquired health behaviors. And although these determinants may indeed be proximal 'causes' of poor health, it is the social determinants of health (SDOH) - the material and social conditions in which people live - that are the most significant because they influence health directly as well as indirectly through the other determinants." (Reutter and Kushner 2010, 270). Thus, the authors link the social inequities experienced to the health inequity experienced. This link is key when discussing potential interventions. Citing Bryant (2009), Blas (2008), and Raphael and Bryant (2006), the authors note:

> "Linking social inequalities to health outcomes reflects a critical/structural approach to health that incorporates political economy (Bryant 2009). An SDOH perspective framed around a political economy approach explicitly exposed the 'causal chains [that] run from macro social, political and economic factors to the pathogenesis of disease' (Blas et al. 2008 1685). In short, 'how a society produces and distributes societal resources among its population - that is, its political economy - are important determinants of population health...'" (Reutter and Kushner 2010, 271)

This link leads to recommendations for the nursing profession - that nurses need a more socially conscious approach to care and must work outside of the clinical domain to influence policy affecting all social structures which impact health. These recommendations are stated as such:

> "We contend that the overarching mandate of nursing in addressing health inequities is to ensure access to health (and its determinants) and health-care. This mandate requires a two-pronged nursing approach: (i) providing sensitive empowering care at the individual/community level to those experiencing inequities, and (ii) working to change the environmental and social conditions that are the root cause of these inequities. To realize this mandate, nurses will need to invoke a 'critical caring approach' (Falk-Rafael 2005) to understand the context of inequities and to tackle inequities through policy analysis and advocacy." (Reutter and Kushner 2010, 273)

Without explicitly defining the 'critical caring approach', the authors make recommendations for what nurses need to know about the context of inequities and how nurses can tackle them. Regarding what nurses need to know, the authors advocate for 'emancipatory knowing' as stated by Chinn and Kramer (2008). This concept is one of an inherent human ability to recognize injustice and piece together elements for change. (Reutter and Kushner 2010, 274). Additionally, they assert that nurses will need a deeper understanding of the 'why' of health inequities; for example, the social and political factors that support SDOH, such as "...globalization...and political forces..." (Reutter and Kushner 2010, 274). Furthermore, they advocate for an "...appreciation of how these inequities are experienced by vulnerable populations and communities in their day-to-day lives..." (Reutter and Kushner 2010, 274).

Regarding the 'tackling of inequities' the authors primarily assert a policy driven approach, stating, "Given that SDOH and the policies that enable them are at the root of inequities, policy advocacy is the key strategy to reducing inequities." (Reutter and Kushner 2010, 275). In order to succeed at policy advocacy, the authors recommend strategies of consciousness-raising among the public, policy-makers, and health professionals. Additionally, they advocate for action on additional policies such as living-wages, affordable housing, education and working conditions. They suggest accomplishing these through 'intersectoral collaboration' with the stakeholders in these alternative policies. (Reutter and Kushner 2010, 275)

Lastly, Reutter and Kushner (2010) identify barriers within nursing itself that have prevented the profession from addressing SDOH to date. First, they identify the em-

phasis on the 'nurse-person relationship.' The authors state, "This individual focus is evident in nursing frameworks and models, most of which incorporate a very proximal view of environment that does little to extend the gaze to broader social conditions as targets for nursing interventions, and may contribute to the perception that advocating policy is outside the scope of nursing practice" (Reutter and Kushner 2010, 276). Additionally, the authors point out that policy advocacy tends to be viewed by nurses as the purview of community health nurses and not all nurses (Reutter and Kushner 2010, 276). And lastly, the fact that nurses are not trained or educated in political science and, thus, may fear advocacy beyond the bedside, could impact the professions involvment in matters of SDOH. The authors state, "Inadequate knowledge and skills or lack of political competence has been identified by many nurse scholars as a key barrier to engaging in policy advocacy." (Reutter and Kushner 2010, 276). Addressing these barriers is the first step in activating nurses to take the political steps towards equity in SDOH and health.

