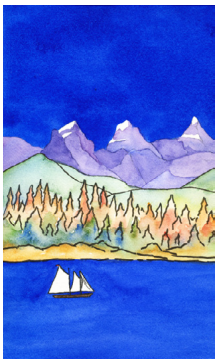

CHAPTER 9

Promoting Health Equity in Nursing Practice: Challenges and Opportunities

Bernie Pauly and Corey Ranger

> *"There must exist a paradigm, a practical model for social change that includes an understanding of ways to transform consciousness that are linked to efforts to transform structures"*
> **(bell hooks, *Killing Rage: Ending Racism*, 1995)**

THE UNITED NATIONS, in its *2030 Agenda for Sustainable Development* (2015), points to important goals for health systems globally, including "[t]o ensure healthy lives and promote well-being for all at all ages," and "[r]educed inequalities" (p. 3). However, we have yet to achieve these goals, or the other 15 listed; meanwhile, there are new threats and widening gaps in health and wealth which continue to emerge. The global pandemic of COVID-19, declared by the World Health Organization (WHO) in March 2020, exposed and deepened pre-existing inequities in health and impacted the ability of many to

stay at home safely. Alongside an infectious disease pandemic, "pandemics" of racism, domestic violence, drug overdose deaths, poverty, and homelessness—escalated by systemic restrictions to prevent the spread of COVID-19—were further exposed. More than a decade ago, the WHO (2008) emphasized the importance of closing the gap in health in the next generation by addressing the conditions in which we live and work. These conditions are known as the social determinants of health (SDOH).

Nurses have played an unprecedented and critical role in ensuring the health and safety of individuals, families, and communities through activities aimed at preventing COVID-19 and providing care for those with COVID-19. In every aspect of the pandemic response, nurses have been front and centre. Nurses have rapidly responded to individual, community, and population-level health needs, which is characteristic of their deep ethical commitments to care for others. For example, public health nurses stepped up to provide education, testing, and contact tracing, and to facilitate rapid uptake of vaccines. In hospitals and communities, nurses have cared for those who are sick, as well as those who are highly vulnerable and susceptible to COVID-19. This response has come at a high cost to nurses themselves. Nurses have raised alarm bells about the cracks in our systems, voicing concerns about the health and well-being of the nursing workforce. During COVID-19, the visibility of nursing work and the stresses associated with that work have never been greater (Abuatiq, 2021).

Nurses often witness people experiencing systemic inequities in the health care system, and therefore are able to highlight and bring awareness to these inequities (Pauly et al., 2021; Scott et al., 2020). This duty to advocacy bears its own cost to health care providers (HCPs). Working in the context of deep inequities and systemic violence—such as often-undeclared and ongoing emergencies related to structural racism, violence, drug overdoses, homelessness, and poverty—are less visible sources of overwhelming workloads and distress for nurses, particularly in community and public health nursing (Marcellus et al., 2022). As such, there is a tension between advocating for the profession at the same time that there is an urgent need to advocate for reducing inequities and promoting health equity. This is both a challenge and an opportunity, requiring

a depth of knowledge and understanding that is often not available within health systems (Farrer et al., 2015; Wright et al., 2022).

Health equity is a fundamentally ethical concept. Canadian health systems have goals related to achieving health equity, and nurses have a professional and ethical commitment to the promotion of health equity (Baum et al., 2009; Canadian Nurses Association, 2017). However, within these systems, there are ethical issues associated with promoting health equity that have been termed the "health equity curse" (Pauly et al., 2021). Health systems are dominated by ideological commitments that privilege individualism, biomedicine, and capitalism, and are steeped in settler colonialism and racism—all factors which can negatively impact health equity (Allan & Smylie, 2015; McGibbon et al., 2021). It is difficult to promote health equity, as within conflicting value systems, equity and equality may not be prioritized. Furthermore, while health equity may be upheld as a value in theory, there is little critical understanding of the concept in practice, or of the actions its achievement would require (Marcellus et al., 2022; Van Roode et al., 2020).

In this chapter, we name ethical issues associated with health inequities, and we locate these inequities within a critical social justice perspective that highlights power imbalances and the structural and systemic conditions that create inequities (Farmer, 2001, 2009; McGibbon & Lukeman, 2019; Navarro, 2009; Stevens & Hall, 1992; Young, 1990). We examine strategies for navigating these issues in practice, therefore promoting a vision of health equity that is more in line with the stated goals of health systems. First, we provide some definitions of basic concepts central to understanding professional goals and commitments related to health equity. Understanding of core concepts, such as health equity and inequities, the social determinants of health, and social justice, are central to advanced nursing practice. This knowledge helps nurses to name issues and thus informs their understanding and action on professional ethical commitments.

