Witnessing Social Injustice Downstream and Advocating for Health Equity Upstream

"The Trombone Slide" of Nursing

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Two aspects of a study examining the congruence of critical caring theory with public health nursing practice are reported. They confirm a congruence between expert public health nursing practice and the theory in terms of (*a*) a caring/social justice ethics that underpins practice and (*b*) the relevance to their practice of the carative health promoting process of contributing to the creation of supportive and sustainable physical, social, political, and economic environments. Public health nurse participants encountered many barriers to a practice underpinned by a caring/social justice ethic, some of which limited their moral agency. **Key words:** *critical caring, ethical dilemma, health inequities, moral agency, political advocacy, social determinants of health, social justice*

Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. A girl born today can expect to live for more than 80 years if she is born in some countries—but less than 45 years if she is born in others. Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.[1]

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HEALTH DISPARITIES become health inequities when they are unnecessary, unfair, and preventable,[2] resulting from social injustices that become engrained in the fabric of society through its social, economic, and political structures, laws, policies, and culture so as to become largely invisible. What become societal norms are created deliberately to advantage select members of society at the expense of others[3] and maintained through (*a*) slick marketing of oppressive ideologies, such as neoliberalism (eg, by making the rich richer, the whole of society, including those disadvantaged, will benefit) and individualism (eg, since everyone is created equal, those with advantage have earned it and those disadvantaged deserve it); (*b*) systems of rewards and benefits for enough members of society to buy their silence and/or support); and (*c*)

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political apathy, prevalent in many Western democracies and/or threat and punishment in more ruthless oppressive regimes. The call for social justice in the opening quote, issued by the World Health Organization Commission on the Social Determinants of Health (CSDH), builds on the Ottawa Charter's inclusion of social justice as a prerequisite to health.[4] It unequivocally links health inequities to social injustices created by human action and urges amelioration by a different set of human actions guided by the ethical ideal of social justice.[1]

Critical caring has been proposed as a nursing theory that is informed by ethics of caring and social justice[5] and, as such, considered an appropriate framework to guide nursing actions directed toward taking up the CSDH challenge to "close the gap."[6] The purpose of this article was to report findings pertaining to the ethics of caring and social justice in public health nursing practice. The findings are one aspect of a study designed to explicate critical caring theory, examining the degree to which it reflects current public health nursing practice and modifying or further developing it as necessary. Other aspects of the findings will be reported in a forthcoming publication.

DISCURSIVE CONTEXT FOR CANADIAN PUBLIC HEALTH NURSING PRACTICE

The CSDH Final Report[1] is the culmination of the commission's 3-year task of examining the growing body of evidence linking social injustices to health inequities within and between countries. This understanding of the relationship of broad social factors that impact health has been labeled by some as "the new public health"[7] but acknowledged by others as simply a return to traditional, premedicalized public health.[8,9] In nursing discourse, renewed calls for social justice similarly have been recognized as a return to the values that underpinned the social and political activism of Nightingale and early North American nursing leaders.[9-11]

North American professional nursing codes of ethics have not necessarily kept step with the renewed pursuit of social justice as a moral imperative. As Bekemeier and Butterfield[10] pointed out in their seminal article of 2006, the American Nurses Association documents they reviewed failed to provide "clear, consistent direction to nurses in the United States who participate in social reform."[10(p161)] In response to the authors' challenge for similar analyses in other countries, 2 such analyses[11,12] of the Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (CNA Code) were completed in 2006 and each identified areas that required improvement in many respects similar to the analysis of Bekemeier and Butterfield.[10]

The CNA Code was revised in 2008 and although there is significant improvement in the description of justice, referring to the "safeguarding of human rights, equity and fairness,"[13(p17)] the 2008 code differentiates between "core ethical responsibilities" and "ethical endeavors," which are identified as "broad aspects of social justice that are associated with health and well-being and that ethical nursing practice addresses."[13(p20)] The ethical endeavors are intended, however, only to "serve as a helpful motivational and educational tool for all nurses."[13(p2)] Although the code states that nurses "should endeavor as much as possible, individually and collectively, to advocate for and work toward eliminating social inequities,"[13(p19)] the very removal of the identified ethical endeavors from core ethical responsibilities implies that they are optional despite their characterization as "part of ethical practice."[13(p2)] A number of substantive concerns raised by Kirkham and Browne,[11] for example, that social justice was conceptualized in the 2002 code as "something that can be achieved without disrupting the current status quo—rather than a politicized ideal that will require challenging hegemonic structures and practices,"[13(p331)] have not been fully addressed in the 2008 revision. However, in the revised code's[13] glossary definition of *social justice* as the "fair distribution

of society's benefits and responsibilities and their consequences,"[13(p28)] there is at least acknowledgment that the focus of social justice is "the relative position of one social group in relation to others in society as well as on the root causes of disparities and what can be done to eliminate them."[13(p28)]

In Ontario, Canada, the regulatory body for nursing practice, the College of Nurses of Ontario, also issues a practice standard specific to ethics.[14] Social justice is not mentioned explicitly in that standard. Fairness is identified as one of the underpinning values of ethical practice, but its definition is limited to the fair allocation of health care resources. Thus, the noncompulsory nature of political activism to address broader health inequities communicated by the CNA Code is reinforced by the practice standard in Ontario.