6.1.3 Being and doing politics: an outdated model or 21st century reality?

Alleging that the political role of the nurse is undeveloped, the authors believe that the nursing profession would benefit from the addition of a sociological theory known as 'critical social theory' (Carnegie and Kiger 2009, 1976). Defining 'critical social theory' as one that, "...seeks to understand a situation and to alter conditions, thus leading to emancipation, equality and freedom for individuals", (Carnegie and Kiger 2009, 1977), the authors explore their perceived benefit of such a theory as a tool in the nursing profession. In totality, it is asserted that the use of 'critical social theory' would lead the nursing profession to a more holistic, ethical, and socially just practice of collective treatment. Additionally, the authors believe that this more holistic, ethical and socially just practice will stem from a more developed political role of the nurse that includes political participation that will change the social structures that cause health inequities. (Carnegie and Kiger 2009, 1976).

Carnegie and Kiger (2009) initiate their discussion by clarifying their understanding of critical social theory. In addition to defining the term (above), the authors make two assertions about the theory. First, they state that critical social theory, "...explores the underlying interests and the legitimacy of these interests and whether they serve equality and democracy." (Carnegie and Kiger 2009, 1977). In essence, the applica-

tion of critical social theory is to look deeply at a situation to gain a better understanding of the forces and power that shape the situation. Regarding health inequity, this tool would be applied to examine what upstream social determinants of health are causing poor health, rather than just looking for proximal causes. Second, the authors state, "Critical social theory emphasizes the collective rather than the individual." (Carnegie and Kiger 2009, 1978) Thus, critical social theory helps consider the whole of a population and not just an individual. Although strengths and weaknesses to the theory are identified, the authors believe that this shift in thinking is vital to addressing observed health inequities.

Moving forward in their discussion, Carnegie and Kiger (2009) broach the topic of health inequities. Continuing the theme of moving from the individual to the collective, the authors cite multiple sources that advocate for this change, and then state, "Tackling health inequalities requires a shift in focus from the individual as patient to communities," and "Attention to deprivation within populations or neighbourhoods is important as it highlights links between material distribution, social position and opportunities to participate in the community." (Carnegie and Kiger 2009, 1978) Thus, the authors affirm their belief in a more critical social approach to health care - one that focus more at the population level than the individual patient or family, and specifically one that looks upstream at the causes of poor health status. Carnegie and Kiger (2009) carry this belief into the nursing practice. Repeatedly citing Browne (2001), the authors purport that the trend of widening health inequity is partly due to a lack of socio-political understanding by the nursing profession which has led to lack of political participation by nurses. (Carnegie and Kiger 2009, 1979). To counter this widening trend, the authors agree with Brown (2001) that "...the science of nursing should go beyond the theoretical to the social and moral, owing the responsibility to improve health collectively in society and for individuals." (Carnegie and Kiger 2009, 1979). Thus, nursing has a mandate to correct a wrong through the adoption of a critical social theory approach to pursue a better understanding of the social causes of ill-health while formulating solutions; even political solutions.

Next, the authors discuss political advocacy in relation to nursing. Primarily, they make suggestions for the needs of nurses as they enter this role, "In order to realign the value of a lay community role with a professional political role, it will be essential for community nurses to gain confidence in collective action and to explore their un-

derlying values of citizenship. If they are not confident as citizens, they are unlikely to consider a political role." (Carnegie and Kiger 2009, 1979) Thus, in the same way that nurses are encouraged to define their own ethics, they must define their beliefs in civil service. Beyond, the article states, "...political advocacy must include an understanding of decisions made in the contexts of local, national, and international policy." (Carnegie and Kiger 2009, 1979-1980) So, in addition to defining their own civil values, nurses need a better grasp on how politics at any level function, and how those decision can impact their own community.