Social Determinants of Health, Health Equity, and Critical Social Justice

Social Determinants of Health

An array of social factors, beyond health systems and services, influence individual health and the overall health of the population (Mikkomen & Raphael, 2010; Navarro, 2009). We often refer to these social conditions as the social determinants of health. Simply stated, where we are born, live, work, and age matters to our health (WHO, 2008). As noted by the WHO's Commission on the Social Determinants of Health,

> The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples' lives—their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a "natural" phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries. (Commission on the Social Determinants of Health, 2008)

The social determinants include both material and non-material factors that influence health (Graham, 2004). Material determinants include housing, income, education, and other resources, while non-material determinants refer to elements that impact advantage and disadvantage, such as privilege, race, sex, gender, and social class. These elements are the

> interrelated social, political and economic factors that create the conditions in which people live, learn, work and play. The intersection of the social determinants of health causes these conditions to shift and change over time and across the life span, impacting the health of individuals, groups and communities in different ways. (National Collaborating Centre for Determinants of Health, n.d., emphasis in original).

Importantly, social positioning matters to health with the recognition that individuals, groups, and communities are differently positioned within existing social conditions and such conditions are embodied in relation to health, illness, and disease (Friel et al., 2011; Kreiger, 2009). One way of understanding this is to use an intersectional lens to consider differing dimensions of sex, gender, class, ethnicity, and ability (Crenshaw, 2005; Dhamoon & Hankivsky, 2011).

Intersectionality refers to social positioning and how individuals are positioned in relation to overlapping systems of oppression and advantage (Cole, 2009; Varcoe et al., 2012; Walby et al., 2012). The particular set of conditions and positioning affecting each individual's health care is not simply additive; it is multiplicative, creating advantage and disadvantage within systems that simultaneously privilege and discriminate (McCall, 2005). In Canada, this can be seen in the benefits White settlers have enjoyed from colonization and capitalism, while Indigenous people were stripped of land and resources and suffer ongoing generational impacts of systemic racism (Reading & Wien, 2009).

Health Equity

Health inequities are produced and reproduced by structural injustices deeply rooted in policy and political processes. For example, it was a political decision to disinvest in social housing in the 1990s and treat housing as a commodity rather than as a basic social good or a determinant of health (known as the financialization of housing; Office of the High Commissioner for Human Rights, n.d.). Health inequities are systemic injustices that are unfair, potentially

modifiable, and remediable (Crombie et al., 2005; Whitehead & Dahlgren, 2006). Conversely, health equity means everyone (individuals, groups and communities) has "a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions" (National Collaborating Centre for Determinants of Health, n.d.). While health equity is a goal of health care systems (Baum et al., 2009), health systems are permeated by biomedical values, as well as the ideologies of capitalism, neoliberalism, and colonialism that contribute to systemic inequities (Allan & Smylie, 2015; McGibbon et al., 2021; Pauly et al., 2021). As such, health systems are falling short of meeting espoused goals of health equity. Thus, although health equity may be a stated value in health systems, it may not be prioritized over other competing priorities and ideologies (Van Roode et al., 2020). Further, health equity is often not well understood, and nurses, policymakers, and others have very different understandings of what health equity means (Pauly et al., 2017).

Equity is often confused with equality. Health inequalities refer to differences in health outcomes between groups in the population without any moral assessment of fairness or justice. When these differences are produced by systemic and structural conditions and are potentially remediable, these differences are known as inequities (Whitehead & Dahlgren, 2006). For example, people who are unhoused often have poorer health and die prematurely compared to the rest of the population because they lack a fundamental material determinant of health: a place to live (Hwang et al., 2009). This issue is systemic because housing has become a commodity rather than a social good, resulting in a loss of social housing and a lack of investment in affordable housing. Structural violence, a term coined in the 1960s by Galtung, has been taken up in health and health care by social scientists to describe these sorts of social structures, institutions, and processes that prevent people from accessing basic resources for health, thus causing harm (Farmer, 2001, 2009; Rhodes et al., 2012).

