Where justice is denied, where poverty is enforced, where ignorance prevails, and where any one class is made to feel that society is an organized conspiracy to oppress, rob and degrade them, neither persons nor property will be safe.

—Frederick Douglass, 1886

As long as justice and injustice have not terminated their ever renewing fight for ascendancy in the affairs of mankind, human beings must be willing, when need is, to do battle for the one against the other.

—John Stuart Mill, “The Contest in America,” 1862

Introduction

This chapter explores the responsibilities of advanced practice nurses (APNs) for recognizing and addressing injustices that affect the health of persons. The APN’s ethical responsibilities include “the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health” (American Nurses Association [ANA], 2001, preface). These are simply stated yet complex obligations. Fulfilling these goals may mean that APNs have to look for the antecedents of a patient’s or population’s problems in the value structure or politics of the larger community and that APNs take remedial actions either on their own or collaboratively with concerned others. Two important assumptions of professional nursing practice are (1) that each patient is equally worthy of attention and (2) the concerns of patients often cannot be effectively addressed without understanding the environment in which they live their daily lives. However, it can be very difficult to balance the needs of individuals within the APN’s care with the needs of other patients or the larger population of patients. It is also difficult...
to know what social justice demands of nurses without understanding how ideas of social justice, including individual human rights, developed and why. This chapter first explores the nature of problems associated with asserting that attending to social justice is an obligation of the nurse. Second, solutions and strategies for nurse actions alone or in concert with others are proposed. Finally, underlying assumptions about the relationship of societal conditions and health are explored and illustrated with cases. The following provides a brief overview of these aspects of social justice and APN practice that are developed in more detail within the body of the chapter.

**The Concept of Social Justice**

**Problems with the Concept of Social Justice**

Both the International Council of Nurses (ICN) and the ANA posit that nurses should be concerned with addressing social justice issues that affect their populations, but neither entity defines social justice or what social justice demands of nurses. Various definitions and theories of social justice have been proposed, but all are subject to criticisms that they are inadequate to structure just societies for various reasons. Buettner-Schmidt and Lobo (2012) completed a concept analysis of social justice for the purpose of nursing work and settings. They drew on a broad array of related literature from different disciplines. Their definition captures many essential characteristics of the concept as it is generally, if somewhat vaguely, understood. No resulting framework for action is proposed, although the authors do note that one is needed to guide nursing actions. Grace and Willis (2012) propose a framework for remedying injustices in health care that draws on the ideas of Powers and Faden (2006). Their framework may not be applicable to all nursing situations, but it does provide a starting point, and modifications can be made in concert with ethical decision-making tools to address other situations.

Although it remains unclear what a good theory of social justice would look like, there is growing agreement among disparate cultures that justice demands, at a minimum, that each individual be treated as equally worthy of moral concern. This basically means that no individual can be treated as an object or the possession of another. The United Nations’ (UN’s) Universal Declaration of Human Rights affirms that “... recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.”
The UN consists of at least 192 member countries from all continents, cultures, and geographic regions, demonstrating that regardless of cultural ideology there is global recognition that respect for individuals is a worthy ideal. However, in balancing the needs of each person within the society against the needs of fellow citizens, some constraints on permissible individual actions are necessary. For example, a person cannot be free to cause another person serious harm. Additionally, balancing is needed in relation to the distribution of benefits and harms that occur as inevitable consequences of communal living. Societal values, nature, and powerful human interests all play a role in the distribution of individual benefits and harms; for this reason some inequities are difficult to avoid and the project of trying to remedy inequities is complex.

Many commentators have proposed that a just society should maintain a just healthcare system; support for this proposition is given later. However, a large body of literature critiques the U.S. healthcare system as being systematically unjust (Mechanic, 2006). The healthcare systems of many other countries, although not as inherently unjust, may well disadvantage or fail to appropriately serve the needs of certain populations. Even within a relatively just healthcare system that is accessible to all—that is, where all are able to get help with the resources needed for the protection or improvement of their health (within the boundaries determined by the society’s political process)—nurses may face problems mediating between the needs of a particular patient and the needs of a patient population. Thus, gaining an understanding of the nuances associated with human rights and justice is important for all nurses, but especially APNs, who can be considered the profession’s leaders, regardless of country of practice.

The general ideas behind social justice are that within a society everyone has a right to benefit from the collective skills and resources of its members and that any associated burdens should be fairly shared. Claims can be made against a society (via its political institutions) to ensure this right. However, the actualization of this ideal has proven problematic philosophically and politically, as explained in more detail shortly.

Social Justice Solutions

What does ambiguity about the concept of social justice and its warrants mean for APNs who encounter injustices then? Do they just throw up their hands, asking “If the philosophers and politicians can’t agree on what a good
theory of social justice is or how social institutions ought to be arranged to maximize fairness, then, how can we be expected to address injustices?” The answer is that there are actions that nurses can take (and as a profession have historically taken) to address particular injustices. APNs need not focus on this larger question of how societal institutions should be arranged and/or financed to ensure fairness (e.g., government, the legal system, education, health care, etc.), although they do need to understand the complexities of it. APNs have responsibilities to address injustices that affect their populations of concern. These responsibilities may include political action to influence inadequate local or national policies—indeed they may be the only observers of certain sorts of injustices (as discussed shortly). Problematic policies are those that negatively influence health or mistake the actual source of a problem. Additionally, there may be a lack of policies aimed at anticipating future health problems. In this context political action means activities—informed by nursing knowledge and clinical judgment (see Table 4-1)—undertaken by the nurse, often in collaboration with others and with the purpose of influencing necessary changes in policy at the institutional, local, or societal levels. At no time has it been more crucial for APNs to grasp the importance of this responsibility than now. Many countries are developing APN roles because of otherwise unmet health needs of populations (Ketefian, Redman, Hanucharurnk, Masterson, & Neves, 2001; Pulcini, Jelic, Gul, & Loke, 2010). As disciplinary leaders, APNs have crucial collaborative and integrative roles to play in addressing justice issues for their patients. The next chapter explores APN leadership responsibilities in more detail. The latter part of the chapter provides examples of different types of problems stemming from societal injustices and the nature of healthcare systems more broadly. APN responsibilities for addressing these problems at a multitude of different levels are delineated, and strategies are proposed for effective action, including, where necessary, political activism on behalf of the population served.

Social Justice Assumptions
Societies have formed both historically and contemporarily because no one individual is capable of providing for all of his or her own personal needs. Contemporary societies ostensibly exist to facilitate the lives of the individuals within them. Arguably, and as discussed shortly, not all societies deliberately intend to provide for the freedom or well-being of all persons who fall under their canopy. Historically, many societies have had a free class...
Clinical judgment in nursing is the nonlinear process of using knowledge, reasoning, tacit (experiential) skills, and interpersonal skills to determine—within the limits of available information—probable best actions given the inevitable existence of uncertainty about the possession of adequate knowledge and outcome of actions.