Carnegie and Kiger (2009) continue by discussing the merging of theory into practice, how nurses can work at a political level, and the implications of these changes to nursing. First, they note that in order for there to be a change in nurse perception, "...the boundaries of community nursing need to be constantly challenged...to place themselves within the political arena without being fearful of dominant voices that may attempt to regress and reduce any substantial debate about the parameters and purpose of nursing." (Carnegie and Kiger 2009, 1981) Thus, nurses need to assert their own power, without fear. However, for most nurses to get to this point they will need additional personal and professional role development. Second, the authors write, "This role development requires the profession to reflect more extensively on its position within healthcare systems and society. In line with critical theory, the first step to empowerment for nurses is to have a clear grasp of their historial relations and the development of the profession. Community nurses will need supporting structures, knowledge and skills from education and management. Only then will they be free to choose to act as nurse or activist." (Carnegie and Kiger 2009, 1982).

The work of Carnegie and Kiger (2009) can be summarized as such: Nurses have a political role that is currently being unfulfilled. This void has led to growing health inequity. Thus, nurses need to assume this political role to truly affect change. However that process will require additional development. The required role development can be successful by using a critical social theory approach to nursing. This approach will provide nurses the ability to holistically perceive their patients and the social structures affecting their patients. Furthermore, the use of critical social theory in nursing will prepare nurses with a stronger political competence and required sense of citizenship to address the upstream social determinants of health that lead to poor health outcomes and the observed inequities.

6.1.4 Injustice, suffering, difference: how can community health nursing address the suffering of others?

Similar to the articles above, Denise Drevdahl, RN, PhD, (2013) presents an argument for nursing to take a more active role to address health inequities through the use of a social justice perspective. However, differentiation occurs in the characterization of the moral imperative for nurses. Drevdahl (2013) characterizes health inequities, and their unjust causes, as suffering. She states, “I argue that [Community/Public Health Nursing] actions have inadequately addressed health inequities and continuation of these injustices constitutes a form of suffering, to which all contribute.” (Drevdahl 2013, 50) Thus, nursing, like Carnegie and Kiger (2009) state, has neglected its role in social justice and the alleviation of suffering. In fact, the neglect from the profession has emboldened the suffering of their own patients.

Drevdahl (2013) begins her argument with the definition for health inequities used above (by Braveman (2011)). She adds clarification of this definition, stating that, “Health inequities capture the notion that identified differences are due to injustices rather than from health differences in general.” (Drevdahl 2013, 51). Here, Drevdahl (2013) exposes, and reinforces, the point that health inequities are as much, if more so, caused by social injustices than by biological differences in populations. This leads to the following statement, “...if health inequities are due to social and political injustices, interventions targeting individual behaviors or genes are insufficient to alter those inequities.” (Drevdahl 2013, 51). Like the previous authors, Drevadhl (2013) believes that current interventions addressing downstream determinants of individual behaviors is not an adequate solution to the growing issue of health inequities. To solve this issue, health care must begin approaching inequities as a failure of social structures requiring remedy. But changing this focus is difficult.

To change perspectives, Drevdahl (2013) reiterates her argument to view injustices as suffering - or to adopt a social justice perspective by writing, “...viewing health, economic, and social inequities as forms of suffering may convince some that addressing injustice is of paramount importance...” (Drevdahl 2013, 51). However, she notes that the suffering needs to be personal. For those not experiencing the suffering first hand, adopting others suffering is accomplished through a social justice lens: “Only when

one sees one's relations with others from an ethical, moral, and human rights perspective does one begin to understand that the well-being of the one rests on the well-being of the collective Other; this obligates each person to ameliorate and, if possible, prevent the suffering of others." (Drevdahl 2013, 53).

With the framework of health inequities as suffering, the attention shifts to incorporating this perspective into nursing practice. First, Drevdahl (2013) notes that nursing has a moral mandate to address suffering, thus it has a moral mandate to address health inequities caused by social injustice - which she asserts is done through a social justice approach. Drevdahl writes, "...a social justice approach would advocate for larger-socio-political-environmental actions such as taking on issues of poverty, jobs, education, nutrition, and housing, rather than only focusing on helping individuals manage their diabetes." (Drevdahl 2013, 53). She continues, "This way of thinking about possible interventions moves health professionals well beyond targeting individual behaviors as mechanisms to address inequities and towards existing structures that create and support conditions of poor health." (Drevdahl 2013, 54). In line with the previous articles, a more critical social theory is needed for health professions, especially nursing, to bring an end to health inequity.

