Social Justice: Added Metaparadigm Concept for Urban Health Nursing

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ABSTRACT  Historically, the nursing metaparadigm has been used to describe 4 concepts of nursing knowledge (person, environment, health, and nursing) that reflect beliefs held by the profession about nursing’s context and content. The authors offer an assessment of the metaparadigm as it applies to community and public health nursing in urban settings and offer an amendment of the metaparadigm to include the central concept of social justice. Each of the metaparadigm concepts and the central concept of social justice is discussed as it applies to a model of urban health nursing teaching, research, and practice.

Key words: nursing metaparadigm, social justice, urban health.

Nursing has within its power the theoretical and practical foundations to do great good in improving the health of urban populations through social justice interventions. The reality, however, is that in many arenas, ideals are a vision of the possible, not the usual. Coming together as an informal group of five faculty members from various nursing specialties (community health, pediatrics, midwifery, women’s, and adult health), we sought to articulate what we meant by urban health nursing (UHN) as a core curricular and practice focus. We began this endeavor by considering the traditional nursing metaparadigm concepts of person, environment, health, and nursing and then describing the way in which we include the concept of social justice in our teaching, research, service, and practice in urban health and community health nursing.

A Conceptual Model for Urban Health Nursing

In the United States, the nursing metaparadigm has been widely used to describe four spheres of nursing knowledge that reflect beliefs held by the profession about nursing’s context and content. Historically, the metaparadigm has encompassed the four concepts of person, environment, health, and nursing (Fawcett, 2005). Alternatives have been proposed and challenges have continued (Reed, 1995), but most nurses in the United States have some awareness and understanding of the metaparadigm. It is with this common awareness in mind that we examined our UHN practice using these concepts as a foundation. As we discussed our experiences and vision of UHN practice, we concurred that the concept of social justice belonged at the center of our model (Fig. 1).

The concept of social justice interconnects UHN practice with the four acknowledged concepts of the nursing metaparadigm. It is our contention that UHN centered on the practice of social justice ensures distribution of life resources in a way that benefits the
marginalized and constrains the self-interest of the privileged. It is our goal in this paper to articulate a model for urban health nursing that is organized around the central concept of social justice.

Urban Community

The first definition to consider within UHN is urban-ness. We utilize U.S. census definitions to define an urban metropolitan statistical area (MSA). In 2003, the United States Census Bureau classified an urban MSA as an area with a population density of at least 1,000 people per square mile and a surrounding overall density of at least 500 people per square mile. MSAs contain a large population nucleus and a high degree of economic and social integration with their adjacent communities. The largest city in each MSA is the principal city.

For almost 20 years, the international movement called Healthy Cities has attempted to improve conditions in urban areas. A healthy city or community is defined as one with affordable housing, accessible transportation systems, employment for all who want to work, a healthy and safe environment with a sustainable ecosystem, and accessible health care services that focus on prevention and staying healthy (Awofeso, 2003). Although many of the issues important to urban health have counterparts in rural and suburban areas, there are critical health issues that are unique to U.S. urban settings. Special urban issues include: (1) economic and social marginalization of inhabitants, (2) disparate access and use of health care systems, (3) higher mortality rates from an array of acute and chronic diseases, and (4) higher rates of morbidity from preventable diseases. The authors have argued that the leading health issues in the United States demand public health solutions (Lee & Estes, 2003; Smedley, Smith, & Nelson, 2003). Dismantling the systemic issues of urban settings requires population focus.

Social justice should be the central conceptual philosophy for urban community and public health nursing practice. The discussion of nursing’s metaparadigm concepts with social justice added as the central concept demonstrates why many of the gaps between the Healthy Cities initiatives and the realities of American city life continue to exist. The gaps are related to social justice disparities that can only be addressed through the persistent pursuit of change at the systemic and population level with political and economic solutions.

Social Justice

While the need for social justice as a central theme in nursing is acknowledged by nurses (ANA, 2001), our collective definition of social justice is often assumed. Contemporary philosophers have written and discussed a variety of social justice theories. These theories include definitions and demands of social justice from the perspectives of: (1) communitarian (Barry, 1989; Etzioni, 1998; Sandel, 1998; Tams, 1998; Waltzer, 1983), (2) contractarian (Gauthier, 1990; Rawls, 1993), (3) egalitarian (Dworkin, 2000), (4) feminist (Gilligan, 1982; Hampton, 1998; Okin, 1989), (5) libertarian (Nozick, 1974), and (6) religious (National Council of Catholic Bishops, 1986; Niebuhr, 1996).