So far, we have focused on health equities, as well as structural and systemic conditions that impact health. Yet most of the determinants of health fall outside of the health system, despite their major influence on health, meaning HCPs often lack a direct means

of improving outcomes for their patients. Gaps in health equity are compounded by inequities in access to health services. This is sometimes called the inverse care law, in that people who have the least access to resources for health also face the most barriers in accessing health services (Hart, 1971). Frequently, equity of access is a primary focus in health systems (Pauly et al., 2017). In part, this focus stems from the nature of acute care services, where there are concerns about various dimensions impacting access, such as geography, gender, ethnicity, and ability. Health systems are typically not oriented to public health and the SDOH, as the focus of health systems is biomedical and acute care.

Critical Social Justice

While traditional approaches to bioethics have centred on distributive justice, the achievement of health equity centres on social justice. Beauchamp (1976) highlighted the connection between social justice and acting on the determinants of health. Specifically, he wrote, "Public health should be a way of doing justice" (Beauchamp, p. 8). Peter (2004), drawing on Rawls, argued that social inequalities (differences in health) are wrong when they stem from unjust social, political, and economic institutions, thus embedding "the pursuit of health equity in the pursuit of social justice in general" (p. 160). Iris Marion Young (1990), when discussing feminist and relational bioethics, highlighted that conditions shaping distribution of resources, including power and privilege, are critical to social justice. In order to achieve fairness, participation of those impacted by inequities is central to the achievement of health equity. Fraser (2007) identified the importance of social arrangements that allow for participatory parity, with parties being able to participate as equals based on a three-dimensional theory of justice: recognition, redistribution, and representation. As will be discussed later, engaging with the individuals impacted by health inequities is a cornerstone of equity-oriented action. These individuals often have less power, advantage, and resources in society, and are often underrepresented in health and social systems.

McGibbon and Lukeman (2019) outlined the core features of a critical perspective for informing critical social justice for nursing. These included

> 1) explicit analyses and critique of hegemonic power structures and ruling relations; 2) organized public protest and acts of resistance in the face of oppressive, often murderous, regimes, public policies, and the like; and 3) explicit goals of disrupting, unsettling, and interrupting processes and practices of oppression in local and global spheres (all of which are synergistically connected). (p. 4)

Thus, reducing health inequities requires fundamental shifts and redistribution of power. Unfair and inequitable structures and processes must be changed to enable a better distribution of wealth, resources, and privilege in society. The complexity of changing structures and processes makes it challenging to shift organizations and systems towards equity. In what follows, we present an Ethics in Practice scenario where we highlight challenges in regard to changing structures and processes, particularly when racism is involved. As we describe below, racism can be both a determinant of health and a cause of inequitable access to health care.

ETHICS IN PRACTICE 9-1

Racism in Health Care

On September 28, 2020, Joyce Echaquan, an Indigenous woman, died in a Montreal hospital after being subjected to abusive remarks from nursing staff.* The words and actions were captured on video and shared on social media (Page, 2021a). While the investigation into her death found that understaffing played a role, the comments and actions of the nurses were inconsistent with professional codes of ethics and practice standards (Page, 2021b.) Furthermore, this was not an isolated incident, as there have been many reports of racism in health care experienced by Indigenous people. For example, in June 2020, there were media reports of allegations that staff in a BC emergency centre played a game to guess blood alcohol levels of Indigenous patients. A systematic inquiry into this situation (British Columbia Ministry of Health, 2020) found that 84% of Indigenous people have experienced racism in health care. For example,

Indigenous people who did not drink alcohol were told not to drink; in other situations, they were assumed to be intoxicated when they were not.

As illustrated in the Ethics in Practice scenario above, racism is a determinant of health and acts as a deterrent that limits access to health care (Reading, 2015). For Indigenous people in Canada, racism is deeply rooted in health and social systems. In a 2015 study, *First Peoples, Second Class Treatment*, Allan and Smylie described how racism against Indigenous people in the health care system was a major factor contributing to poor health among Indigenous people across Canada. The researchers found that Indigenous people experienced so much racism from health care workers that they often strategized ahead of time about how to deal with racist behaviour before visiting emergency departments, or they avoided hospitals altogether.

Racism, whether conscious or unconscious, impacts the care nurses provide. Nurses are in a position to call out racism. However, nurses often remain silent and, further, do not always recognize the historical role they have played in the marginalization of racialized people in Canada. For example, until their discontinuation in the early 1980s, "Indian hospitals" racially segregated Indigenous people from others, often displacing them from their communities with requirements to travel thousands of kilometers to the nearest facility, and providing harsh and inhumane treatment. Thus, Indigenous people have a legacy of well-earned distrust in the Canadian health care system (Lux, 2016). In fact, the *Indian Act* of 1985 (Government of Canada, 1985) can compel hospitalization for Indigenous people to this day.