Despite the disappointing equivocalness of the national CNA Code with respect to actions toward achieving social justice, and the absence of it in the Ontario ethical practice standard, public health nurses (PHNs) practicing in any one of the Canadian provinces and jurisdictions have for some time found more definitive professional direction from other sources. National community health nursing practice standards[15] were developed in 2003 and revised twice since then, most recently in 2011.[16] Social justice was identified in the 2003 standards as the basis for caring, whereby "the nurse brings an awareness of equity and the fundamental right of all humans to accessible, competent health care and essential determinants of health"[15(p4)] and integrated throughout the standards. It has been considerably strengthened in the 2011 revision in which public/community health nurses are expected to "consider and address the impact of the determinants of health within the political, cultural, and environmental context of health" and "advocate and engage in political action and healthy public policy options to facilitate healthy living."[16(p4)] Social justice is integrated throughout many of the 7 standards, more fully explicated in the standard of "access and equity" and highlighted as the

central tenet of the practice model. Social justice is not explicitly defined in the most recent Community Health Nurses of Canada document, with readers being directed to the CNA code. (*Note:* The terms *community health nursing* and *public health nursing* are used interchangeably in this article to reflect the different usages in different Canadian jurisdictions; both refer to population-focused nursing practice, whether or not that practice also includes nursing care of individuals and families and whether or not nurses are employed by official public health agencies.)

Several other documents provide guidance to PHNs regarding social justice. In identifying public health nursing roles and responsibilities, the Canadian Public Health Association expects nurses to be "proactive about social and health care trends, changing needs, and new policies and laws that may affect the health of communities, families, and individuals—and the health care system," noting that "social justice and equity are the foundations of nursing" and that "caring is a principle of social justice."[17(p13)] Generic core competencies identified for public health workers in Canada include advocating for healthy public policies and recognizing the impact of broad determinants of health.[18] Although acknowledged as an important value, the attributes of social justice are not explicit in the core competency statements. Edwards and Davison[19] challenged the decision of not embedding social justice in the competency statements and proposed inclusion of competency statements such as "Describe public health role in righting social injustices . . . . Recognize the potential differential effects of health interventions on population subgroups . . . [and u]nderstand and apply the Universal Declaration of Human Right."[(p131)] To augment those generic competencies, the Community Health Nurses of Canada developed discipline-specific competencies for PHNs.[20] These competencies identify social justice as a value that underpins the promotion of health and is integrated throughout many of the competencies.

It is within this context that Reutter and Kushner[6] urged PHNs to take up the CSHD challenge to "close the gap," building on the premise of Smith[21] that

when its capacity for caring is healthy and intact, nursing is the health profession *best suited* for leadership in reducing inequities . . . [because it] is the discipline for which caring—in its fullest and most elaborated and profound meaning—is absolutely central to theory and practice.[(p286)]

Reutter and Kushner[6] argued that the time is right for nursing to address its fundamental responsibility to reduce health inequities and suggested adopting critical caring as an appropriate theoretical framework for guiding this work.

EXPLICATION OF CRITICAL CARING THEORY

Critical caring is a positioned as a hybrid midrange nursing theory,[5] grounded in nursing through Watson's caring science and Nightingale's legacy of social activisim,[9] as well as in feminist, critical theory.[5] Critical caring emerged from practice experience and built on scholarship, arguing for the suitability of Watson's theory of human caring as a framework for guiding community health nursing practice[22] and previous research to develop the concept of empowered caring.[23] Critical caring is conceptualized as a way of being (ontology), knowing (epistemology), choosing (ethics), and doing (praxis) expressed through 7 carative health promoting processes derived from Watson's 10 clinical caritas processes.[5] (See Table 1, Carative Health Promoting Processes, Supplemental Digital Content 1, available at: http://links.lww.com/ANS/A1).

Further research was needed to explore the theory in relation to current public health nursing practice. In 2005, a study was undertaken to explicate the theory, examine the degree to which it was reflective of current public health nursing practice, and modify or expand the theory as suggested by the findings. Circumstances beyond the principal investigator's control resulted in the study not being completed until 2011.