### Table 4-1 Clinical Judgment in Nursing

<table>
<thead>
<tr>
<th>Components</th>
<th>Categories</th>
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<tbody>
<tr>
<td>Knowledge</td>
<td>Knowledge base of nursing:</td>
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<td></td>
<td>- Nature of the discipline</td>
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<td></td>
<td>- Purposes and goals</td>
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<td></td>
<td>- Nature of persons and environment</td>
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<td>- Characteristics of good practitioners</td>
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<td></td>
<td>- Scope and limits of practice</td>
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<td></td>
<td>Knowledge derived from other disciplines: philosophical (including ethical theory), physical, social, psychological, spiritual, biological</td>
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<tr>
<td></td>
<td>Knowledge related to the situation:</td>
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<tr>
<td></td>
<td>- Primary subject/who is involved</td>
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<td></td>
<td>- Subject’s understanding of the situation, values, beliefs, and context</td>
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<td></td>
<td>- Goals</td>
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<tr>
<td>Experience</td>
<td>Previous experiences:</td>
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<td></td>
<td>- Personal</td>
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<td></td>
<td>- Professional</td>
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<tr>
<td>Characteristics and skills</td>
<td>Perceptual:</td>
</tr>
<tr>
<td></td>
<td>- Grasp the nature and complexity of issues</td>
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<td></td>
<td>- Identify needed/potential resources</td>
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<td></td>
<td>- Envision resolution</td>
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<tr>
<td></td>
<td>- Reflect on practice; engage in self-reflection</td>
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<td></td>
<td>- Be creative, articulate</td>
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<td></td>
<td>Relational:</td>
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<td>- Interpersonal</td>
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<td>- Collaborative</td>
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<td>Motivation:</td>
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<td></td>
<td>- Professional responsibility</td>
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<td>- Emotional engagement</td>
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and an enslaved or indentured class. Nevertheless, contemporary democratic societies globally have as a guiding principle the idea that all citizens are equal under the law. As the UN Declaration of Human Rights, Article 7 reads, “[a]ll are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination” (2012/1948). That is, everyone is subject to the same freedoms and the same restrictions upon those freedoms that are needed for a fair distribution of the burdens and benefits of societal living. This is a starting place for justice and a helpful foundation for nurses in understanding their dual obligations to individuals and society.

The Historical Development of Ideas of Social Justice

The Social Contract: Hobbes

The mechanisms of many contemporary societies are rooted in some form of the idea of a social contract. This “is the view that persons’ moral and/or political obligations are dependent upon a contract or agreement between them to form society” (Friend, 2006). Although traces of social contract theorizing are visible as far back as the time of the ancient Greeks, contemporary theorizing about the structure of a good society arguably begins with the writings and thoughts of Thomas Hobbes (1588–1679). Hobbes is well known in philosophical and other circles, both for his assertion that a social contract is necessary for an orderly and mutually beneficial society and for grounding this assertion in a graphic description of what life would be like for human beings without such a contract.

Like all philosophers, Hobbes’ theorizing was influenced by his context. He lived in the turbulent times of the English civil war, a war fought between Royalists (supporters of the monarch) and Oliver Cromwell’s supporters, who wanted parliamentary rule. His theory is based on a rather pessimistic view of human nature that does not take into account the possibility of human capacity for altruistic actions (action that is either not primarily or not wholly self-interested). Hobbes felt that an overall ruler, such as a monarch, was necessary to impose order. However, he did not believe that royalty derived its power directly from a supreme being. That is, he did not believe in the divine right of kings. Individuals comprising the potential society would elect a leader they felt could provide the most impartial leadership.
Once elected, the ruler would be entrusted with maintaining social order and permitted to do what was necessary for that end.

Hobbes’s particular view of the social contract has been criticized on many levels. Most contemporary critics do not find his characterization of human beings accurate, nor do they agree with the structure he proposes. Nevertheless, his graphic description of life in a state of nature captures some of humanity’s worst fears about how human life could be in the absence of some sort of societal structure and how these fears are exemplified currently by the terrible conditions that exist in certain parts of the world, where no identifiable or coherent social infrastructure seems to exist (for example, Haiti, Libya, Afghanistan, Iraq, and Sudan). Some have argued that even within so-called civilized societies, the conditions of certain marginalized groups of people are not so terribly far from Hobbes’s conception of life without a social contract (Iceland, 2006; Papadimos, 2006; Rank, 2005).

The Social Contract After Hobbes

As noted, the structures and functioning of many modern societies are based on some conception of a social contract. Ideas about human nature and the social contract, however, have gone through several evolutions since the time of Hobbes. Contemporarily, many scholarly writers in bioethics and justice use John Rawls’s (1971) ideas, detailed in *A Theory of Justice* (and explained in more detail in Chapter 1), to explore and/or critique the notion that justice is a particular view of fairness in the distribution of the benefits and burdens of living within a socially contracted society (a distributive justice theory). There are two important principles that emerged from his theorizing: (1) the *principle of equal liberty*, whereby each person has an equal right to the most extensive liberties compatible with similar liberties for all, and (2) the *difference principle*, which states that social and economic inequalities should be arranged so that they are both to the greatest benefit of the least advantaged persons and attached to offices and positions open to all under conditions of equality of opportunity (Rawls, 1971, p. 60).

As discussed, criticisms of these sorts of distributive justice theories derived from ideas of a social contract are varied. Feminists worry that the voices of women, the weak, and the vulnerable are muffled or muted by more powerful societal members, and thus their concerns are left out of the contract (metaphorically speaking). Additionally, the person at the center of the contract is generally conceived to be a self-sufficient, rational individual
who is able to reason objectively. However, contemporary philosophers, feminists, and others have pointed out that in fact humans live in a web of relationships that inevitably are influential in complex ways that are not fully understood; therefore, the ideal of a rational person who can be divorced both from emotions and his or her relationships with others for the purposes of objective decision making is a myth. In view of this problem, the existence of a stable, just society is not possible. A more reasonable perspective is that there is an ongoing struggle to achieve justice within society. This struggle entails, among other things, a concerted effort to bring out and magnify the perspectives of the disempowered by those who are in a position to recognize the nature and origins of perceived injustices. It includes efforts to rein in the influence of the powerful or redirect such influences toward a just cause.

One other conception of justice that is sometimes used as a basis for discussions related to the allocation of scarce resources concerns the view that people should receive benefits in proportion to the contributions they have made or according to what they deserve (Pojman, 1999). Whether a person is considered deserving of special consideration or not depends on societal, community, or religious values, and these will be discernible from the supporting rationale. The problem for healthcare providers in relying on a conception of justice based on merit is that their knowledge base includes theoretical and empirical evidence that those who are privileged by supportive backgrounds and environments are often those who will appear more meritorious. It is easier to be meritorious if a person is not caught up in the struggle of merely surviving from day to day, for instance.