In our conceptual model, social justice, as described by Barry (1989), is the guiding philosophical orientation (theory) and the dynamic implementation process (practice). Barry’s approach to social justice requires that institutions and nations must be motivated to act in “ways that can be defended . . . without appealing to . . . advantage” (p. 361). Barry calls this approach “social justice as impartiality.” In social justice as impartiality, justice is decided as if neither side knew which position they were in: the advantageous (stronger bargaining) position or the disadvantageous (weaker bargaining) position. Thus, instead of an intervention or action being deemed just because it advantages one side or the other, it is done because its outcome would be just when viewed by a dispassionate outsider. The point of negotiations, then, is to get an equal share and no more. Self-interest is rationally put aside in favor of the greater good.
The difference between this approach to social justice and previous similar approaches (e.g., Rawls’ “veil of ignorance,” walking a mile in another’s shoes, or the biblical Golden Rule) is that Barry applies the principle to institutional and international populations rather than to individuals. Nurses traditionally have been taught to place the individual patient foremost in care planning, a position that does not correlate with Barry's social justice. As a guiding philosophical orientation, social justice in nursing must go beyond current pedagogy and simple definitions of ethical principles. Individual-based nursing relies on a “material principle of justice” that recognizes the characteristics of patients in distribution of health care resources. These characteristics include individual need, effort, societal contribution, merit, and a desire for distribution of equal shares among individuals. Barry and other communitarian philosophers criticize these approaches because they promote microallocation of health care resources at the patient level. The individual patient is unfairly given an advantage just because they happen to be somewhere (in the bed, in the clinic, in the emergency department, etc.). Social justice in nursing must be viewed from a population vantage point that supersedes individual characteristics and the advantage of presence as the basis for claims of disproportionate shares of health care resources. If the nursing profession is to improve the well-being of persons, environments, health, and nursing in the urban setting, it must endorse and implement a revised nursing metaparadigm that places the communitarian notion of social justice at its center. Additionally, the extant metaparadigm concepts need to be reconsidered at the community and population levels (Ervin, Bickes, & Schim, 2006).

Environment

Nursing’s concept of environment includes the physical environment, as well as the psychosocial environment. It has traditionally been circumscribed by the confines of the clinic, hospital, or geographic community in which nurses worked. Interventions are often individually targeted and mistakenly based on an assumption of individual free choice in altering the impact of the environment on health (Kneipp & Drevdahl, 2003). Chopoorian (1986) expanded the context of environment to include political and economic structures and the relationship between these structures and the origins of health or illness. Kleffel (1996) and Butterfield (2002) propose a shift in nurses’ environmental consciousness that would lead to “upstream” or population-level solutions to health care problems associated with environmental causes. We endorse these conceptualizations of environment that focus on a movement from the solely individual “downstream” approaches to look at upstream community, societal, and global solutions.

Health

The concept of health within nursing developed from multiple and disparate paradigms (Newman, 1991; Smith, 1981). Research based on a wellness-illness continuum conformed to scientific methodology and sought to control contextual effects. A unidirectional developmental perspective sought to address the dynamic nature of health experiences. Health from both perspectives is viewed as a personal or individual process. Newman describes an interaction between person and environment in the definition of health; yet, the consequence of this perspective remains a focus on the individual with limited emphasis on the larger institutional and societal effects. These conceptualizations place excess responsibility for improved health within the individual person, as opposed to the environment. Our view of health must
be expanded to include the dynamic agency of a person within a dynamic institutional and societal environment. Our view uses a simultaneous-action worldview in which the sociopolitical aspects of a person’s life that impact on health are considered along with the individual aspects (Reed, 1995).

**Nursing**

Nursing theorists have variously defined nursing as a learned humanistic art and science that focuses upon personalized individual and group care and a caring relationship (McEwen & Wills, 2007). These and other theoretical definitions of nursing have generally focused on the individual; however, problems that affect health in urban communities are complex, requiring multifaceted resources, knowledge, and efforts. Nursing’s ability to respond to the multitude of community-level health system and environmental challenges will have a great impact on the effectiveness of the profession in urban settings.

We believe that urban health nursing requires a population consciousness. Nurses with a population consciousness see the community and global aspects of health care beyond the immediate situation (Thorne, 1997). Nursing from this viewpoint requires a critical analysis of the status quo in health care and the larger society, exposing oneself to the larger societal issues that form the upstream precursors to urban health disparities. Nursing as population consciousness holds the view that traditional professionalism focused on the individual may lead to cultural paternalism and racism. It may also lead to the dominance of high-technology and facility-based Western biomedicine.