Methods

The study used a feminist, multisite, comparative, and collective case study design[24] to explicate specific aspects of the theory. This design is considered useful for illustrating[25] and refining[26] theory, as comparisons are made across cases. Cases were defined as individual expert PHNs. Phase I consisted of interviews with 11 individual community health nurses who worked in 3 different cities in southern Ontario, Canada. After ethical approval was obtained, expert PHNs, who had a minimum of 10 years of experience in public health nursing, and who were known to the principal investigator through previous research, practice, and/or professional activities, and who consented to participate in the study, were interviewed by the researcher. A snowball technique was used to identify additional expert nurses, that is, those with 10 or more years of experience in public health nursing and generally acknowledged by their colleagues as expert nurses. Cases continued to be selected until saturation of data was achieved, that is, interviews yielded no additional insights. Interviews lasted between 1 and $1\frac{1}{2}$ hours. Questions followed an interview guide and consisted of open-ended questions, each specifically addressing an aspect of the theory; for example, "Describe the ethics that guide your practice." When probes were necessary, because none of the participants were familiar with the theory, a brief description of what the theory postulated about the question was given; for example, "Critical Caring theory suggests that PHNs are guided by ethics of caring and social justice. How does that relate to your practice?" Data collection for phase I was completed in 2005, but, although some initial data analysis was concurrent with the interview process, systematic and comprehensive data analysis was not completed until circumstances allowed for the resumption of the study in early 2011.

At that time, a systematic data analysis of the 2005 interviews, considered a preliminary data analysis, and phase II of the study were completed. The focus groups of phase II had been part of the original research design as a

means both of member checking and of possible generation of additional data. With the considerable lapse of time between the interviews and the focus groups, a secondary purpose to ensure temporal relevance of interview findings was also fulfilled.

After ethical approval was renewed, 2 focus groups of community health nurses were held in 2011. The first group consisted of 6 nurses from 3 different Canadian provinces who were attending a national community health nursing conference and who volunteered to participate in the study. The second, with 10 participants, took place in a midsize city in southern Ontario. Although all participants in the second focus group were employed by the same public health unit, they represented 8 different program foci.

As it was not necessary for study participants to know or consciously use critical caring theory in their practice, focus group participants were given a brief overview of each aspect of the theory and a summary of the relevant preliminary data before being asked to think about their practice in relation to both; for example, "How relevant are an ethics of care and social justice to your practice?" and "How is your experience different from or similar to the themes identified by nurses in phase I?" At the conclusion of each of the focus groups, participants were asked open-ended questions, "Is there anything about critical caring theory that is not consistent with your public health nursing practice?" and "Does anything need to be added to the theory so that it could better guide public health nursing practice?"

All interviews and both focus groups were audiotaped with permission. Audiotapes were transcribed and transcriptions coded using the Ethnograph version 6 software (Qualis Research Associates, Amherst, Massachusetts) for qualitative data analysis.[27] Related codes were grouped under "parent" codes, which were then compared with critical caring's ways of being, knowing, choosing, and doing, and the 7 carative health promoting processes. During the process of sharing the preliminary findings with focus groups, although the latter added much depth and richness in understanding how each aspect of critical caring was experienced by the participants, no substantively new data emerged. Consequently, focus group data were integrated with the initial interview data for final analysis in which parent codes were grouped together into discreet themes.

Demographics

Eleven community health nurses were interviewed in the summer of 2005. During data analysis, it became apparent that one of the participants had fewer than 5 years of practice experience and thus had not met the inclusion criteria. Consequently, the data from that interview were not used.

All study participants were women. The number of years of public health nursing practice experience among interviewees ranged from 12 to 29 years, with a mean of 21 years; among focus group participants, practice experience ranged from 8 to 33 years, with a mean of 19.28 years. Study participants represented a total of 518.5 years of public health nursing experience.

All study participants had earned a baccalaureate degree in nursing. In addition, 33% of the nurses interviewed had completed graduate degrees outside of nursing and 10% were nurse practitioners. Among the focus group members, 18% of participants reported having a master's degree in nursing. Twelve percent of nurses identified being in the process of completing a graduate degree, either in nursing or in an unspecified field, and 6% indicated having completed a nonnursing graduate degree.

Interviewees were predominantly employed in provincial health units (80%), whereas the other 20% worked in inner-city community health agencies. Among the focus group participants, 75% indicated that they worked in provincial public health departments, 18% did not indicate the type of agency in which they were employed, and 6% worked in a rural health center.

Forty percent of interviewees explicitly identified their practice focus as including political advocacy, although each of them also provided care directly to individuals and/or families. Thirty percent described working previously as generalists but indicated that their practice had shifted to population-focused programs such as injury prevention, chronic disease prevention, and healthy lifestyle. Twenty percent described their practice as working with vulnerable populations, such as persons with mental health, or in schools and 10% provided telephone counseling. Among focus group participants, 38% identified their focus as young families; 18% worked in communicable disease management and control; 12% with young adults; and 6% each in school health, injury prevention, and research/knowledge translation. Twelve percent did not identify their practice focus.