Powers and Faden on Social Justice in Public and Health Policy

Recently, Powers and Faden (2006) proposed a theory of justice that does not focus on trying to discover the best ways to distribute goods. Instead of focusing on discovering which conception of justice is correct—which they think is something of a futile quest—they wanted to focus on discovering “which inequalities matter most” (p. 3) and what is necessary for living a minimally decent life. For this, they concentrated on what they argue are essential dimensions of human living. A life missing, or “seriously deficient,” in any one dimension will also have problems in all of the other dimensions because they are interrelated. These dimensions, they assert, are universally shared—people across cultures need a minimal level of each in order to have a meaningful quality of life, and they are not hierarchical. The essential aspects are roughly stated:
Health—a common sense perspective of physical and psychological well-being or flourishing

- A sense of personal security—not living in constant fear and vigilance
- The ability to reason (theoretical as well as practical reasoning) — allows understanding of the world, helping individuals “make logical connections and detect logical errors . . . allowing [them] to navigate both the natural and the social world.” (p. 20)
- Respect—self-respect, as well as respect for and from others
- Attachment—being able to form trusting relationships with others
- Self-determination—a person’s ability to make his or her own choices, act on them, and be accountable for them

Powers and Faden were especially concerned with the effects of missing or inadequate dimensions in the lives of children, because effects on children tend to be pervasive and long term. Danny Willis’s work exploring the experience of healing from childhood abuse exemplifies their point (currently prepublishation). His study, which included only men who perceived themselves as healing subsequent to abuse, revealed that for most the healing process took decades. For many the main dimension affected could probably be pinpointed as a loss of sense of personal security—they reported persistent problems with physical and psychological health, inability to make and retain relationships, poor self-respect, and problems with reasoning and consequently self-determination (Grace & Willis, 2012). For the present purposes, then, Powers and Faden’s (2006) ideas about social justice are helpful in many situations (although probably not all) that APNs face. Their main purpose was to determine “which inequities matter most” (p. 3). The next section provides a very abbreviated and simplified account of the evolution of contemporary democratic societies and the relationships of individuals to the societies in which they are members by virtue of location or abode. The purpose of this section is to highlight the nature and source of tensions that exist between individuals and society and, thus, implications for advanced practice in negotiating the levels of professional responsibility that exist.

**Individuals and Society: Tensions**

There are, of course, many different types of societies. The idea of a social contract is implied in some societies and not in others. Not all societies either historically or currently have held respect for individuals as a crucial value. In many societies, the interests of the group, or some other value, are
considered by the society’s rulers or traditions to be more important than respect for the individual. And, as noted earlier, even when consideration for the equal moral worth of each person is valued, some individuals are more powerful than others and thus more capable of ensuring that they are accorded respect.

The sinking of the Titanic provides a striking example of this point. The Titanic was a new type of oceangoing ship, touted as being indestructible. However, after a catastrophic encounter with an iceberg, many of the lower-class passengers traveling in steerage class were trapped below deck by gates meant to separate the classes. This meant that they could not easily reach the lifeboats (of which there were too few to accommodate everyone) as the ship was sinking. It was obvious that the lower classes were not treated as equally worthy of moral concern as the upper classes—their very lives were obviously deemed less important than those who had paid more for their passage. Although that event took place almost a century ago, disparities based on class and race continue.

For the purposes of this chapter, though, and because this text is written primarily for APNs in contemporary democratic societies such as the United States, the discussion assumes the existence of a society that (1) takes itself to be democratic, (2) values each citizen as being of equal consideration in the distribution of the benefits and burdens of community living, and (3) has developed implicit and explicit (moral and legal) rules for the conduct of its daily business. Another way of saying this is that within the society each citizen is considered the equal of any other citizen in influencing policy. Ideally all have a say in determining what goods and services are important and what restrictions on personal freedoms are necessary to achieve the desired ends. These assumptions, which represent values espoused in the Constitution of the United States of America and in the constitutional documents of many other countries, allow for critique of contemporary healthcare arrangements or policies that unfairly disadvantage people.

Democratic Societies, Cooperation, and Legal Protection
Democratic societies are to a certain extent cooperative, meaning that such things as goods and services are gained that would not otherwise be accessible to individuals, and such things as materials, time, labor, and money are given in exchange for needed goods and services. Cooperation permits efficiency in the production of goods and the delivery of services, but it also
means that the actions of individuals within society necessarily have an impact on the lives of others with whom they interact or, even more broadly, on others in society. The impact may be positive in that mutual benefit occurs or negative in that someone’s freedom is restricted or the expected or contracted service is not provided.

Tensions between the needs, desires, and freedom of individuals and what is perceived to be the good of the larger society are inevitable and often lead to political unrest. Not surprisingly, it is frequently those who are the most powerful or who have the most resources, natural and/or material, whose interests prevail. For societies to be successful in balancing individual interests with the interests of the larger group, effective rules and guidelines are needed to deal with inevitable tensions. These rules or guidelines are necessarily influenced by philosophical analysis and empirical evidence about problems, their antecedents, and promising remedies. Each democratic society, supposedly, develops its own system of justice based on the values of the society. “The provision of goods, when these are deemed by the society as vital for the well-being of individuals in the society . . . are safeguarded” (Grace, 1998, p. 98) by a system of laws. “The legislative system [of the society] determines in what manner, and to what extent, people will be legally protected from having their rights to these crucial goods violated” (Grace, 1998, p. 99). These, then, are the legal rights that a person within a society can claim as his or her due. Legal rights, however, are only one type of right. Moral rights also exist. The basis for moral rights may be the same as or different from those of legal rights depending on the underlying value systems of the society, that is, what sorts of belief systems are accorded legitimacy within the system and which values are deemed important enough to protect via formal sanctions.

Moral Rights

General Moral Rights
In addition to legal rights that are conceived within the society (and in democratic societies with the input of citizens) and for which impingements warrant formal sanctions of some kind, other conceptions of rights exist. So-called moral rights, Feinberg (1973) asserts, “exist prior to, or independently of, any legal or institutional rules” (p. 84). Moral rights may or may not be protected by laws. But what does the term moral rights mean? How do
these rights differ from legal rights? As usual, in philosophy there is a variety of answers that can be given to these questions—as many answers as the different perspectives or theories that exist. Some of the important aspects of moral rights are sketched in the following paragraphs.

The idea that an individual has certain moral rights is centered on conceptions that some human goods are critically important and should be protected, preserved, or promoted. What is held to make these goods important may differ with varying religious and cultural beliefs, but there is a subset of goods that is universally important because without them people would not survive. These can be called critical human goods. The actions of protecting, preserving, or promoting critical human goods imply interactions taken by others on behalf of the subject. An evaluation of the proposed or actual actions is made on the basis of whether the action can or does actually serve its purpose. Moreover, some actions may be forbidden if they are likely to cause more harm than good.

In moral philosophy, the appraisal of actions usually falls into one of three categories. The action by the agent is required (obligatory), permissible (neutral), or forbidden. Although here the discussion is about action framed in positive terms, refraining from acting when action is needed to prevent harm or further a person’s good is also subject to moral appraisal. The moral status of actions is generally linked to values espoused within a society—such as freedom of speech and equality of opportunity. These values may be based on a variety of moral theories (deontology, utilitarianism, virtue, and so on) or on a belief in divine rules. For example, say that a patient (an individual within a society) is conceived of as having a right to make his or her own decisions by virtue of societal values; no provider may interfere with that decision, all things being equal (in the absence of some reason to suppose that the person is incapable of acting independently). Admission to the hospital does not remove that right. This may seem rather obvious, but it is not always honored, and patient rights were frequently not respected historically. Physicians were often considered to know what was best for a patient whether or not the physician had a sense of the patient’s own values. Moral rights are not always subject to legal enforcement, although they may be.