As a way to provide more direction to nurses regarding racism, national and professional nursing organizations created a nursing declaration on anti-Indigenous racism (Canadian Association of Schools of Nursing & Canadian Indigenous Nurses Association, 2021) that affirmed the importance of the *United Nations Declaration on the Rights of Indigenous Peoples* (United Nations, 2007) and reports of the Truth and Reconciliation Commission's *Calls to Action* (Government of Canada, 2015). Given that there is a pressing need to address Indigenous racism in nursing, we believe that advanced practice nurses have the expertise and are in key leadership roles to facilitate change in education, policies, and culture.

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* Refer to Chapter 20 for another discussion of this case.

Naming Ethical Issues in Promotion of Health Equity

Ethical issues related to the promotion of health equity frequently go unrecognized and unnamed in nursing practice. In what follows, we describe a number of equity issues that emerge in multiple settings, including in hospitals, public health clinics, and primary care

settings, as well as community and outreach services. These issues surfaced in research with public health providers who focused on ethical issues that arose in the context of promoting health equity (Pauly et al., 2021). They highlighted tensions that occurred as nurses and other practitioners tried to navigate different agendas in systems where health equity was not necessarily prioritized. We briefly describe some of the issues in the next section.

Conflicting Values

Health systems dominated by values that are integral to biomedicine include an emphasis on managing illness and disease within a system focused on acute care. Public health, in contrast, has explicit commitments to health equity and promotion of the determinants of health, and is therefore more oriented towards preventative action than acute care. As a result, public health is often marginalized and underfunded.[1] HCPs also do not necessarily have control of resources that impact all the determinants of health; for example, housing, income, and education, adding further barriers for public health practitioners.

Individualistic and Biomedical Lenses

Within acute care and biomedical systems, health inequities are blamed on the failures of individuals, who are also blamed for any negative situations in their lives which contribute to poor health. There is often little attention paid to broader structural or systemic conditions that impact both the health of individuals and the health of communities as well as subgroups in the population. This is ethically concerning because of a failure to recognize harms and vulnerabilities that are a product of structural violence and systemic conditions. Individuals, groups, and communities should be self-determining; however, when caregivers individualize or medicalize a person's situation or concerns, this contributes to harm and creates barriers to care.

Efficiency and Business Models (Capitalism) Versus Person-Centred Care

Public health providers have described an emphasis on bureaucracy and efficiency that often undermines and diminishes the ability of nurses to provide patient-centred care. This is critically apparent in the checklists and tick boxes that dominate care provision, as well as eligibility requirements for services (Pauly et al., 2021). Nurses are often unable to individualize or personalize care in the context of bureaucratic requirements, and frequently have to find workarounds or bend the rules in order to ensure that individuals receive the care they need. Additionally, in the context of stigma and discrimination, there is often a lack of respect, as well as more attention placed on surveillance and control rather than on trust and autonomy.

The issues described above are some of the ethical difficulties that nurses confront in daily practice as they care for vulnerable patients facing threats to their health. It is a sampling rather than an exhaustive list. To further illustrate some of these issues, we provide the following Ethics in Practice scenario where we describe the need for structural and systemic attention to health inequities.

ETHICS IN PRACTICE 9-2

Structural, Systemic, and Individual Determinants of Homelessness

Homelessness is a product of systemic and structural issues that intersect with personal situations, such as job loss or injury (Gaetz et al., 2016). The root causes of homelessness in Canada include poverty, loss of social housing, neoliberalism, capitalism, and colonialism. Indigenous people are over-represented among unhoused populations due to displacement and loss of lands and resources. Homelessness is often medicalized, problematized, and stigmatized as an individual problem, a mental health issue, a substance use issue, or some combination of the three. Prior to and during COVID-19, encampments became increasingly visible across Canada, and communities grappled with how to respond to visible homelessness. For many, the privilege of staying at home was not possible. People living outdoors and in encampments do not have access to the basic requirements for health, such as housing, income, public sanitation, garbage disposal, food, privacy, and safety. These

basic requirements are the most crucial determinants of health; they are necessary for health and well-being.