Findings

The findings demonstrate how caring and social justice figured in participants' practice and often led to social activist actions that were consistent with the carative health promoting process of "contributing to the creation of supportive and sustainable physical, social, political, and economic environments." Three overarching themes emerged in participants' accounts of caring, social justice, and social activism in their practice.

The moral imperative

Study participants generally struggled to articulate an ethical framework that guided their practice. A few referred to the CNA Code, and, on occasion, organizational policies were relied upon to provide boundaries for ethical practice. On further probing, however, participants readily identified values such as respect, autonomy/self-determination, honesty, fairness/justice, and social justice as underpinning their nursing practice. When asked about how a caring ethic might be relevant to their practice, many participants initially struggled with formulat-

ing a response. However, when a caring ethic was described in terms of protecting and enhancing human dignity, participants readily related to it as extremely relevant and important to their practice, linking it directly to their efforts to ameliorate social injustices that eroded human dignity. Following is an example.

I think ... when we talk about the human dignity piece ... that's sort of intrinsic, part of that relationship building, that people have a voice, have a say, that they're heard, that communication goes both ways.... [D]ignity is enhanced and really honoured in terms of really concrete little things.... [For example, when financial hardship is a barrier, some] community partners ... have said, "Well all that the mother has to do is just acknowledge that she's having a hardship financially and we'll cover the cost of physical activity for her children." That's a huge barrier [because of its public nature].

The nurse spoke about her efforts to bring an awareness of the humiliating effects of such well-intentioned practices to the agency and work with them to find alternative approaches.

The protection of human dignity is seen in another participant's description of the ethics that guide her practice:

Everyone has the right to everything from access to the supplies and what I can offer them, the right to decent housing, and the right to be treated without prejudice. People deserve kindness and respect.... I have a responsibility to deal with the bigger picture. Otherwise I don't think it would be ethical to do my work.... To be just seeing people as a nurse, one-on-one, and not dealing with the bigger picture issues would be, I think, irresponsible and complicit with the homelessness-making mechanizations.

On a similar note, another participant argued, "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." Another's conviction was similar: "[An ethic of caring and social justice] to me is an imperative. It's

just part of the absolute core of nursing as I see nursing."

Clearly, participants' sense of urgency to influence policies and societal structures through political advocacy came from witnessing firsthand the social injustices suffered by their clients. One participant reflected on her coming to understand how poverty adversely affected health:

You know, you read about it—the poverty, the homelessness, the abuse. Until I was faced with it, face-to-face, and [saw] how ill and the lack of services that people have . . . . I don't think I really realized the impact on health. And so, we continue to advocate where we can on a one-to-one basis and on a collective basis with [specific community agencies] . . . . But it's very difficult.

The evolution of the nurse's emancipatory knowledge, which is evident in the earlier-mentioned quote, was not unique among study participants. Others also spoke of similar wisdom that came with years of working with community clients and agencies. For example, on reflecting on the ethics that informed her practice, another nurse noted, "As I've gotten older I've seen how rigid class systems are and the power structures of the large multi-nationals and all of the lattices of involvement and control." Similarly, another pondered:

"[M]y thinking about social justice has evolved as I have matured in my practice . . . . [W]hen I thought about social justice as a new practitioner, I was thinking about it in terms of individual families or individuals and now my perspective is more at a systems level of social justice or population perspective."

Although usually the ethics evident in participants' accounts of their practice were an amalgam of caring and social justice, there were times when one or the other predominated. For one nurse, an ethic of caring meant supporting clients' values, opinions, and beliefs and not imposing her values on them; another equated enhancing human dignity with empowerment. Working with people who were homeless and/or had been abused, she reported how disempowered they were and looked for ways to support them in regaining a measure of control over their lives. Still others equated caring with linking clients with needed community resources.

Participants frequently referred to ethical dilemmas in enacting a caring ethic when their decision was not supported by others, either colleagues or community partners, or their employment agency's policies. One nurse spoke about feeling pressure from others to report a man to the Children's Aid who, although "rough and loud," she believed was not abusive to his children. Another nurse gave an example in which caring required disregarding her agency's policy:

Everybody should be able to feel good about themselves. I'm thinking of a [home visit] I did . . . . [the Mom] had cancer and her daughter had head lice and . . . [agency policy is] we don't go and pick nits or check for head lice. I have to say I did. First I trained the home care worker to do it who then quit and then I was called back in to train another one and I just said, you know what—I'm going to do it. You make a caring decision even though it's out of your scope of what you're supposed to be doing. And would I do that for everybody? No. But you make a decision based on the situation. [I asked her how she related that to human dignity. She responded]: The mom was dying and this was one more stress. She was just sitting there not coping at all with life and the daughter had intellectual difficulties and lots going on.