Eventually, the article turns to the role of advocacy as a difference maker in the fight for more equitable health. Initially, several barriers are identified, such as the lack of conceptual models to look beyond the individual to the macro/social levels, technology that removes nurses from patients, and limited resources. (Drevdahl 2013, 54). Additionally, the difficulties of advocacy itself, are named as a barrier, since advocacy can simply lead to a redrawing of power relations, setting up a scenario where the advocate holds power over those, on whose behalf, they are advocating. Citing Kirkham and Anderson (2010), Drevdahl states, "...nurses [need] to recognize their complicity in needing Others to do their work of advocacy." (Drevdahl 2013, 55). Therefore, in nursing, when adopting a social justice approach (and beginning political work) the idea that the nurse works 'for' someone needs to shift to one where the nurse works 'with' them. In other words, nurses cannot make change happen, their goal is to promote their clients to make social change happen.

Overall, Drevdahl (2013) has presented an argument for the adoption of a social justice perspective into nursing. First, she makes the appeal that through social justice,

nurses can and will view the inequities of the world as a form of suffering that requires acton. Second, this social justice perspective will lead to a more systematic understanding of inequity (social or health) and its causes. Third, the social justice approach will result in political action that affects change. This action, however, will be thoughtful, to ensure that it is taken with and by those needing justice and not for or at them. And ultimately, through a social justice approach in nursing, a more equitable health, and society will be attained.

6.2 Collective analysis

Above, it was shown that the current ethical doctrines of nursing provide a mandate for nurses to understand, consider, and take action for social justice to address health care inequities stemming from upstream social determinants of health. With this acknowledgment, the immediately proceeding section has explored a small handful of articles that detail the existing and potential intersection between nursing practice and the concept of social justice. As stated earlier, this review was not intended to be a complete analysis of the topic. Rather, the intent was to present some of the existing knowledge regarding this intersection, in hopes that themes emerge to give a more full understanding of nursing and social justice, how social justice can and does apply to nursing, and what limitations exist preventing a more adequate social justice response to the upstream social determinants of health that lead to health inequity.

First, it was shown that social justice currently has a place in nursing beyond the ethical mandate described in the nursing codes of ethics. Due to nurses unique place in the health care domain, they are consistently witnessing social injustices and inequities that lead to health inequity, or contribute to the degradation of health status in certain disadvantaged populations. From this position, as shown by Falk-Rafael and Betker (2012), nurses, consciously or not, are undertaking social justice practices to address the injustices they witness. This has led many nurses to an ‘emancipatory knowledge’ about the societal structures and systems impacting their clients and their care. Additionally, the nurses positon has led to a belief by some, that nurses are best suited for addressing social ills and have potential political power to affect change.

Second, in addition to limited time and resources, a main barrier to social justice in nursing is the prevailing worldview of individualism. This worldview emphasizes that

individuals are responsible for their success and their failure - and that both/either are deserved by the individual. This view is exaggerated to the point that outside interventions in peoples lives are viewed as 'nice' and 'charitable' but not necessary, nor warranted. When applied to health care, this has led to a nursing practice that focuses on the individual client or family, with little regard for the collective whole. The result is an intervention strategy that primarily targets downstream (proximal) social determinants in repeated efforts. Few, if any, attempts are made to alter the fabric of society that breeds social inequity, and ultimately health inequity. In addition to this dominant worldview, nurses suffer from a lack of political competence due to a lack of political education. Thus, even when nurses experience the 'emancipatory knowledge' that leads to a desire to create social change, they are held back by their own understanding and awareness of how to initiate or create the change desired.

Third, the addition, or rather, the further development of social justice within nursing has a two-fold application. The first application is knowing and understanding. By applying a social justice theory to the education of nurses, they become predisposed to the political, economic, racial, social, and gender biases (the social injustices) that limit the potential of their clients. In essence, they are enlightened to the upstream social determinants of health that are the cause of the health inequity they witness everyday. With this broader understanding, the potential for an altered worldview that focuses on the collective, rather than the individual, can thrive. Secondly, the development of social justice in nursing behooves political action to address the causes that lead to and perpetuate ill-health. The linkage between social justice theory and political action is a natural one, thus social justice theory, in practice, results in an understanding of civil service, politics, and the tools necessary to initiate change. So, the application of social justice to nursing triggers a better understanding of political processes in which collective intervention can occur for the collective whole.