**Nursing and racial/ethnic competence**

At a minimum, nursing will require an emphasis on racial and cultural competence to uphold the population consciousness described above. Yet, nursing has not always supported the ethical ideal described by Barry. An emphasis on a colorblind perspective was common to the assimilation models of early nursing theory (O’Neill, 1992). Likely, unconscious classism and racism interlocked and operated together to influence the early scholars. Although nursing theorists were working to separate the discipline from the dominance of medicine, these scholars put forth theoretical underpinnings that were influenced by the nurse’s own generic person, environment, health, and nursing biases.

Limitations in nursing’s perspectives toward persons of color, those with foreign or immigrant status, and people with nontraditional lifestyles continue to exist. Benkert, Pohl, & Coleman-Burns (2004) found that nursing school undergraduate and graduate education was not cited as the primary source for student knowledge about diverse cultural groups. In fact, most Nurse Practitioners (NPs) in Benkert’s study reported that their primary learning about people from various backgrounds was derived directly from their patients. Among those NPs reporting familiarity with the concept of social justice, the knowledge grew out of their personal desire to learn more; neither the profession nor their schooling had prompted their learning. NPs who retained the patient as the sole source of their knowledge were limited in the ability to recognize the larger systemic issues confronting patients (Benkert et al., 2002). Bell (2005) reports that nurses lack an understanding of the distinctions between the concepts of social justice and cultural competence. Recent work suggests that nurses and other health providers at all levels of practice demonstrate deficits in understanding and working with diverse clients and communities (Doorenbos & Schim, 2004; Doorenbos, Schim, Benkert, & Borse, 2005; Schim, Doorenbos, & Borse, 2005; Schim, Doorenbos, Miller, & Benkert, 2003).

Nursing has the theoretical foundations to engage in a proactive shift toward social justice. Reed (1995) described a neo-modernist perspective in her treatise on nursing knowledge for the 21st century. Within this perspective, nursing scientists must link the process of critique to a metanarrative that is found in nursing philosophy and nursing practice. Still, it is important to be cautious as in many arenas of nursing, these ideals are visions of the desirable rather than the actual (Corley & Goren, 1998). The institutions, societal norms, and reference groups within nursing practice create a “dark side of nursing” (p. 99) that perpetuates stigma and lack of just care. As Drevdahl (1999) suggests, “staying moored to the familiar and comfortable in nursing theory [and practice] is limiting” (p. 1) and potentially destructive to the profession.

**Nursing education, practice, and research**

We provide a revolutionary challenge: to develop approaches to nursing education, practice, and research that utilize an expanded nursing metaparadigm with
social justice added at its very core. We believe that there are four initial approaches to achieving this ambitious goal.

First, urban health nurses can adopt Barry’s 
*justice as impartiality* as the common definition of social justice that is free from the political influence of the moment. Emphasis must shift to population health over individual health, to disease prevention and health promotion over intensive care, to community care over hospital care, and to the pursuit of quality of life over quantity of life.

Second, the new metaparadigm of nursing with social justice at its center must be taught to nurses currently engaged in practice as well as those entering the field. As demonstrated by Bell (2005), some nurses do not accurately define “social justice,” let alone apply a “social justice as impartiality” orientation in their practice. Bell found that only nurses age 50 and older had social justice as part of their vernacular or their lived experience. Nurse educators can seek ways to teach and model social justice through service learning, community commitment, and emphasis on the common good. One community health faculty member, for example, assigns a “Heart & Soul” project to senior undergraduate students. Books are selected from a reading list of fiction and nonfiction works that address such issues as ability/disability, race, ethnicity, gender, immigration, marginalization, discrimination, and health economics. Students then work in groups to present the books to their colleagues through skits, videos, slideshows, poetry, or other creative expressions (Schim, 2004). Student evaluations reveal that for many, this assignment provided a first opportunity to think in-depth about the worldviews of people who are in various ways disadvantaged and to consider the moral implications for the students’ own nursing practice.

The third way to utilize the expanded metaparadigm is for nurses to work consciously to diversify the profession. Nursing and other health professionals are making only modest gains in recruiting traditionally underrepresented minorities into the discipline (Barbee & Gibson, 2001; Buerhaus & Auerbach, 1999; Coffman, Rosenoff, & Grumbback, 2001; Sullivan Commission on Diversity in the Healthcare Workforce, 2004). A concerted effort to enhance the recruitment and retention of racial, ethnic, gender, and other diverse groups into nursing, and specifically engaged in urban public and community health nursing, has the potential to enhance our service with multiple populations. Diversification of the nursing workforce is one of the national goals of *Healthy People 2010* (2000) because it is associated with expanded public trust, acceptance, and access to quality health services (Objectives 1–8). One example of an initiative in this area is a Midwestern nursing college, which has obtained state and federal funding to enhance specifically the recruitment and retention of African American prenursing students through a “Future Nurse Professionals” program. The program provides mentoring and guidance to students who may benefit from additional support during their initial year of socialization in an academically challenging college environment.