Her example, as many others, point to participants' practice being guided much more by situational and relational ethics rather than stemming from a framework of universal principles or professional codes. Although at times the influence of ethical principles, such as beneficence, nonmaleficence, and utilitarianism, were evident, they did not seem to be a dominant factor in the ethical decision making of participants. More frequently, participants' stories reflected ethics that emerged from the situation and relationship between nurse and client. One example was simply referred to by those involved in it as "the special diet clinic":

They're called special diet clinics because it's a diet form that we're filling out. You really could call

them hunger clinics where primarily nurses are actually operating these clinics that [another agency] . . . organizes, assisting people to get the additional income on their social assistance cheque. I have to say, it's probably one of the most important things I've done as a nurse in my career. It's immediate. It's concrete. You know, a Somalian immigrant woman comes in and she might have 7 or 8 children and you're taking a history, talking to the person, figuring out what are the health signs of hunger and not enough food, filling out the forms, and then that woman is going to walk away with a whole bunch of paper and she'll take it in to her worker and she's going to end up with an additional $250 for herself and each child—so, a couple of thousand dollars a month. It's incredible! It's kind of what you might call intentional subversion because it's figuring out something that was there, an opportunity that we can now justify and use. What's happening now is that after 10 years of the welfare cuts in Ontario it's very evident, the need for it—the signs of hunger and kids not doing well in school and all the health conditions.

As might be imagined, the actions of the participants in the special diet clinic were somewhat controversial. Another participant commented:

So this special diet campaign that's happening, a lot of health professionals are saying. "Well it's unethical that you're signing everyone up for $250/month extra if they don't have health problems. And some of us are saying it's unethical not to because the only intervention we make that saves people's lives is increasing their income. And so there's an interesting debate around ethics. But I would say it flavours everything I do in terms of what's ethical and, you know, ethics . . . [is] not very cut and dried here. There . . . [are] things you do that your nursing school teachers—it would make their hair curl. I buy people cigarettes. If it's what's going to help somebody stay in detox for five days rather than kill herself out there on the street from using crack, I'll buy her cigarettes. I don't have an ethical problem with that. But technically maybe, a nurse isn't supposed to do that. Those are the kinds of things that we're confronted with all the time.

Some participants' accounts suggest a professional source for ethical dilemmas, for example, a participant's initial nursing education, professional codes, or the counsel of colleagues to act in a different manner. Other ethical dilemmas were related to administrative constraints, one form of which involved a change in nurses' scope of practice. For some nurses, this meant moving away from the individual and family contact that had previously informed their political advocacy efforts, and for others, the reverse was true—they related being so overwhelmed by their work with individuals and families that they had no time for community engagement, community development, or political advocacy. For example:

Right now I work with communities of women who are either pregnant or have families with new babies and work with them either in their home setting in a drop in kind of program . . . . But over the last 2 months, the work that I'm doing has been kind of degraded—the shift is happening for public health nurses to work more intensely with . . . [individuals] and families and have no room or little room to do anything else . . . . [G]iven the time pressures, nurses are less able to be a part of helping to create and strengthen the [community support] network. It's population as opposed to community and I find that really troubling myself.

Organizational policies and structures, funding priorities, and/or what nurses perceived to be administrative shortcomings were identified by participants as barriers to being able to care, thus creating ethical dilemmas for them. Yet, participants understood that at least some of the organizational barriers originated in the political realm of government policies. The origins of mandatory programs and fiscal restraints might be further from the nurse than administrative and organizational barriers but created ethical dilemmas that were equally morally distressing. One participant stated the following:

I think that as decision makers or policy makers or managers in the system we actually don't operate ethically in the way that we should. 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 constantly are 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." I think for me that poses probably my biggest ethical dilemma every single day.

As the report of nurses' involvement in the special diet clinic illustrates, in the face of barriers to care that they could not change, nurses sometimes resorted to judiciously circumventing the barrier, at least temporarily and as best as they could. As one participant said, "So much of the work I did . . . [with a homeless population] was done on the QT. It was done in the evening or on the weekend. Or it had to be snuck in."

In pursuit of social justice: Advocating for health equity

The instances in which social justice was the predominant feature of participants' caring/social justice ethic involved descriptions of their work as political advocates to create supportive and sustainable physical, social, political, and economic environments, in other words, to address social determinants of health. In relation to the physical environment, one participant reported that PHNs and others in her health care department were becoming involved with city planners to consider the impact of the "built environment" on health, including such issues as walking paths and accessibility of grocery stores and other community amenities by walking. Another nurse worked with school boards to advocate for healthy choices in vending machines, and yet another spoke about her work with a community to pass a no-smoking bylaw to reduce secondhand smoke exposure. The purpose of the bylaw was not only the physical environment but also the social environment with the intent of beginning to change

social mores regarding smoking. It had potential economic implications:

I'm thinking of the no-smoking by-law. A big role there was trying to educate businesses that their businesses won't go under and that 75% of the population doesn't smoke and [that] they may see a blip for a while but then . . . [business is] going to increase. The other angle of that was working with charities which did some of their fund raising through bingos, you know, smoke-filled bingos, and talking to them about, "Is it fair to fund raise for children's activities on the backs of an activity that is unhealthy?"