Last, it must be noted that the concept of social justice is both a means and an end. As a means, social justice is a tool. That is to say, that social justice can be used to change perceptions and create advocacy. As Drevdahl (2013) noted, the application of social justice in nursing leads one to view observed inequities as ethical, moral, and human-rights issues - or suffering. Thus, it is the tool of social justice that causes this change. It is this change that leads to action with the continued application of social justice advocacy. However, as an end, social justice is a continued equitable society for all. In

this ideal, the structures (or upstream social determinants) that lead to ill-health are limited, and in turn, decrease the suffering they cause. It is for this end that nurses must strive.

6.3 Main findings

These four main points can be summarized as such: 1. Social justice has a place in nursing beyond its ethical tradtion as nursing holds a unique place in health care (and society) as witnesses of injustice, to speak on behalf of those suffering, and to motivate those suffering to take action for social justice; 2. Despite the potential as societal change agents, nursing is limited by the dominant neoliberal worldview of individualism which does not consider outside influences in a persons successes or failures - this worldview has led nursing to primarily treat downstream (proximal) social determinants of health, almost exclusively; 3. Social justice can have a 2 fold impact for nurses, by enlightening them to the systematic limitations, power structures, and social determinants that affect the health status of their clients AND it can foster a political competence that can lead to political/policy action for change to benefit clients and the collective Other; and 4. Social justice is both a means and an end. As a means it is a tool for personal, collective, and political change; as an end it is a continual equitable society for all, with decreased suffering and just opportunities extended to the disadvantaged. As the ‘eyes and conscience of the community’, Emerson said, nurses are ‘a powerful social instrument’ that can create the socially just change to bring about a more equitable society with more equitable health.

7 CONCLUSION

The following section synthesizes the concepts presented in this work. This section seeks to blend the concepts and analysis presented from each section into one, more holistic truth about nursing practice. In other words, the concepts of each section, namely “Nursing and social justice” are applied to the other sections “Health disparity and social determinants of health” and “nursing ethics” to arrive at a better understanding of each section and the overall topic of health equity in nursing.

To begin with, however, it is important to recap the general conclusions central to each section. First, health inequities should be defined as "...systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups" (Braveman et al 2011, S149). These stem from 'bigger picture' societal structures called 'upstream social determinants of health' and these inequities are increasing as their causes continue to increase as well. Second, the foundational documents of nursing, that is the Codes of Ethics, encourage and mandate nurses to be more conscious of broader social causes of health, to view them with a social justice perspective, and then take action to address them. And third, the practice of social justice theory has been neglected in nursing, but it, and the profession, still maintain a potential to have a strong impact for health equity. For this to occur, nursing needs to reincorporate social justice theory into practice, as both a means and an end to bringing health parity and societal equity.

Now that the general conclusions have been restated, the synthesis of the concepts can be explored in more depth.

7.1 Social justice as it pertains to the social determinants of health

Stated prior, the trend in health disparities and health inequities is one of growth. The gaps in health status among groups - particularly the advantaged and disadvantaged - are widening. As upstream social determinants such as race, education, and neighborhood socioeconomic status change, so do health status measures such as mortality, behavioral risk, and metabolic factors. (Bleich et al 2012 and Doubeni et al 2012) As differences in upstream social determinants grow, so do the differences in health status. The result of these trends is that the socially disadvantaged are consistently subject to poorer health than their advantaged counterparts. Basically what is seen is that social inequity leads to health inequity. This is particularly concerning knowing that both forms of inequity are preventable.