Next on the list of ways we can achieve a new paradigm is for nurses to promote primary and secondary prevention at the local, state, national, and international levels through political action. Using a variety of approaches such as coalition building, campaigning, confronting, and convening community partnerships, nurses working for urban health have the skills and abilities to leverage political power for change. Nurses can work to ensure that community-based health care services survive politically motivated cost cutting. We can speak along with those who are, all too often, not given a voice when budgets must be “right sized.” We can assist communities to speak for themselves. We have demonstrated the ability to conduct research that addresses health concerns from the perspectives of diverse populations that have not had active roles in the creation and use of research findings before (Jackson, Early, Schim, & Penprase, 2004; Kulwicki, Miller, & Schim, 2000; Kulwicki & Rice, 2003). Nurses must also advocate for increased and continued funding for Medicare, Medicaid, and nurse-managed centers, along with health departments and community social and health service agencies. Building bridges of social justice across populations requires available, accessible, affordable, and sustainable health care that is equitably and impartially distributed without regard to personal advantage or disadvantage.

Equally important, nurses can keep doing what we in public health nursing have been doing for many years: demonstrating the efficiency and effectiveness of nursing services for meeting the needs of special urban populations. For example, nurse-managed centers have provided direct primary health care access to uninsured and underinsured communities for many years (Glass, 1989; Glick, 1999). In fact,
a consortium of nurse-managed centers in Michigan, which included several clinics associated with the authors’ own institution, has provided a “safety net” of needed health care to multiple urban communities (Pohl, Vonderheid, Barkauskas, & Nagelkirk, 2004). Increased use of Certified Nurse-Midwives (CNM) is also making positive contributions to women’s perinatal outcomes in urban environments. CNMs have historically cared for women who are ethnically diverse, using Medicaid or reporting no insurance, and clients representing younger age groups (Declercq et al., 2001). In addition, Davidson’s (2002) comparison of high-risk women’s outcomes in an urban health setting revealed that the CNM clients experienced incidences of complications that were similar to or better than national averages. In an era of limited access to care in urban “medically underserved” areas, advanced nurse practitioners, such as CNMs, provide high-quality cost-effective care within the context of overall community social justice principles.

Preparation of more advanced practice nurses (MSN/CNS) for community health and urban public health practice and administration is necessary to support an expanded focus on population health. Nurses educated at the MSN level are able to bring a unique and valuable population perspective to their various roles in traditional health departments, health systems, workplaces, schools, jails, parishes, and community agencies. As both graduate and undergraduate curricula are pressured to include ever-increasing amounts of critical care and primary care content, community and public health programs are threatened. Introduction of the core content specific to population health with an emphasis on social justice is imperative in the preparation of nurses for practice in urban health nursing at all levels.

Conclusion

Our revised model of urban health nursing’s metaparadigm can enhance our effectiveness in addressing pressing urban health issues and add significantly to acquisition of disciplinary knowledge (Thorne, 1997). Margaret Mead is often quoted as having said, “never doubt that a small group of thoughtful committed people can change the world.” We have no doubt that nurses can change the future, but it remains a challenge to each of us to embrace the notion that part of nursing’s social mandate is to assure the health care rights of all people, whether known to us as patients or not. We must not perpetuate a health care system that needlessly abandons nearly one-third of its patients in the United States and countless millions in the world at large. Nurses are in a unique position of access to diverse communities and have the privilege of working with the most vulnerable groups as well as with people at their most vulnerable moments. We are experts at helping patients, families, and communities to navigate and negotiate in complex systems to get their needs met. We need to expand our efforts now to focus on a new social justice orientation that propels us to change systems and then to change ourselves as a profession. The preferred future requires a proactive and conscious decision to change our traditional philosophy of social justice as practiced at the individual level to one practiced at the population level.

We offer a challenge to our nursing colleagues to embrace the notion that nursing’s focus should be assuring the rights of all people. We hope to spark a revitalization of the metaparadigm concepts with an added central philosophy of social justice. Equal access to the benefits and protections of society are characteristics of a just society and a caring profession. We cannot maintain a status quo that epitomizes the divisions between rich and poor, urban and suburban, dominant race/ethnicity and dominated race/ethnicity, by being a separate enclave with little access, relevance, or tolerance for the majority of our populations. We must stand up for a social justice framework of care.

References