For most participants, the pursuit of social justice stemmed directly from witnessing social injustices in the lives of their clients, as can be seen in the examples of clients who did not have enough money to feed themselves and those who were homeless and underhoused. Although nurses may at times have used somewhat subversive strategies to meet the immediate needs of their clients, they recognized the ethical imperative of also trying to change public policy. This nurse's comment is typical of participants' sentiments: "I don't think that you can be a credible sort of advocate for the health of a population without being pretty well grounded in the day-to-day realities of people."

Being grounded in the situated reality of her clients was evident in this nurse's reflection on advocacy efforts following the closure of an informal housing community:

When Tent City was demolished, people, including nurses, argued that [the occupants] had to be housed. There was nowhere for them to go. If they were going to be removed from that piece of land, then they had to be housed somewhere and not warehoused somewhere. And so that political advocacy got those people the Tent City rent supplement program, and out of those 100 people I think 97 are still housed . . . three years later . . . . So that, to me, is the epitome of nursing.

Nurses spoke of organizing protests, meeting with politicians, writing letters, and sitting on committees to influence current policy and believed strongly that it was their unique ability to bear witness to the situated realities of their clients, which they believed gave

them credibility in the political arena. Their actions, in turn, gave them credibility with their clients:

You don't have any credibility to speak about populations unless you know day-to-day what people are dealing with. And so I think likewise that when you advocate for populations and when you go to the city and say, "These people are trying to sleep with bedbugs and that's intolerable," then it increases your credibility with individuals because they see that you're working with the bigger issue.

Although nurses were involved and often led such activities, they did not do so alone. Partnerships and coalitions with various groups, across professions within the health care sector and across sectors, and with community groups that shared goals for policy change were evident in participants' reports. Typically, nurses' efforts involved mobilizing communities and building or enhancing their capacity to influence the policies that posed barriers to health. The nurse who spoke about her involvement in advocating for the no-smoking bylaw noted the following:

I worked with a community group that very much wanted to see no-smoking by-laws passed by the municipality and at that point the municipal government wasn't that receptive to the idea. So it ... [helped] to work with that community group to build their capacity, to educate the community, to mobilize other community members, to advocate on behalf of the community to the municipal government.

Another participant, whose political activism centered on securing affordable housing, reported the following:

There was this whole group of people that lived at Tent City ... [who] became very strong partners. Some had been [my patients] in the past in that traditional sense, but my role ... [in Tent City] with them was more to facilitate and organize the infrastructure around their community with them—for them and with them—it was both. [That included] everything from involving them in community meetings and bringing them to City Hall and also responding to crises they had there and then ultimately winning the rent supplement program with them. So some of them actually are part now of our speakers' bureau. Another guy is on our

steering committee [of a housing advocacy group which the participant was instrumental in starting]. And it's not a smooth transition but I think my role now is a little bit of that, trying to identify some of those people ... [who] could be doing some of this and they want to and they're very able actually once they get into it.

Nurses advocated for policies that would promote health equity by ensuring equity in distribution of societal resources at whatever level was necessary, from corporate board rooms to school boards and at municipal, provincial, and sometimes national levels of government. They fought for the policies that would provide equitable opportunities for health, such as food security, housing, and sufficient income; healthy, safe, supportive, and inclusive environments; and accessible transportation. In so doing, they engaged in an intricate dance of meeting basic needs downstream, either directly or indirectly, through linking people with existing resources and moving upstream to advocate for healthy public policy. As one nurse phrased it, "I believe that it's a kind of trombone slide—that it's like the imperative of our discipline."

Barriers to moral agency

Despite the many successes reported in the previous excerpts, participants also identified considerable barriers to their being able to slide harmoniously back and forth between their downstream work, in which they met health needs and witnessed injustice, and their upstream efforts to influence the policies that contributed to that injustice. The barriers identified earlier that created ethical dilemmas by hindering participants' ability to exercise an ethic of caring, for example, financial and administrative constraints, often also hindered the expression of caring through activities to promote social justice. Some participants identified feeling powerless to effect the necessary changes. A number expressed similar concerns to those expressed by this participant:

I work with families living in poverty and as a public health nurse I would really like to help them get

past ... [the barriers they come up against] but because it is [at the] systems level and I don't have a lot of power in changing the systems, individually I'm stuck there.

Another nurse expressed similar exasperation and powerlessness in the shift in her health unit from setting priorities based on the expressed needs of community members to an overreliance on electronic data that would require less involvement of the nurse with her community. "We're being interfered with," she mourned, "and I don't know what to do about it."