Encampments often include communities of people who are working to support themselves and each other when housing, income, and other systems have failed (Olson & Pauly, in press). Yet, communities often respond to these encampments with stigmatizing and criminalizing responses, such as more policing or restrictive bylaws that further punish unhoused people (Olson & Pauly, 2021). In fact, public health can be weaponized to displace encampments and municipal policies are often used to displace unhoused persons who have nowhere to go. This raises difficult and challenging ethical issues for public health practitioners as well as for health providers, who are often unable to provide a level of essential health care for people in these situations. Confiscation of belongings often includes essential medications that are lost and need to be replaced, as well as essential health care supplies, such as naloxone for reversing overdoses. Constant moves make it difficult for HCPs to find and follow up with individuals to provide health care. COVID-19 has worsened these conditions; HCPs are often unable to support people in following public health guidance, because individuals without housing have nowhere to self-isolate, no ability to stay at home or wash their hands, and lack the funds necessary to procure personal protective equipment like face masks. The health care system's lack of attention to the SDOH creates a myriad of daily ethical challenges for nurses and HCPs to navigate.

Multiple Forms of Stigma and Discrimination

As illustrated in the Ethics in Practice examples presented so far, stigma and discrimination are fundamentally ethical issues that violate basic principles of respect and dignity. These issues involve moral judgments about persons in terms of their worth and value as people, including a lack of recognition and respect for human rights and the ability to be self-determining. Stigma and discrimination have similar roots, but some authors distinguish between the two (Ahern et al., 2007). Stigma is often associated with marginalizing a person or group because of their particular behaviours; some conditions that are highly stigmatized include illicit drug use and mental health issues. Discrimination, on the other hand, is focused on the innate characteristics of individuals which "other" them, such as race, sex, and gender.

Enacting stigma is a form of power in which one group has the ability and authority to label, stereotype, and judge others on the basis of certain characteristics or behaviours (Link & Phelan, 2014).

Labels and stereotypes are based on assumptions and moral judgments about people and groups. Stigma is harmful and has a negative impact on the health and well-being of those who are stigmatized (Biancarelli et al., 2019; Couto e Cruz et al., 2018; Gee et al., 2012). Racism, sex, and gender discrimination, as well as discrimination on the basis of poverty and homelessness, impact health and act as barriers to health care services (Allan & Smylie, 2015; Chan Carusone et al., 2019; Gabet et al., 2019). Abusive, stigmatizing, or discriminatory comments are inconsistent with the professional and ethical commitments of nurses to treat people with respect and dignity. In many ways, these kinds of negative behaviours reproduce the structural trauma that is already endemic in health and social systems.

Professional Commitments to Health Equity and Social Justice

Nurses and other HCPs should provide safe, competent, and ethical care in accordance with professional values that include commitments to health equity and social justice. These commitments are outlined in professional standards of practice and codes of ethics (Canadian Nurses Assocation, 2017). Nurses and others often find themselves at the nexus of ongoing systemic injustices, inequitable health systems, and commitments to promote health equity in the face of inequities. In Part 1 of the CNA *Code of Ethics for Registered Nurses* (2017), seven key values that nurses must uphold are outlined, including promoting justice. Nurses are specifically directed as follows:

> F1. Nurses do not discriminate on the basis of a person's race, ethnicity, culture, political and spiritual beliefs, social or marital status, gender, gender identity, gender expression, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability, socio-economic status, or any other attribute.
>
> F2. Nurses respect the special history and interests of Indigenous Peoples as articulated in the Truth and

> Reconciliation Commission of Canada's (TRC) Calls to Action (2015).
>
> F3. Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care or toward other health-care providers, students and each other. (p. 15)

Nurses have ethical responsibilities to promote justice and not discriminate against individuals. In practical terms, it may include not discharging individuals from care facilities into unsafe situations where they do not have a suitable place to live, or face domestic violence. Further, promoting justice should and must capture the ethical responsibilities of not discriminating against groups or communities. To this end, the authors of the CNA *Code of Ethics* highlighted the importance of knowing the history of Indigenous people, but in our view, this measure does not go far enough in combatting stereotypes, judgments, and labelling of Indigenous people and other groups. Further, all Canadian provinces and territories have human rights legislation prohibiting discrimination of groups and communities.

Part II of the 2017 CNA *Code of Ethics* also includes specific aspects of social justice and the ethical endeavors of nurses to improve systems and societal structures for greater equity. However, this portion of the CNA *Code of Ethics* is considered to be aspirational, non-binding, and in some cases, the responsibility of collectives rather than individuals. Yet, for public health and community nurses, this is central to their practice as outlined above, in that health equity is foundational to public health.

Strategies for Ethical Nursing Practice

To promote health equity in nursing practice requires a set of competencies that nurses should acquire during their nursing education or through continuing education. There are multiple strategies for gaining the knowledge and skills required to promote health equity. Advanced practice nurse leaders can role model, practice, and promote these skills as part of their leadership roles. Such strategies

can help shift thinking and cultures within health care organizations. Further, it is also important to shift policies at micro, meso, and macro levels, as educational opportunities alone will not be enough.

