

International Column

“Upstream” nursing practice and research

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Nursing practice often brings the nurse into an intimate relationship with suffering individuals and vulnerable communities. To fully and effectively conduct our practice and pursue our scholarship, the socially unjust systems that maintain the vulnerability of whole populations must be addressed through broader political participation and the examination of broken systems (Bekemeier & Butterfield, 2005). Although political action has a poor fit with traditional caring models that were described for nursing practice, theory, and research toward the end of the last century, notions of caring can and should be expanded to include our political responsibilities to respond to social injustices that impact population health.

Research increasingly suggests that when nursing and other health-related sciences focus their attentions on the social determinants of health, we will achieve improved health status and greater health equity in the populations we serve (Evans, Whitehead, Diderichsen, Bhuiya, & Wirth, 2001; Labonte, 2003; Raphael, 2003). This focus requires an “upstream” approach. Upstream approaches refer to an analogy used in the United States for describing efforts focused on primary prevention and addressing root causes of disease and disability. This upstream analogy addresses the underlying issues that cause “downstream” problems rather than going to great lengths to address fully developed and ongoing crises downstream. Many of us in nursing are in downstream positions, researching questions and working with programs that relate to caring for acutely at-risk, vulnerable families or communities and without a focus on activities that would drive a movement from downstream work to upstream measures that change harmful systems instead of responding to their negative outcomes. Our present emphasis on downstream approaches occurs, in part, because of the complexity of addressing social conditions

that impact health from upstream and, in part, because of our traditional conceptions of “care.”

Nurses can be natural leaders in addressing the social conditions that impact health, given our holistic perspective on health, our intimate experiences with individuals and communities that provide a unique view of the outcome of social forces such as poverty and failed policies, and our “skills in fostering health protection at the individual and collective level” (Butterfield, 2002). Focusing our research and practice pursuits on the underlying causes of poor health status and health disparities requires an upstream perspective that brings nursing (back) into the realm of policy analysis, social reform, environmental health, sociology, and international health.

This focus on legislation, social reform, the environment, and international policy is not new to nursing, however. We have been there before. Among nursing’s early leaders in the United States, Lillian Wald and her cadre of nursing activists stand out as vital figures in the American history of distinguished nursing forerunners. Visiting nurses around the turn of the 20th century among Wald’s fledgling Nursing Settlement in New York City concluded that reforming the existing conditions that create and exacerbate disease was the most effective mechanism for helping support relief in their communities. “Charitable nursing” simply as a form of service to those living in poverty avoided awkward notions of class conflict and brought temporary relief to people without creating substantive change, thereby perpetuating the impression that weak individuals, not an unjust society, created unhealthy conditions (Bekemeier, *in press*). Nursing service without a complementary participation in reform ignored the consequences of the rapid industrialization and urbanization of the day and reinforced inequalities (Reisch & Andrews, 2001).

Ultimately, Wald’s Henry Street Settlement House in Manhattan not only supported visiting nurses interested in social reform but also fostered what was considered a supportive atmosphere for radical intellectuals (Reisch & Andrews, 2001). These nurses used the strong base of

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encouragement from their community and from wealthy contributors to influence public policy in favor of improvements in population-level health and social welfare. For Wald, this meant opposing social issues that impacted health such as war, child labor, and unsafe working conditions and using public health principles of research and data gathering to expose social problems and direct solutions (Bekemeier, *in press*).

A complicated set of factors that included the growth of hospitals and hospital-based care, the decline in acute communicable disease, and changes in funding had a tremendous impact on the roles and opportunities of nurses during the middle 20th century in the United States. At the same time, tensions and changes within the nursing profession itself focused nurses more on their differences than on their strengths as a collective social force for improving health in communities and influencing healthy policy (Bekemeier, *in press*).

Tensions within nursing were made evident, according to Reverby (1987), by the many who opposed formal professionalization of nursing, negatively equating the establishment of educational and practice standards with unionism and who condemned political activism, hospital nursing strikes, and organizing efforts as out of place for the profession. Denial of professional reform during this period in the middle 20th century was based on a doctrine of individualism within nursing that was resistant to collective action and widely believed in the nurses' submissive role to physician authority and to patient needs (Reverby, 1987).

Even today, our primary role as nurses has often been regarded (by those in the health professions as well as by the public) as "caring" professionals providing service to others, mostly individuals. This is done within the context of a now well-established system of hospitals, insurance companies, and pharmaceutical corporations that are presumed to directly "support" our work, but often instead perpetuate the lack of attention to broader health solutions that address poverty, unsuitable social conditions, and other root causes of disease.

Cloyes (2002, p. 203) described the concept of our nursing care as having been described by many to be the foundation of what we do as nurses and who we are. These models of care, developed primarily in the latter part of the last century, have tended to be based on a narrow view of the humanistic sciences that does not take systems and social context into account. Traditional caring theories place caring in a position of primacy in nursing "rather than a means to a goal" (Schroeder 2003, p. 159). Can our "goal" as nurses be to "help people" (including communities and populations) live the healthiest possible lives in oppressive poverty and unequal access to healthy environments? Surely, in this context, caring must be seen as the nurse applying her or his knowledge, power, and participation in community to the fullest, acting on social and political institutions that keep whole populations from living healthy lives. Cloyes (2002, p. 210) suggested that we begin "thinking of care as a

constituted, particular form of political agency within a productive context of power."

Nursing education and research reinforce traditional caring models of service and have dissuaded us from acting to create and support policies that assure "healthy conditions," from researching root causes of poor health, and from changing the systems that overspend health dollars on illness rather than prevention. Nurses tend to be educated in theoretical models of "service" (not advocacy), thereby focusing practice on caring for individuals in need. A study conducted by Rains and Barton-Kriese (2001) of baccalaureate nursing students nearing graduation found that nursing students "did not see connections between the personal, professional, and political. Nursing seemed grounded in application and service." Similarly, nursing research generally works to substantiate what is done rather than what could be different and, as a result, reinforces a distance between the tasks of service-oriented nursing work and the complexities of social change. Instead, nursing research could focus on that which challenges political structures that oppress, employing a critical paradigm that is more interested in how data can be used for social change than the extent to which it is scientifically compelling (Ford-Gilboe & Campbell, 1995, p. 22).

Nursing scholarship around the analysis of care cannot be apolitical when contrasted with the politicized systems in which nurses practice today. Thankfully, opportunities do exist to participate in an emerging critical discourse on caring that expands the notion of caring as the "core" of nursing and envisions a more "emancipatory practice" in which nurses participate in communities in a caring paradigm different from that in which we were taught (Stevens 1992). In exercising a practice of caring that joins with vulnerable populations and with each other, we can respond to the complex problems of social inequities through the "collective" action and participatory research, which these problems require (Beauchamp 1975, p. 276). This future could be ours with a collective commitment to social change, political participation, and expanded notions of caring.

While improving the health of the few, we may serve as individuals, as nurses we are complicit in the illness and death of many. Alternatively, our experiences with patients or populations, and the communities in which they live, ought to be the impetus for making our primary responsibility be practice and research that enables healthy policy change and identifies innovative strategies for addressing the social determinants of health. Surely, barriers exist in nursing theory, education, and research that have inhibited support for this expectation of ourselves. For us to be effective, however, in assuring healthy conditions for all populations, the caring practice of nursing necessitates participation in the political process and challenging imbedded social systems and powerful interests (Beauchamp 1975, p. 278). The public should (and perhaps does) expect this of us. We should also expect this of one another.

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