Participants in one focus group characterized such dilemmas as "what is versus what should be" and agreed that it caused them considerable moral distress. One participant asked the following:

How can I keep going out to visit these people in their homes and seeing these patterns over and over again? But it seems like our hands are tied sometimes because of funding or the way that we're structured not only within public health but the health system in general to actually act.... It breaks your heart and I know what's right but it doesn't seem like I can actually do that within the constraints of the role I have.

Another believed that Canadian society had lost sight of its values, adding the following:

It feels like there's an incredible need for some kind of a pan Canadian values discussion about what kind of a society do we really want to live in—what is it that we do value—so that perhaps if the values become clear then some of the other policies will become unacceptable or some of the policies and our priorities that are now constraining [us and creating] barriers may, in fact, fall away.

A frequently identified factor that participants stated as eroding their moral agency was relentless public health restructuring and refocusing that isolated individual and family health promotion work from political advocacy work. One nurse expressed her profound distress at this change and hinted that she was considering leaving public health as a result. Another nurse admitted the following:

I've always felt guilty about ... being part of the process that actually went from generalized public

health practice to what we call specialized public health practice. And again it speaks to those compromises within the organization you're working. And I suppose ethically, I should have resigned rather than participate in the process but I didn't.... But you have to have those connections or you can't be really effective.

Yet, there was also some evidence of resistance and, as seen in some of the excerpts, stories of success in overcoming barriers. One participant reported that she was being pressured to move to "specialized areas of focus" because they were promoted as more efficient and effective. "I'm resisting it for exactly that reason," she added. Some nurses who had been moved to a population-based practice were able to draw on their previous public health nursing experiences and connections. Others who were working with vulnerable populations and had no time for upstream political advocacy were able to bring their concerns to the attention of colleagues who were working more upstream. A few reported engaging in political advocacy on their own time, either alone or together with colleagues, or by calling upon their professional nursing organization for action on an issue.

DISCUSSION

The findings from this study support critical caring theory's premise that public health nursing practice is guided by ethics of caring and social justice. Participants' practice accounts reinforce the conceptualization of social justice as an expression of caring[9] rather than its being separate from and complementary to a caring ethic, as originally postulated.[5] This finding is consistent with the ethics evident in the early nursing practice of Nightingale and early North American nurses,[9-11] with Watson's recent call for sacred activism[28] informed by an expanded caring science that includes social justice, and with feminist literature in which caring and justice are integrated into one moral theory.[29,30]

Participants' difficulty in articulating an ethical framework is perhaps understandable. It might be akin to asking an experienced driver how to drive a car, a question that would require most to stop and raise to a conscious level something that has become quite unconscious. A caring/social justice basis for nursing practice was evident in the work of Nightingale and early public health nursing work, before the establishment of professional codes of ethics. These early nursing leaders knew experientially that addressing issues of social injustice, such as poverty, would improve health.[9,10] Quite probably, both study participants and early nursing leaders, as women, make/made ethical decisions differently than men, as documented in the landmark work by Gilligan[31] and more recently argued by feminist nursing ethicists.[32-36] Moreover, both historical and participants' accounts of social justice as an expression of caring reflect feminist critique and extension of the work of Gilligan by combining caring and justice ethics.[29,30,37]

The importance of social justice to participants' practice is consistent with the argument that because both public health[8,19,38] and nursing[9,21] are rooted in social justice, PHNs are best suited to address health inequities. In addition, participants' practice examples bring further conceptual clarity of social justice as 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. This dual perspective is consistent with the CNA[39] social justice framework. Furthermore, many of the attributes of social justice identified in the framework, such as persuasion of equity, protection of human and civil rights, capacity building, advocacy, poverty reduction, partnerships, and creation of supportive and empowering environments were evident in participants' descriptions of their practice.

The findings, however, also support arguments that definitions of social justice as the distribution of health care[14] or social resources[39] are not broad enough for public health nursing practice. Consistent with analyses on the relational nature of nursing ethics

generally,[34,35] participants' practice accounts of social justice are more closely aligned with the critical conceptualization of social justice of Kirkham and Browne[11] as relational and contextual. To a lesser extent, several participants' reports suggest the awareness of intersectionality[11]—the intersection of characteristics, such as class and gender (among others), with historical and sociopolitical contexts to create injustices.

Although the relational basis for ethical decision making was prominent in participants' accounts, a few identified ethical codes as their basis for moral practice. Even when not articulated as such, the moral knowledge of principles and codes received at times conflicted with contextual and relational moral knowledge, as in the comment of the nurse who bought cigarettes for some people: "But technically maybe, a nurse isn't supposed to do that." Such concomitant influence of antithetical forms of ethical decision making is consistent with the dialectical model given by Gadow[32] but was a source of moral distress for some participants.