Thinking Differently

Thinking differently means using a different lens for how one views individuals, groups, and communities in practice. Using a dominant societal lens results in people seeing inequities as a problem of individuals (a view which aligns with neoliberalism) or as a problem of biomedicine. In addition, heteronormativity, gender bias, and ableism colour our thinking in ways that impact how we provide care. Thus, we have to think differently about individuals, groups, and communities, and how they are positioned in society, as part of the provision of ethical nursing care. Another way of saying this is to use one's ethical imagination. For example, ask the question, what would it be like if I had to walk all night because there was nowhere safe to sleep?

Another aspect of thinking differently can be understood in terms of recognizing different social locations by drawing on intersectionality and social ecology. An intersectional lens helps us focus on how people are positioned differently within society, and an ecological lens helps us recognize the different contexts which impact experiences of those affected by inequities. The Systems Health Equity Lens (SHEL) was developed to guide nurses and other health care leaders when reviewing systems and creating organizational health equity plans (Pauly et al., 2018). The SHEL can be used by nurses in practice and leadership positions in many settings to encourage shifts in thinking about health equity.

Medical educators—particularly in social medicine, where the focus is on the social factors that contribute to health and illness—have embraced the idea of practitioners attaining structural competencies to understand how social conditions impact health for individuals (Metzl & Hansen, 2014). Learning is centred on understanding individuals and their circumstances, which extends to a structural understanding of why someone might not be able to follow a plan of care if they are, for example, living in an abusive situation or have to prioritize survival needs such as finding food

and shelter. Experiential learning has also been highlighted as a way to mitigate stigma through human interactions with individuals experiencing inequities (Livingston et al., 2012).

Understanding History and Policies

Knowledge and understanding of history and policies that have produced inequities is essential to ethical nursing practice. This knowledge contributes to thinking differently about people and situations. Knowledge is essential to disrupt stigma and discrimination and accurately contextualize and understand situations and behaviours. In the 2017 CNA *Code of Ethics*, there is specific reference to understanding the history and ongoing influence of colonization, which is a critical context for understanding Indigenous mistrust of health systems. There are many avenues for gaining this knowledge, such as through programs like San'yas Anti-Indigenous Racism Cultural Safety Training (Provincial Health Services Authority, n.d.).

In Ethics in Practice 9-3 below, we share insights offered by an examination of the history and policies that underlie the current high rate of overdose deaths in Canada. We also discuss how the system can be improved by framing substance use as a social and political issue, rather than an individual failing.

ETHICS IN PRACTICE 9-3

Overdose Crisis Within a History of Drug Policy, Racism, and Colonialism

Prior to 1908, currently illegal drugs, such as cocaine and heroin, were available in over the-counter medications such as cough syrups. These substances were used by all sectors of society (Boyd, 2017; Boyd et al., 2016). Key catalysts for the current drug policy of prohibition were the 1907 race riots in Vancouver and the influence of the temperance movement led by White settler and immigrant forces. Within this temperance movement, abstinence was promoted, and moral corruption was associated with the use of substances. This view was fuelled by the anti-Asian and anti-Indigenous racism that was part of colonialization. Mackenzie King, the prime minister

at the time, visited Vancouver, and upon return to Ottawa advocated for prohibition policies that were meant to control Chinese migrant workers and immigrants. In 1908, the *Opium Act* was passed (Canadian Drug Policy Coalition, n.d.), and although the *Act* has been amended several times, it is still in force today. This long-standing legislation of prohibition is contributing to a high rate of harms for people who use drugs. The harms include an epidemic of drug overdoses related to an increasingly toxic drug supply, as well as stigmatization of people who use drugs.

Almost 25,000 Canadians died of a drug overdose between 2016 and 2021, with a dramatic increase in the number of deaths during COVID-19 (Government of Canada, 2021). Indigenous people are disproportionately impacted by drug overdose deaths due to high levels of trauma associated with colonization (First Nations Health Authority, 2017).

Ongoing overdose deaths are dramatically affecting communities in which nurses work—communities which are experiencing constant loss and grief. Understanding the history of prohibition is key to developing important drug policy reforms that can be part of collective nursing advocacy and action. Additionally, knowledge of the history of prohibition should help nurses recognize how some communities are disproportionately impacted, and how stigma, racism, and discrimination are founded on and fuelled by current drug legislation. Speaking out against stigmatizing and discriminatory care of people who use drugs is essential to counter prohibitionist rhetoric, which creates the political inaction that results in people dying daily. Advanced practice nurse leaders can set the tone in health care in terms of creating new norms, cultural attitudes, and understanding of substance use, reframing it as a policy and political issue rather than a moral and individual one.