Viewing these trends through a social justice lens, as suggested for nursing, new questions can emerge to gain a better understanding. The social justice perspective can lead the nurse to ponder the following: Why social and health inequities exist? What societal structures lead to these inequities? Is racism present? What differences among populations affect levels of educational attainment? What factors determine where

people live and the status of their neighborhoods? In an effort to find answers to these questions, naturally a new set of questions arise about solutions: What can be done to curb affects of racism? How can we improve the level of education attained? What should be done to strengthen the socioeconomic status of our neighborhoods? Ultimately, as these questions arise, the result for nurses is to think personally: What can I do to address trends in health inequity? What can I do to affect change?

Now, this is not to suggest that a nurse with the social justice perspective is a savior; capable of solving all of societies ills. However, the intent is to point out that in consideration of widening inequity in health as caused by upstream social determinants, nursing needs a new position. With the development of the social justice perspective in nursing, the profession begins to think differently about causes of poor health. Additionally, the nurse can think of solutions beyond the individual client, and for collective society. In turn, this thinking moves nursing care from tertiary (reactionary) care to primary (preventative) care.

Furthermore, the application of the social justice lens to social determinants of health aids in understanding intersectionality between determinants. For instance, when observing a determinant such as neighborhood socioeconomic status, other factors such as education and economic opportunity have an impact. Additionally, neighborhood socioeconomic status impacts behavioral risks and/or access to health care. A similar construct applies to education, where race, gender, and economic opportunity affect the level of educational attainment while the level of educational attainment affects economic opportunity, the neighborhood in which one lives, and access to care. In essence, the social justice lens provides a way for more complex and critical thinking for the nurse. It allows the nurse to perceive beyond the clients immediate facade to understand their situation with more depth.

Beyond the trend of the growing gap, what is more striking are the deaths caused by social and health inequities. As shown in the study by Galea et al (2011), in 2000 nearly 875,000 deaths in the United States were attributable to upstream social determinants of health (Galea et al 2011). Using a social justice purview and applying Braveman's (2011) definition of health inequities, which categorizes them as avoidable, to this statistic an additional level of suffering emerges. First, this amount of death, from preventable causes, must be considered 'grave', with an added layer of sorrow to

them. Additionally, the social justice perspective allows one to view this suffering longitudinally, as powerlessness of the family and client who will wonder: What if we had more education or money? What if we weren't a minority or had more social support? Could these outcomes be different? The nurse can wonder the same. Observing these statistics with the social justice lens, aids in personalizing the suffering for the nurse and a desire for change can grow.

As has been stated immediately above, the social justice lens puts the focus on the upstream social determinants of health. The statistics are viewed as a societal problem, and not that solely of the individual. This encourages action on behalf of the nurse - action to treat the upstream factor to bring greater health parity downstream to alleviate the longitudinal suffering of clients.

7.2 Social justice as it pertains to nursing ethics

As stated early, the foundation of nursing practice is its ethics, which are stated in the professions multiple Codes of Ethics. In the previous review, it was determined that both Codes - the ICN and ANA - encourage the use of social justice concepts, albeit minimally, within the practice of nursing - meaning that an ethical mandate for action on upstream social determinants of health is, arguably, in existence. The following is an expansion of the ideas above using a more liberal interpretation of the Codes to highlight where and how social justice concepts can ethically apply to nursing.

Both Codes define the role of nursing, in part, as the alleviation of suffering. As Drevdahl (2013) pointed out, the application of social justice in nursing aids nurses in personalizing the social suffering of others as it leads to diminished health status. This alteration in perception, expands the scope of ethical nursing practice to address observed social inequities in addition to the immediate suffering caused by ill health. However, it must be noted that to take action to alleviate upstream suffering for one, is to take action to alleviate the suffering of a larger collective who are subject oto a similar burden from the upstream social inequity. Thus, the application of social justice extends the ethical reach of the nurse from the individual client to the collective whole of society.

Beyond the alleviation of suffering, both Codes regard nursing as a practice aimed at the prevention of illness; either through ‘traditional’ health care models or by ensuring access to health care and other services. By encouraging nurses to prevent illness, the Codes are further encouraging nurses to adopt a social justice model of care. As has been seen, too much death is the result of poor social structures promoting inequity across populations. Thus, ethical nursing practice is one that adopts a role as social advocate outside the clinic. In this role, nurses will prevent illness by promoting policy changes to obtain/restore equity in all societal structures - not just health care. In fact, both Codes of Ethics encourage nurses to do exactly this. Unfortunately, it does not occur as it should. Thus, nurses must place social advocacy higher up in importance in their practice, understanding it is a necessity to the prevention of illness and promotion of health. For that ethical understanding, a more developed sense of social justice will be needed.