Most frequently, however, moral distress arose from nurses being impeded in acting on their knowledge (whether emerging from relationships or received through professional standards) that redressing social injustices was morally required. As employees of bureaucratic agencies, such actions were not simply within the context of the nurse-patient relationship but required organizational support and resources. Barriers to participants' moral agency as social justice advocates included frequent reorganizations and reassignments at the agency level and mandatory programs imposed by government on their employers, often resulting in increased workload and decreased resources for social advocacy. Some participants could "get around" the restrictions through what has been described elsewhere as judicious circumvention.[40] The despair of others is reflected in comments such as "I suppose, ethically, I should have resigned." Similar experiences have recently been described in other nursing workplaces as constrained

moral agency[36] and attributed to the rapid and relentless corporatization of workplaces in general[41] and health care environments specifically.[34-36]

Many of the barriers that participants faced are essentially the same as those faced by hospital nurses studied by Rodney and Varcoe.[35,36] The prevalence of the scarcity paradigm, with its mantra of insufficient resources, was experienced by participants in this study as either the rationale for not being able to do political advocacy work or increased workloads that indirectly kept them from that work. Likewise, participants experienced what Rodney and Varcoe term "corporate streamlining"[36(p128)] in the pursuit of ever more efficient processes. For many of this study's participants, corporate streamlining took the form of incessant reorganization, changing scope of practice, reassignment at the local level, and changing mandatory requirements handed down from governments.

Resistance to the constraints that participants faced through somewhat subversive means, as in the special diet clinic, or judicious circumvention that involved work on personal time was also documented in the studies by Rodney and Varcoe.[36] However, they point out that such activities are not without potential legal and/or professional risks to the nurses who engage in them. Furthermore, it has the danger of rendering vital nursing work, such as political advocacy, invisible.

Rodney and Varcoe[36] argued that the net result of nurses' constrained agency was compromised patient care and moral distress of nurses. Similarly, the moral distress experienced by this study's participants most commonly related both to being constrained from exercising their moral agency and to knowing that because of those constraints the social injustices they witnessed would not be redressed.

CONCLUSION

Two aspects of the findings of a study to explicate the critical caring theory[5] further

were reported here. These findings support the theory's premise that critical caring is a caring ethic through which social justice may be expressed. The findings add to the theory the notion that critical caring is a relational ethic, emerging from PHNs' experiential context. In addition, the findings reported here support the practice relevance of the carative health promoting process of creating supportive physical, social, economic, and political environments. The rich detail of participants' practice accounts adds much understanding to public health nursing practice in these respects.

Three themes were evident in these findings. The first 2, "the moral imperative" and "in pursuit of social justice," provide insight into participants' caring/social justice moral center and illustrations of how it informs their practice. Within these 2 themes is ample evidence that to the extent that the participants' comments are typical of PHNs generally, the latter are ideally prepared and willing to take up the CSDH challenge to reduce health inequities through working with others to effect change in the social, cultural, economic, and political structures and policies that have been instrumental in creating social injustices. Study participants reported considerable success in mobilizing communities, forming partnerships, and initiating or joining coalitions to increase their power for effecting change.

The third theme, "barriers to moral agency," however, raises questions about PHNs' moral agency to meet the challenge of reducing health inequities. The significant barriers that participants reported would suggest that, in the terms of Smith,[21] their capacity for caring may not be healthy and intact and, consequently, their ability to assume a leadership role in reducing inequities may be compromised. Since most of the participants were, in effect, agents of the state in that they were employees of government-managed and/or government-funded organizations, it also raises the question of whether it is reasonable to expect that they can effectively challenge these governments to change

policies toward achieving social and health equity. To the extent they can, they will be able to practice according to the Canadian national community/public health nursing standards and practice model and critical caring theory will be a useful framework in guiding them to do so. To the extent they cannot, the theory may keep nurses grounded in nursing moral ideals and serve to strengthen their sense of professional autonomy, identified as a prerequisite to free moral agency.[36,42]

A strong sense of professional autonomy may lead nurses to finding solutions within their organizations to overcome some of the barriers they face in addressing social and health inequities. Alternatively, it may lead some to enact their political advocacy as private citizens or partner with professional nursing organizations or nursing unions in doing so. In Ontario, the province in which most of the study participants practiced, the Registered Nurses Association of Ontario is a very visible leader in this regard and possibly an underutilized ally for the province's PHNs. Sadly, if moral distress is not relieved, some nurses may change their place of employment or leave nursing altogether.

The study findings are thus a clarion call to national and jurisdictional professional nursing organizations. The equivocalness of the CNA Code[13] concerning actions toward social justice notwithstanding, the code does acknowledge that advocating for social justice is ethical nursing practice. It is not sufficient, therefore, for professional associations simply to urge nurses to do so "as much as possible."[13(p20)] Ultimately, ensuring that nurses' capacity for caring—including through 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.

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