Although it is beyond the scope of this chapter to engage in, or even present, some of the many philosophical debates related to rights and obligations, it is perhaps helpful to note one differentiation that is sometimes made between a positive moral right—where a claim may be made against someone or some institution for assistance or for the provision of goods and
Moral Rights

Human Rights

HUMAN RIGHTS AS A CATEGORY OF MORAL RIGHTS: HISTORY

Human rights are a specific type of moral right that is no less important in healthcare settings than in wider contexts. But what are they? Where do they come from? And what is their force? In developed countries human rights are as natural as having legs or lungs: their existence is not questioned, and people believe that these rights are theirs to claim. People object to murder and torture whenever they occur and consider these acts violations of human rights. To take away a person's life puts an end to all of that person's potential future choices, aspirations, and actions. It ends their humanity.

Modern ideas about human rights trace their origins as far back as the Magna Carta of 11th-century England. Under pressure from his noblemen, King John was swayed to institute what was essentially a contract between the king and his subjects. It limited the power of the state to control its populace and delineated what individuals could lay claim to in the courts (British Bill of Rights, 1994). In essence, it served as the foundation for contemporary rules of law. This was an important development because prior to the Magna Carta the citizens of many societies were subject to the whims and desires of their leaders, often kings. Individual freedom was limited by the dictates of these rulers. The Magna Carta was pivotal for certain political changes but did not extend to all subjects, only to those who already had some power.

It was several centuries later during the Enlightenment when the issues of moral rights and human rights were taken seriously. The Enlightenment represents a period in American and European philosophy when the use of
reasoning or analytic thought became valued as the main route to knowledge and was viewed as an essentially and uniquely human characteristic. Locke (1690/2003), for example, claimed that rights naturally flowed from the nature of humans as free and rational beings. Kant’s ideas about the innate dignity of human beings served as his justification for the existence of human rights. According to Kant (1785/1967), human beings by virtue of their capacity for rational thought and for making moral rules are, and thus should be allowed to be, self-governing. For this reason, they should never be used purely as a means of serving someone else’s advantage. Kant had a complicated argument for this but basically proposed that it is irrational to use an individual purely or primarily as a means to someone else’s advantage. For example, if a person assented to this, that person would essentially be saying, “Everyone can treat anyone else as a means to an end” (this is Kant’s Categorical Imperative roughly stated). But people would not want to be treated purely as a means to someone else’s end; thus, it is irrational to treat someone else as a means to one’s own end.

Moral rights, then, include such things as being free to make one’s own choices and being free from the interference of the state in personal affairs. Human rights are a more fundamental category of rights. Whereas particular moral rights are based in theories of moral philosophy and may or may not hold depending on the values of a society, human rights are asserted to apply to every human simply by virtue of their humanity. Therefore, human rights apply to everyone regardless of the society to which they belong. Some human rights are considered to be inalienable, that is, they cannot be given away by the person. A classic example of an inalienable right is the right to be free. This means that a person cannot agree to be enslaved even if this would benefit his or her family in some way because it is the nature of humans to be free. It is important to note that there is no agreement about exactly what is the set of rights that are called human rights, although certain rights are generally agreed to be included.

HUMAN RIGHTS: CONTEMPORARY UNDERSTANDINGS
Following the Enlightenment period, attention to the issue of human rights waned temporarily. However, renewed interest emerged partly as a result of human abuses during World War II (1939–1945) as documented in Chapter 6, Research Ethics: Advanced Practice Roles and Responsibilities. This prompted a revisiting of the issue of human rights and attempts to further define what
they are and why they should be honored. Fagan (2006) noted that contem- temporarily, “human rights have been defined as basic moral guarantees that people in all countries and cultures allegedly have simply because they are people.” According to Nickel (2005), human rights “are concerned with ensuring the conditions . . . of a minimally good life” (p. 386) and, as noted earlier, Powers and Faden (2006) based their theory on this same premise.

Fagan (2006), in his thoughtful discussion of human rights, noted that this idea of a minimally good life “has been enshrined in various declarations and legal conventions issued during the past fifty years, initiated by the Universal Declaration of Human Rights (1948) and perpetuated by, most importantly, the European Convention on Human Rights (1954) and the International Covenant on Civil and Economic Rights (1966).” Conceptions of a minimally good life are necessarily different depending on the society and its resources.

The idea behind an assertion that all human beings have rights simply by virtue of being human derives from the “philosophical claim: that there exists a rationally identifiable moral order, an order whose legitimacy pre-cedes contingent social and historical conditions and applies to all human beings everywhere and at all times” (Fagan, 2006). This can be stated a little differently by saying either each human is equally worthy of moral consider- ation (viewed as important in his or her own right) or no one is. If no one is to be accorded moral consideration, then any person at any time might find their interests discarded on someone else’s whim. Indeed, using Rawls’s ideas about people in the original position deliberating behind “a veil of igno- rance” (Rawls, 1971), it is imaginable that no one would feel secure about abolishing human rights for fear his or her position in society and assets might make them particularly vulnerable to the absence of such rights.

Human rights, however, are not bound to a particular society but are taken to apply across societal and national borders and political contexts. The declarations cited earlier allude to human rights as supporting such goods as a basic standard of living that includes education, provisions for health care, and protection from the effects of destitution. They prohibit torture, slavery, and exploitation. Unfortunately, the interpretation of these rights and how they should be applied in actual situations is a more difficult undertaking than asserting that they exist—as is enforcing them. Currently, in moral philosophy and bioethics circles there is debate about whether human rights imply the right to a certain basic level of health care that is consistent with the status of healthcare knowledge and societal resources.
Complicating things further is the absence of a definition of health that everyone can agree upon.

Is There a Right to Health Care?
This question has been raised by many scholars in the United States and elsewhere. It is an important problem to explore in this text because nurses assert, via the policies and position statements of their professional bodies (ANA, 2003; ICN, 2012) and the writings of scholars, that they exist to attend to the health needs of individuals and society in a nondiscriminatory manner (Ballou, 2000; Gaylord & Grace, 1995; Grace, 1998, 2001; Raphael, 1997; Spenceley, Reutter, & Allen, 2006). Thus, clarity about the influence of all of the following on health is important: universal human rights and their demands on societies, societal values implied (what people would tell you) versus actual (how societal institutions are set up), a person’s social and/or economic standing, and the nature and accessibility of healthcare services. These factors are fundamental for understanding what actions are required to meet the health needs of an APN’s population (where the definition of health depends both upon the patient’s conception of this and insights from nursing knowledge development and the APN’s specialty knowledge base).