7.3 A deeper understanding of nursing and social justice

As has been shown, social justice concepts and theory are already in existence in nursing. Presnt in the Codes of Ethics and in the nursing model known as critical caring theory, social justice concepts intersect those of nursing, yet they do so without a deeper recognition, understanding, or application by nurses. Thus, despite a recognized need for a different approach to care, one that is more aligned with the tenants of social justice, the nursing profession has neglected its collective advocacy role, sticking to the neoliberalism ideology of individualism. However, consistently nurses are gaining ‘emancipatory knowledge’, or the combination of witnessing social injustices, the impact of these injustices on their patients health and finding some form of solution - be it short or long term. In spite of these occurances, barriers such as time and resources, political competence and will, and the lack of a stronger political and civic education exist that prevent broader social change in the name of health. Future successes for health and social equity are going to require a stronger commitment from the nursing profession to social justice. The following is a clarification of why the further development of social justice theory into nursing practice is desired:

1. The existing barriers to a more holistic, ethical, and socially just nursing practice can be overcome using the tools that exist in social justice theory and practice. A nursing force that understands social justice theory can emancipate

themselves from the constraints of the profession prohibiting a focus on the collective Other and an enduring social equity and health parity across groups.

2. As stated exhaustively throughout this thesis, the critical caring (social justice) approach gives nurses an understanding of why health inequity persists by more fully understanding the societal structures (social, political, economic, historical) at its root cause. This understanding leads to improved interventions that focus on the upstream determinants of health to provoke social equity.

3. The use of a critical caring approach continues to expand the focus of care to the collective. This approach places more attention on the deprivation among populations by highlighting inequitable distribution of resources, social position, and opportunities (also known as social determinants of health). Witnessing the collective suffering leads to action for the benefit of the collective.

4. A social justice/critical caring approach pushes the boundaries of nursing by challenging nurses to take up action in the sociopolitical arena. Nurses experience role development and gain confidence and competence in their ability to help the collective whole improve the health of the collective whole.

5. The critical caring/social justice approach to nursing practice creates a working use (means) of social justice theory to build a more socially just society (ends) for the collective whole. In other words, it provides nurses with the means to the idealistic ends of social and health equity.

8 SUGGESTIONS FOR FUTURE RESEARCH

Stated in the introduction was that this thesis was born out of the idea to create a nursing model that blended nursing with social justice community organizing. Obviously, that was not accomplished. However, the belief still persists, but it will require additional work.

To begin with, one difficulty in this thesis was fully understanding the concept of social justice as it pertains to nursing. Much of the research currently in circulation,

struggled with providing a clear definition of the concept that encompassed all its variability as both an ends and a means. Thus, current research on the topic as it applies to nursing was fragemented and at times, conflicting. This needs to be corrected. Thus, nursing needs to select a more explicit definition for the term as it applies to the profession. To best accomplish this, future research of the term, outside of the field of nursing would be beneficial. Part of this definition should be a collection of more clear descriptions of how social justice is practiced.

For this latter suggestion, it is imperative that the nursing profession dig deeper into the social justice concepts for examples of activism for the fight against upstream social determinants of health. For this, it is suggested that nursing turns to recognized scholars in these fields such as Saul Alinsky, Angela Davis, Frantz Fanon, Patricia Hill Collins, Michel Foucault, Betty Friedan, Paulo Friere, and Gloria Steinem. In line with this suggestion, is that nursing begins to explore tenants of community and political organizing. It was stated that advocacy can be difficult, and runs the risk of redefining power relations between the advocate and those whose on behalf they are advocating. Thus, research should be initiated to find strategies to avoid this pitfall.