Developing Trust

In situations of inequities, there are often high levels of distrust of health and social systems due to colonial and capitalistic systems of oppression. Institutions such as residential schools and Indian hospitals, and the poor treatment of Indigenous people at these institutions, have contributed to high levels of distrust. For people who use drugs, stigmatizing experiences are cumulative and generate distrust. Homelessness is the product of the failure of multiple systems, and people are distrustful of systems as a consequence. In light of this, the ability to build trust is a profound skill that can promote health equity as, in part, it can facilitate access to health care (Pauly, 2014b). According to the 2017 CNA *Code of Ethics*, "Nurses build trustworthy relationships with persons receiving care

as the foundation of meaningful communication, recognizing that building these relationships involves a *conscious* effort. Such relationships are critical to understanding people's needs and concerns" (p. 8, emphasis in original). Although the work of developing trust in situations of distrust is complex and time-consuming, it is essential to promoting health and health equity.

The pathway to trust begins with respect. In Part I of the 2017 CNA *Code of Ethics*, the value of honouring human dignity encompasses recognizing and respecting the intrinsic worth of each person, and suggests that nurses should relate to all persons receiving care with respect. Relevant and important responsibilities written in the CNA *Code of Ethics* include

1. Nurses, in their professional capacity, relate to all persons receiving care with respect.
2. Nurses support persons receiving care in maintaining their dignity and integrity.
3. In health-care decision-making, in treatment and in care, nurses work with persons receiving care to take into account their values, customs and spiritual beliefs, as well as their social and economic circumstances, without judgment or bias.
4. Nurses intervene, and report when necessary, when others fail to respect the dignity of a person they are caring for or a colleague (including students), recognizing that to be silent and passive is to condone the behaviour. They speak up, facilitate conversation and adjudicate disputes, as appropriate/required. (Canadian Nurses Association, 2017, p. 12)

Speaking up requires skill, strength, and courage. Due to power imbalances among providers, this is not always easy or safe to do. It can be unpopular for nurses to advocate for some groups, such as people who are unhoused, and by doing so, nurses risk being marginalized by others (Pauly et al., 2021). Social movements are central to change, yet it can be difficult for nurses to engage in social movements, radical civil disobedience, and action because of legal implications for their careers and their abilities to remain registered

as nurses in their jurisdictions. In what follows, we discuss advocacy and introduce the idea of allyship.

Shifting Culture, Policies, and Practices

Advocacy

Advocacy has long been important to ethical nursing practice (Curtin & Flagerty, 1982). A key area of advocacy is promoting recognition of systemic causes of inequities. Recognition of structural and systemic factors such as colonialism, neoliberalism, and capitalism, and how they operate in nursing, are important to attend to within our profession. This recognition is critical to the processes of accountability and social change.

Nurses are positioned uniquely within health systems and the community to act as advocates. They are highly respected and credible professionals who are closely connected to those for whom they provide care. Advocacy is not speaking on behalf of others, but advocating for and making space for the voices of those impacted by health inequities to speak for themselves (Canadian HIV/AIDS Legal Network, 2005). In nursing practice, this can mean accompanying and supporting a client to speak for themselves when they are attempting to access needed services. In program and policy development and implementation, this can include advocating that people impacted by inequities be directly included in processes of decision making and action. Forming true and equal partnerships with people experiencing inequities is central to the promotion of health equity (Marmot et al., 2008; Solar & Irwin, 2010). Advocating for involvement of people impacted by health inequities is a form of advocacy that is consistent with concepts of critical social justice as described by Young (1990) and Fraser (2007).

Cultural Safety

Cultural safety is a key component of ethical nursing practice. The term "cultural safety" was developed by nurses in New Zealand to address the barriers to care for Maori people (Nursing Council of New Zealand, 2005; Ramsden, 2000). A key principle is that safety is defined by those receiving care. Nurses must reflect on and inter-

rogate their own positions of privilege and power in relation to clients. This aligns with the 2017 CNA *Code of Ethics* responsibility under informed decision making that states: "Nurses are sensitive to the inherent power differentials between care providers and persons receiving care. They do not misuse that power to influence decision-making" (p. 11). However, being sensitive to inherent power differentials goes beyond just decision making; it should apply to all aspects of interactions between nurses and patients.