Nurses, as Curtin (1979) and many other commentators have pointed out, are often the ones who “attend patients when distress is immediate…for sustained periods of time” (p. 4) and thus have the opportunity to experience patients in all of their humanity, including the struggle of the poor and otherwise disadvantaged for survival in an inequitable environment. Certain living conditions have been shown to contribute to or exacerbate health problems perhaps even more than a lack of access alone, although often persons living in substandard conditions also lack easy or adequate access to healthcare services. Thus, there are inextricable links among living conditions, social standing, economic status, and health (Danziger & Haveman, 2001; Iceland, 2006; Powers & Faden, 2006; Rank, 2005). For this reason, even if it can be agreed that there is a right to a basic level of health care, this will not ensure good health because even more fundamental justice problems arise within society that also require attention, such as needs for adequate nutrition, housing, and security, as discussed shortly.

Human Rights Arguments for Justice in Health Care
Before discussing professional advocacy for individual and societal health— which means comprehending the effects of poverty, socioeconomic standing,
and abuse and neglect on persons’ lives and their functioning and flourishing—it is important to gain an understanding of the relationship between human rights and rights to health care. Dernier (2005) notes when it is asserted that a right to health care exists, several related claims are essentially being made. A right to health care means that everyone encompassed by the society (regardless of status and perhaps even including so-called “illegal” immigrants), by virtue of being human, is entitled to a certain level of access to health care and society has a collective responsibility to ensure this. It is a strong societal obligation. This obligation should be reflected in policy debates, and failure to meet this obligation can be said to constitute an injustice.

As a profession, nursing takes the stance that providing basic healthcare services, including those that facilitate the prevention of illness, and the promotion and preservation of health for all members of society are a moral responsibility and should be treated as a human right (ICN, 2007). This is a starting place. A further question that is beyond the scope of this text to explore in detail is to ask, “What are the scope and limits of this right?” Buchanan (1984) noted in the 1980s that there was a growing belief in the idea that “the right to a decent minimum of health care” exists; indeed this is the title of his book. However, d’Orazio (2001), along with many other philosophers, ethicists, healthcare professionals, and citizens, is concerned that viewing a basic minimum of health care as a human right is not compatible with the current U.S. healthcare financing arrangements. Although efforts to change the U.S. healthcare delivery system are in process, certain professional healthcare groups, notably the ANA (2008), have affirmed their belief that there is a right to health care and that this means the system must change. “The ANA endorses a single payer system as a way to integrate services and facilitate accessibility. ANA believes that health care is a basic human right . . . Thus, ANA reaffirms its support for a restructured health care system that assures universal access to a standard package of essential health care services for all citizens and residents” (ANA, 2008, p. 2).

The following section explores the scope and limits of an APN’s responsibilities to patients and society. Role responsibilities are described as both narrow and broad. An argument is presented for understanding responsibilities in three areas: to individual patients, to influence societal conditions that affect groups of patients in terms of access to care or other influences on health, and to overcome obstacles to good care caused by the environment of practice.
Advanced Practice Nursing and Professional Advocacy

Professional Advocacy: A Broad Conception of Role Responsibilities

The term *advocacy* is commonly used in nursing circles as an ideal of practice. However, efforts are ongoing to define what this means in nursing contexts (Bu & Jezewski, 2007; Chafey, Rhea, Shannon, & Spencer, 1998; Grace, 1998, 2001; Mallik, 1997; Snowball, 1996; Spenceley et al., 2006). Consequently, the boundaries of nursing responsibilities related to advocacy are often not fully understood and shift depending on the definition of advocacy assumed. The term has various meanings to various people. I know this to be true both from available literature and from informal surveys of the many graduate and undergraduate students I have encountered over the years. Some say advocacy means defending patients’ rights (Abrams, 1978; Curtin, 1982; Gadow, 1990; Jezewski, 1993; Miller, Mansen, & Lee, 1983; Pagana, 1987; Shirley, 2007; Zussman, 1982); some say it means ensuring that patients get their immediate needs met; still others might say that it is a role-related responsibility of nursing, meaning that any action taken by the nurse while acting in the role of a nurse is advocacy. Indeed, all of these definitions appear in the nursing and allied literature (ANA, 2001; Annas, 1974/1990; Bernal, 1992; Chafey et al., 1998; Gaylord & Grace, 1995; Grace, 2001; Hewitt, 2002; MacDonald, 2007; Mallik, 1997; O’Connor & Kelly, 2005; Snowball, 1996; Spenceley et al., 2006).

Elsewhere, I have examined the concept of advocacy in great detail (Grace, 1998, 2001); indeed, it was the topic of my doctoral dissertation. A colleague and I were initially stimulated to explore this topic by an article that appeared in the *Hastings Center Report* in 1992 by non-nurse ethicist Ellen Bernal. In the article, she chastised nursing for taking the stance that nurses are patient advocates. She argued that nursing uses advocacy to advance its autonomy as a discipline and thus improve its professional status. On closer reading, we realized she was using an interpretation of advocacy as meaning only a defense of patient rights and were moved to explore in more depth what nursing means by advocacy (Gaylord & Grace, 1995). This problem of ambiguity of meaning and thus expectations of the nurse became the impetus for a whole program of study related to professional responsibility. Perhaps the most interesting insight gained during this investigation of advocacy concerned the roots of the term in legal settings. Advocacy as a
practice ideal has its origins in the field of law. In law, it means the verbal act of arguing for a person’s cause against the cause of an adversary. Lawyers, while advocating, have responsibilities only for that client (or group of clients) and the client’s cause. If there are system injustices, these are dealt with outside of the immediate lawyer-client situation.

Nurses, however, do not have such limited responsibilities. In advocating for one patient to have his or her needs met, nurses may well cause disadvantage to another. For example, a primary care nurse practitioner (NP) in a busy clinic is told by one of her patients that she is being physically abused by her boyfriend. This is an urgent matter and the patient needs time and attention. But the nurse is in a practice with two physicians, who in response to economic pressures have limited the time allocated for nurse visits. The NP is the sole available provider this afternoon, and she has three other patients who are also waiting to be seen. She must make a decision that will affect somebody’s care. An immediate decision must be made that balances the risk to the other patients against the likely benefit to the abused patient of spending more time with her. The NP has simultaneous responsibilities to more than one patient; thus, advocating for one to receive extra attention may well disadvantage others. Thus, her responsibilities cannot end with the immediate decision and ensuing action. The problem of inadequate visit time is recurring and results in part from a misunderstanding about the APN role, deliberate or inadvertent, on the part of the collaborating/supervising physicians.

Therefore, a different way of looking at the advocacy role of the APN is to view it as any action taken to further professional goals (ultimately related to promoting patient good). This permits nurses to see that their advocacy actions may be directed at different levels. “Professional advocacy, then, may be conceived both as actions taken to further nursing’s purposes on behalf of individual patients and actions taken to expose and redress underlying problems that are inherent in the larger contexts of institutions, policymaking, and the health care delivery system” (Grace, 2001, p. 161). Many so-called advocacy situations “have their fundamental roots in such things as national health policy decisions, economic conflicts of interests, miscommunication, institutional barriers or a host of other grounds” (Grace, 2001, p. 152).