Furthermore, if model creation is the end goal, research focused on practical steps of community advocacy needs to be addressed. Contained in some of the articles reviewed for this thesis, were suggestions of the types of advocacy for nurses and their patients. However, absent from these was any suggestions on how to practically enact this type of advocacy. Thus, in addition to the theoretical aspects of the model that bridge caring and community organizing, it is imperative that it contain ‘how to’ steps for civic, political, and community participation.

Lastly, health inequity is a topic of considerable concern prompting many organizations and governments to discuss, suggest, and take actions in hopes of bringing them under control. A critique and exploration of the leading efforts, specifically focuses on their impact to nursing, would be valuable. Changes in health policy, aimed at health inequity, will require adaptation by the socially just and conscious nurse. For any model development, these must be considered.

9 DISCUSSION

Prior to entering nursing, my main passion and employment came in the fields of political science. My first college degree was in Activism and Social Change and my first career represented that degree. As a corporate campaign researcher for the labor movement, it was my primary goal to research a corporation, discover potential weaknesses (be they economic or moral) and then expose them as a way to gain leverage in labor negotiations. My final assignment was with the California Nurses Association/National Nurses United (CNA/NNU), a labor union exclusively dedicated to representing Registered Nurses.

At CNA/NNU, I was exposed to not just nursing, but health care. Through my work, I became aware of a growing problem of health inequity in my country. What I noticed was a trend that tied health outcomes to socioeconomic status. Basically, the poorer you were the worse your health. In addition, I saw that my country, one that touted equality and justice as its core, had a health care system that was equally disparate. Those that had resources could get needed care, and those that did not, struggled. Beyond that, this gap in health and in health care seemed to be growing - rising costs and private control of our health care infrastructure was making health less accessible to more and more Americans.

While enlightening myself to this stark problem, I was also witnessing a group of professionals that were fighting these injustices, Registered Nurses. From the bedside to Capital Hill, RN's were standing up to the health injustices in the USA. They were uniting to create one voice to advocate for their patients beyond hospital walls and change the direction of the US health care system. It was from witnessing their movement, that I decided I wanted to be one of them.

Upon entering nursing, I had this dream of being both a practitioner and change agent. I believed that through bedside nursing, I could find innovative ways to treat patients but also reform society to bring more fairness to health care. What I have discovered since being here though, is that nursing in the USA, through already existent flaws in its delivery systems, has serious limitations. High patient censuses, poor nurse-to-patient ratios, traditional (and patronizing) views of nurses, and a corporate approach to health care urging increased efficiency through routinization of health care practic-

es all effect the care a nurse can offer. With all these obstacles, how could I care for patients while effectively working to end the inequities of a broken health care system?

My initial motivation for selecting Finland for the TADD program was its international reputation as both an elite provider of health care services and in education. My basic presumption was, “If you want to be the best, go study among the best.” My belief was that within the best education system AND within one of the best health care systems, I would learn new approaches to addressing some of the major health care issues that plague my own country, state, and community. I assumed that by studying the Finnish model, I would discover, or be able to revise, a model of health care delivery to address the growing inequities I saw at home. However, what I found in Finland was not a model of nursing or care delivery, instead what I found was more of a rediscovery of something I had lost somewhere along the way.

During my final class in Finland, my professor asked the class what motivates us? As students mentioned money, admiration, or approval of coworkers, I sat in the back contemplating the question, hesitating to provide an answer. In the end, I never gave my answer publicly, but I did find one: a commitment to social justice. It is my belief that with this commitment, I can maneuver obstacles in current health care systems, be they US or global, to address persisting health inequities.

As is probably evident from this thesis, social justice is complicated. It can be classified as a theory, a practice, or a goal. To everyone who uses the term it can mean something different. However, for me, its the clearest term available to encapsulate the following: opportunity, equity, fairness, equality, virtue, caring. To me, social justice is a way of living, its a state of being, its an act of doing - it’s deliberate and thoughtful, but also passive and unconscious. Socially just actions are made for the benefit of others emerging from a compassion for others and a desire for something better. Like many, I cannot claim that all my actions fit this description - far from it - but after my time in Finland, I can at least restate my commitment to the concept, and hopefully, always strive to be more socially just.

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