Harm Reduction

Reducing the harms of risky activities, such as wearing seatbelts when driving or using car seats, is part of preventing injury and illness. Another example would be the use of condoms to prevent transmission of sexually transmitted diseases. Applied to the use of substances (legal and illegal), the use of the term "harm reduction" refers to reducing harm, not to reducing use of illicit substances. Harm Reduction International (HRI; n.d.) provides this definition of harm reduction:

> Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts associated with drug use, drug policies and drug laws.
>
> Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support. Harm reduction benefits people who use drugs, their families and the community. (paras. 1 and 2)

HRI outlines the following commitments that are integral to harm reduction: (a) respecting the rights of people who use drugs; (b) commitment to evidence; (c) commitment to social justice and collaborating with networks of people who use drugs; and (d) avoidance of stigma. The goals of harm reduction are to keep people alive and encourage positive change, to reduce the harms caused by

drug laws and policies, and to offer evidence-based alternatives to abstinence from drug use (Harm Reduction International, n.d.).

Often, harm reduction is understood as a set of evidence-based interventions such as needle exchange, safer consumption (for example, Vancouver's supervised site, Insite[2]), naloxone distribution, and other interventions like managed alcohol programs that reduce harms of use without preventing use. Nurses have long been advocates for harm reduction. For example, they spoke in support of Insite, and drew on a significant body of evidence when they acted as intervenors during the federal Supreme Court hearing about Insite (Canadian Nurses Association, 2011). The critical role nurses played alongside other intervenors resulted in Insite remaining open and being viewed as a health service.

While the CNA has official nursing policy and positions in support of harm reduction, many health care organizations do not have organizational harm reduction policies. This lack of policy can be a key source of ethical tension for nurses, requiring advocacy, education, and policy making.

Harm reduction is also a philosophy and set of principles that are integral to ethical nursing practice. Harm reduction as a context for ethical nursing practice means shifting moral values in order to develop trust and relationships so that nurses do not judge or label people for their drug use, but rather provide respectful and non-judgmental care while taking action at other levels to counter stigma and discrimination (Iammarino & Pauly, 2020; Pauly, 2008b; Pauly, 2014a). The use of harm reduction often falls short of addressing the full range of health and social inequities, and thus should be viewed through a social justice lens in which there is attention to the SDOH (Pauly, 2008a; Pauly et al., 2013).

Trauma- and Violence-Informed Care

Browne et al. (2018) have highlighted the importance of trauma- and violence-informed care as part of equity-oriented care alongside cultural safety and harm reduction. They pointed to the importance of understanding that trauma is structurally produced and as such, nurses should recognize trauma as a context for providing care without necessarily having knowledge of specific traumas. Such

sensitivity can guide nurses to align with ethical approaches in the provision of care. However, this requires deep and ongoing attention to and understanding of the structural conditions that cause harm, how nurses can be implicated in that harm, and the potential for the work of nurses to unintentionally cause harm. EQUIP Health Care provides multiple resources for integrating equity-oriented care into nursing and health care practice (EQUIP, n.d.).

Conclusion

Health equity and addressing ongoing historical and structural inequities is complex within systems that do not prioritize health equity and are bereft of a focus on the SDOH. As a result, individual actions and advocacy, in combination with systemic shifts, are needed desperately. For individual nurses, recognizing racism, stigma, and discrimination that threaten health equity can help to mitigate daily injustices that mediate access to health care. Such individual actions have a meaningful impact, especially when nurses challenge daily practices and local policies in their workplaces and communities. Nurses collectively have a critical role to play—and crucial contributions to make—in the fight for global shifts in thinking that elevate health equity as a true priority, rather than just a stated one, in health and social systems. In particular, as leaders in health care, advanced practice nurses are especially well-positioned to support enhanced education, policy, and program development that can help to promote health equity and address the root causes of inequities.

QUESTIONS FOR REFLECTION

1. *What are health inequities and how are health inequities produced?*
2. *What is the role of advanced practice nurse leaders in addressing health equities?*
3. *What might nurses draw from theories of social justice that could inform their practice and enhance social justice in health care?*

Endnotes

1 For a comprehensive description of the challenges in public health, refer to Chapter 4 in this book.

2 Vancouver's Insite, opened in 2003, is North America's first sanctioned supervised drug injection site. Drug users can inject illicit drugs there because Insite has a federal exemption from Health Canada. In addition, Insite provides clean equipment for drug injection, spectrometer testing of drugs, immediate overdose response, clinical care, and connections to health care and community services (PHS Community Services Society, n.d.).

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