To provide some coherent structure to the exploration of advocacy viewed as professional responsibility to further nursing goals (responsibilities of the nursing role), the next section is divided into three parts. The first part describes advocacy viewed as the APN’s professional responsibilities
to individual patients encountered in practice settings. Second, advocacy is viewed as a responsibility to address the environment in which the APN practices. Finally, the APN’s role in influencing social policy is explored. However, this is an artificial categorization because in many cases all three levels of responsibility coexist. When the APN is faced with a tension between trying to provide what is needed for a particular patient and the needs of others within the practice, clinical judgment is needed to prioritize action. Clinical judgment in this sense is synonymous with ethical or moral reasoning (see Table 4-1).

**CASE STUDY: AN EXAMPLE OF COMMON ISSUES**

This case appeared in the *Louisville Courier-Journal* (Coomes, 2007). It exemplifies the various levels of advocacy needed to ensure good care for this patient. Although this case might be considered peculiar to the United States, a review of associated international literature highlights similarities between Ms. Henley’s situation and those in poverty in other countries. Research data from The Commonwealth Fund (2007) found that although the United States lags behind on many healthcare benchmarks, “experiences in all countries (Australia, Canada, Germany, The Netherlands, New Zealand, United Kingdom, United States) indicate the need for more integrated, patient-centered care ‘systems.’” The object of the article was to point out that three simple things are all that is needed to improve health for many people. “They should stop smoking, eat better and exercise more” (Coombes, 2007). However, as the reporter noted, “Lack of access to health care providers, healthy foods and safe places to exercise can be roadblocks to healthier lives for those in rural areas and the poor across the state.” Ms. Henley is just one example of a pervasive problem in healthcare settings. Healthcare providers know from empirical evidence what strategies are needed for health promotion or maintenance, but more than this is needed to keep people healthy. We need to know what the roadblocks are and help them negotiate these.

Additionally, Ms. Henley’s predicament is familiar, one to which many nurses at all levels of practice can relate. “Portia Henley, a 50-year-old [African American] grandmother from Louisville [is] unable to keep a steady job. She has diabetes and struggles to pay for the better food and special drugs her condition requires; asthma inhibits her ability to exercise. ‘I’m fighting a real battle,’ said Henley. ‘It’s hard to stay on the straight and narrow in terms of..."
what you eat when you don’t have the income to handle the price of medicine, the price of going to doctors and the price of keeping a roof over your head, plus the cost of buying food for this one specific health problem.’”

Professional Advocacy for Individual Patients

THE NURSE–PATIENT RELATIONSHIP

The essence of nursing care is the individual nurse–patient relationship. This is a fiduciary relationship based on trust. Whether patients do or do not actually trust their nurses, in the sense of knowing who their nurses are and having confidence in their abilities, nevertheless, they are forced to trust that nurses have their patients’ best interests in mind, know what they are doing, understand the limits of their knowledge and skills, and will steer patients in the right direction or put patients in touch with needed resources when they have reached the limits of their expertise. For this reason, transparency of purpose and affiliation is important. In some cases, especially in advanced practice settings, nursing’s work is not directly aimed at patient benefit. Some examples are performing pre-employment wellness screenings or serving in the role of research nurse coordinator. In such cases, APNs have responsibilities to reveal their purpose and any existing conflicts of interest, to address misunderstandings, and to direct the involved person to a source of help as needed.

However, mostly the APN’s role is to further patient good related to individual persons’ actual or potential health needs. To further this good APNs use clinical judgment to determine appropriate actions. A definition of clinical judgment that was synthesized from extant literature in nursing, medicine, and the cognitive sciences appears in Table 4-1. Clinical judgment is needed to identify patients’ needs, anticipate future needs, and facilitate care that is most likely to meet these needs. Because the goals of care involve understanding what is best for the patient whose life is necessarily contextual and nuanced, nurses need to engage with a patient (and with family members when this is indicated) to discover a patient’s beliefs, values, and preferences so that the nurse’s actions are tailored to that person’s needs. Additionally, because nurses too are human and have their own beliefs, values, and biases, they must be careful to understand what these biases are and how such prejudices (prejudgments about the nature or attributes of a person) are likely to affect their clinical judgment in particular situations.
BIASES
Ms. Henley’s case serves as an example of a possible bias (Doris & The Moral Psychology Research Group, 2010) that providers may exhibit related to poverty. Many people do not have a good understanding of the nature of poverty and its antecedents. Coryn (2002), in his literature review, noted that there are three distinct categories of attitudes people have related to poverty: these are “individualistic/internal, structural/external, and fatalistic.” In the United States, the predominant attitude of the middle class is individualistic/internal, meaning the poor person is blamed for possessing a character flaw such as laziness or lack of ambition that has led to his or her present condition. Perhaps not surprisingly, among the poor themselves the predominant attitude is structural/external, meaning they attribute poverty to external circumstances (Coryn, 2002). Because most healthcare professionals are middle class, a bias against the poor can be anticipated (Crandall, 1990).

One way to avoid the effects of bias that arise from inexperience or ignorance is to try to understand what a person’s life is like. What are the person’s daily experiences and struggles like? Other biases or prejudices may exist because of negative past experiences with someone. For example, a nurse whose parent suffered from alcohol abuse may have a negative attitude toward patients she views as alcoholic. Advocacy, viewed as professional responsibility to further the goals of the profession for good care, obligates nurses to understand who patients are, what is needed for their care, and what obstacles exist to getting them the care they need.

IDENTIFYING AND ADDRESSING OBSTACLES
Obstacles to providing what the APN determines to be necessary for the good of an individual patient may take many shapes and forms. Table 4-2 lays out the different levels at which obstacles may present and provides a synopsis of common problems. Strategies to address obstacles are presented shortly. The specialty chapters of this text provide strategies that are particular and pertinent to that specialty, but issues of poverty and disadvantages of various sorts are commonly encountered across settings. For Ms. Henley there are many obstacles to achieving optimal health even within the limits of her complex issues. Because some of these issues arise as a result of social inequities, addressing these requires influencing social policies, as addressed shortly.

In caring for Ms. Henley at the nurse–patient relationship level, the immediate concern is assisting with her current problems. Professional advocacy at this level means using an approach that is based in nursing’s
### Table 4-2 Categories of Obstacles to Ethical Nursing/Health Care

<table>
<thead>
<tr>
<th>Category</th>
<th>Obstacles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual patient</td>
<td>1. Patient not viewed as unique:</td>
</tr>
<tr>
<td></td>
<td>■ Standardized patient care</td>
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<td></td>
<td>■ Provider lacks understanding of the influence of important contextual</td>
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<tr>
<td></td>
<td>■ Patient “labeled” by others</td>
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<tr>
<td></td>
<td>2. Prejudgment of patient (bias/prejudice)</td>
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<tr>
<td></td>
<td>3. Patient or family’s need for knowledge not fully addressed (related to</td>
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<tr>
<td></td>
<td>#2)</td>
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<tr>
<td></td>
<td>4. Interpersonal conflict:</td>
</tr>
<tr>
<td></td>
<td>■ Provider–patient</td>
</tr>
<tr>
<td></td>
<td>■ Patient–family</td>
</tr>
<tr>
<td></td>
<td>■ Provider–provider</td>
</tr>
<tr>
<td></td>
<td>5. Poor communication:</td>
</tr>
<tr>
<td></td>
<td>■ Provider–patient/family</td>
</tr>
<tr>
<td></td>
<td>■ Provider–provider</td>
</tr>
<tr>
<td></td>
<td>6. Power imbalances—coercion/silencing</td>
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<td></td>
<td>7. Inadequate time—resources to evaluate and address needs (also a practice</td>
</tr>
<tr>
<td></td>
<td>environment problem)</td>
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<tr>
<td></td>
<td>8. Patient’s moral agency diminished (does not see self as having meaningful</td>
</tr>
<tr>
<td></td>
<td>choices (Blacksher, 2002)</td>
</tr>
<tr>
<td>Practice environment</td>
<td>1. Lack of primary focus on patient good:</td>
</tr>
<tr>
<td></td>
<td>■ Economic conflicts of interest</td>
</tr>
<tr>
<td></td>
<td>■ Practice philosophy is to meet economic goals</td>
</tr>
<tr>
<td></td>
<td>2. Autonomous practice constrained:</td>
</tr>
<tr>
<td></td>
<td>■ Senior colleagues</td>
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<tr>
<td></td>
<td>■ Institutional mission</td>
</tr>
<tr>
<td></td>
<td>■ Managed care mandates</td>
</tr>
<tr>
<td></td>
<td>3. Unsupportive environment</td>
</tr>
<tr>
<td>Social injustices</td>
<td>1. Unjust aspects of the healthcare system:</td>
</tr>
<tr>
<td></td>
<td>■ Access</td>
</tr>
<tr>
<td></td>
<td>■ Financing</td>
</tr>
<tr>
<td></td>
<td>■ Priorities</td>
</tr>
<tr>
<td></td>
<td>■ Failure to attend to the real origins of certain health problems</td>
</tr>
</tbody>
</table>

(continues)
philosophy of care and goals of practice. Although priority goals are to meet her immediate needs, it is still necessary to have an idea of who Ms. Henley is as a person. In the absence of a life-threatening emergency that would require immediate measures, it is not possible to adequately help meet her health needs if the nurse does not know more about her. The nurse needs to know, for example, how her maladies are affecting her, what she views as the priority issue, what she knows about her physical conditions, what resources are available to her, and what are her priorities. Advocacy at the level of nurse–patient relationship, then, means professional responsibility to ensure good patient care. This entails understanding what good actions are likely to be for this patient, working with her to determine what are good avenues of action from her point of view, and recognizing and accounting for potential and actual obstacles to good action.

Advocacy viewed as professional role responsibilities for good care presents the same obligations regardless of setting and is based in nursing’s philosophy of care and disciplinary goals. Thus, Ms. Henley could have presented for care at any number of different specialty practices—primary care adult health, family practice, women’s health primary care, emergency room, as a preanesthesia workup, in a diabetes or asthma clinic, and so on. The time required to address all of her issues may be different in different settings because some aspects of her care may well be beyond the knowledge and skills of the clinician, who will then need to refer Ms. Henley to others for care of those aspects. Nevertheless, the APN’s responsibilities include evaluating the quality and appropriateness of the referral made.

### Table 4-2 Categories of Obstacles to Ethical Nursing/Health Care (continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>Obstacles</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Socioeconomic disparities:</td>
<td>Education, Poverty, Discrimination</td>
</tr>
<tr>
<td>3. Lasting effects of violence, abuse, neglect</td>
<td></td>
</tr>
<tr>
<td>4. Profit motive or business emphasis</td>
<td></td>
</tr>
<tr>
<td>5. Fragmented services</td>
<td></td>
</tr>
</tbody>
</table>

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Advocacy, as described earlier, can be seen as an onerous and unrealistic responsibility given current environments of practice with their inevitable time constraints and pressures. This view is not uncommon and may be true in many settings. Nevertheless, the APN’s role responsibilities include understanding and influencing the context of care so that nursing goals can be met. In those situations where the APN finds intractable differences between his or her philosophy of care and those of her practice colleagues, it is the nurse’s responsibility to consider whether a different type of setting might be more fitting.

Nurses see firsthand the effects of unaddressed or poorly addressed problems upon their population of patients. They may be the first or only ones to understand both what those effects are and what changes are needed. Therefore, nurses’ responsibilities do not end when the presenting patient’s priority needs are met, especially when it is recognized that the practice environment may actually be working against nursing goals of providing care for the patient as a person.

Professional Advocacy and Practice Environments

The varied environments in which APNs work and care for patients also give rise to problems that can interfere with optimal care for a given patient (see Table 4-2). Role responsibilities exist so that nurses can understand how a particular setting and its values are impinging on ethical patient care. The problem may involve a particular patient or may be seen as recurrent. In the case of Ms. Henley, a practice focus of constricted time slots or on managing only the acute presentation would lead to fragmented care, is at odds with nursing goals that include anticipation and prevention of future problems, and would affect many of the patients within the practice. As another example, in correctional settings the facility’s goal of prisoner behavior control may interfere with a nursing emphasis on providing for an individual prisoner’s well-being. In yet other settings, unit, institutional, or practice policies, conventions, or expediencies may raise barriers to good patient care. Like other healthcare providers in primary care settings especially, constraints related to financing arrangements, reimbursement issues, and managed care practices pose some of the most troubling, difficult, and time-consuming problems for NPs (Creel & Robinson, 2010; Johnson, 2005; Ulrich et al., 2006; Ulrich & Soeken, 2005).
Professional Advocacy and Social Injustices

At the broadest level, APNs in concert with other nurses, physicians, and allied health professionals have a collective interest in addressing social injustice. This is because the goals of almost all healthcare professions have to do with improving the health of individuals. Improving the health of individuals often requires addressing injustice that is deeply rooted in a society. It is not expected that most APNs will be capable of single-handedly tackling an issue; however, their knowledge and experiences place them in the ideal situation to join with colleagues or collaborate with other professionals to inform policy debates.

Nurses, both because they provide direct care and have a perspective and approach that permits hearing patients’ health and illness stories within the contexts of patients’ daily lives, may be the first or only ones to recognize existing and developing patterns of injustice or disparity. Nurses, along with other healthcare providers, see firsthand the end results of poor access to health care or poor health maintenance. Thus, viewing advocacy as a broader responsibility to further professional goals at both the individual and societal level highlights the range of knowledge, skills, and actions that may be needed. In addition to the fact that taking a broad view of nursing responsibilities is needed for meeting nursing goals, positive action at a level different from the immediate situation is also a way of mitigating the moral distress or unease felt when APNs are unable to provide the care needed for a particular patient because of environmental or other obstacles (Arthur, 1995; Corley, 1995; Corley, Minick, Elswick, & Jacobs, 2005; Erlen & Sereika, 1997; Fowler, 1989).

HEALTH DISPARITIES AND POVERTY

Although health disparities are by no means the only nursing care issues that require professional advocacy at the societal level, the issue of poverty internationally and its pervasive influence on health provides an important exemplar and argument for APNs to take seriously their ethical responsibilities to advocate for health policy changes. Poverty affects people in a variety of ways that are not always easily discernible but that have been well documented in the literature and supported by empirical studies (Danziger & Haveman, 2001; Iceland, 2006; Rank, 2005). Patients like Portia Henley, for whom daily life is an ongoing struggle to make ends meet, may delay seeking care until their problems are out of control. They may have inadequate insurance, transportation difficulties, lack of family support, be the
primary caretaker for others whose needs they put first, or have any number of other obstacles to getting the assistance they need. As a diabetes clinical nurse specialist (CNS) or APN, my immediate goal would be to assess Ms. Henley’s priority needs for knowledge, self-care, nursing, and other necessary therapeutics, which would include understanding her values and priorities. Next steps would be to help her obtain the resources and supports she needs to achieve a level of health that she desires and that is realistic in the context of her life. Finally, what is really needed is an exploration of the environmental and economic conditions that resulted in her current status.

The next section briefly presents some ideas for influencing change in the broader healthcare environment. Nursing has a rich history of activism to improve health care, starting with the efforts of Florence Nightingale (1820–1910). Nightingale used evidence and influence to change the way wounded soldiers were treated during the Crimean War, and she used her knowledge, skills, and influence to ensure that a patient’s environment would be conducive to his or her healing.

**Professional Advocacy: Influential Strategies**

APNs are uniquely positioned to research and articulate the likely consequences of problematic practices to those in charge of policy decisions, whether this is at the institutional, local, and/or societal levels. The current healthcare climate necessitates the political action of nurses individually, collectively, and in collaboration with others and is exceptionally open to the input of nurses because “physicians have lost much of their influence and control to corporate medicine in recent years” (Mechanic & Reinhard, 2002, p. 7). Although not all nurses can, as Malone (2005) notes, “become policy experts . . . in addition to providing direct patient care . . . all nurses can assess, identify, and articulate for [or on behalf of] patients” on certain problematic issues and “provide information to patients on options for impacting policy; and work to effect policy change through professional and advocacy organizations” (p. 136).

Nurses can (and should) include in their nursing assessments possible “policy factors that may have preventive, etiological, or therapeutic significance” (Malone, 2005, p. 136). This may sound complicated but is actually elementary. For example, it means asking why certain poor patients with diabetes are not managing their diet and medicines well. Is the reason that they are unaware of resources (the system is not allowing for adequate patient
education), cannot afford the medicines (health insurance problems), have access problems, or some other issue? One effective strategy is for an APN to join forces with other nurses, physicians, and allied professionals whose concerns mirror their own. As a group they can publicize the problem, provide convincing rationale, and outline probable consequences.

Individual patient narratives as exemplars of a larger problem can be very powerful. Blacksher (2002), a philosopher, documented the life of her mother (only on reading the acknowledgments does the reader discover that Sally is her mother). Sally was born into extreme and unremitting poverty. She had no opportunities to develop a sense of self. She was periodically abused by others—beaten by her mother and then her husband. This affected her health, development of a sense of self as worthwhile, and ability to rise above. Blacksher’s vivid portrayal is of a woman who was “stuck.” She was unable to develop and exercise moral agency, that is, to choose actions that would benefit either herself and others. In fact, she did not see herself as having choices. “Chronic socioeconomic deprivation can create environments that undermine the development of self and capacities constitutive to moral agency—i.e., the capacity for self-determination and crafting a life of one’s own” (pp. 455–456). What nursing can do in such cases on an individual level is to provide a “key” to unlock a person’s potential and facilitate the development of a sense of self as worthwhile. Nursing actions include treating patients with respect, providing resources and referral, and empowering—this is a process. But it is also important to examine the particular aspects of the environment that served to perpetuate the patient’s situation. In Sally’s case, years of neglect from health care and social systems alike had an impact.

Providing a submission to the op-ed page of a newspaper or a letter to the editor often gets public attention and raises questions for discussion in a more public forum. Membership in relevant institutional or local committees is another good strategy and can serve as an important forum for educating other committee members about nursing concerns. For example, acute care CNSs or NPs can provide a valuable voice for patients when they sit on hospital ethics committees and patient care committees. APNs can be instrumental in educating and providing information for grassroots patient organizations. They should recognize that the information they have about patient situations is valuable and can be articulated in a variety of arenas and forums to inform needed changes. For example, family nurse practitioner (FNP) students joined with their mentors and a
specialty organization to change the practice of one managed care company related to antihistamine prescriptions. The formulary allowed only diphenhydramine for seasonal allergy treatments, but this was making many of the children drowsy. A letter-writing and publicity campaign managed to change the practice and make better options available to these children. Another example of effective nursing political activity was given by Murphy, Canales, Norton, and DeFilippis (2005) and is related to improved pain control. “Through regulatory policy advocated for by nurses and many others in the political arena, optimal pain control is now part of standard practice” (p. 22). Nurses are urged to join with colleagues and/or collaborate with allied professionals to publicize a problem. This can also be done via letters to the editor of local papers, or by emailing, calling, or writing to local or state representatives.

**Conclusion**

Professional advocacy is synonymous with the idea that all nursing actions have ethical implications. This is because all nursing actions have the ultimate purpose of furthering the goals of nursing related to patient well-being. The goals of nursing involve providing health and well-being for individuals who are inextricably a part of the larger society in which they reside. Consequently, patients are susceptible to inequities occurring as a result of societal arrangements. Good patient care often requires attention to the underlying circumstances that have given rise to the need for nursing’s services, including poverty and other disparities that leave patients especially vulnerable to their healthcare needs.

**Summary**

This chapter provides an essential background for understanding the breadth of APN responsibilities to attend to the health needs of both individuals and society. An argument is provided for the importance of balancing the needs of individuals with societal needs related to health and health care. To fulfill professional goals, APNs need to engage with individual patients, taking into account their patients’ unique needs and addressing obstacles that prevent meeting these needs. Additionally, APNs may need to engage in political activity at a variety of levels, either singly or in collaboration with others.
Discussion Questions

1. All nurses have patients or types of patients who we find ourselves avoiding. This is human nature. The person reminds us of someone in the past, perhaps, who treated us badly or at whose hands we suffered, the person may just be difficult to please, or their problems may seem intractable, as in the case of Blacksher’s mother, Sally. Other intractable problems might be a person with an addiction whose problem seems overwhelming or who exhibits drug-seeking behavior. In the United States there are a set of patients, often homeless, who are labeled “frequent flyers” because of their repeated visits to the emergency department. In light of the discussion of advocacy, explore ways in which you might make a connection with a difficult patient. What are a nurse’s responsibilities related to different levels of advocacy? To what extent do you see such problems as ones of human rights, moral rights, and social justice?

2. In your practice or from your nursing experience, identify the common barriers/obstacles that make it difficult for you to give the care that in your clinical judgment is required. How should such problems be addressed?

3. You are one of the two APNs in a group practice. You and your colleague are being pressured to assume the same approach to practice as your physician colleagues and the physician’s assistant. Your colleagues are receptive to your input and you have a collegial relationship. How would you explain to them that your nursing perspective requires a different approach?

4. What does it mean to be self-reflective? How does one know when you have been genuinely self-reflective (versus justifying your values)?

5. Do you think that everyone should have access to the same basic level of health care? What would this include?

References


References


