

Research paper

# Shifting moral values to enhance access to health care: Harm reduction as a context for ethical nursing practice

Bernadette (Bernie) Pauly\*

*School of Nursing, University of Victoria, Box 1700, Victoria, BC V8W 2Y2, Canada*

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## Abstract

**Background:** People who are street involved including those experiencing homelessness and substance use are at increased risk of morbidity and mortality. Such inequities are exacerbated when those facing the greatest inequities in health have the least access to health care. These concerns have rarely been addressed in bioethics and there has been a lack of explicit attention to the dominant societal and organizational values that structure such injustices. The purpose of this paper is to describe the underlying value tensions that impact ethical nursing practice and affect equity in access to health care for those who are street involved.

**Methods:** In this paper, findings from a larger qualitative ethnographic study of ethical practice in nursing in the context of homelessness and substance use are reported. The original research was undertaken in two 'inner city' health care centres and one emergency department (ED) to gain a better understanding of ethical nursing practice within health care interactions. Data were collected over a period of 10 months through face-to-face interviews and participant observation.

**Results:** In order to facilitate access to health care for those who are street-involved nurses had to navigate a series of value tensions. These value tensions included shifting from an ideology of fixing to reducing harm; stigma to moral worth; and personal responsibility to enhancing decision-making capacity. A context of harm reduction provided a basis for the development of relationships and shifted the moral orientation to reducing harm as a primary moral principle in which the worth of individuals and the development of their capacity for decision-making was fostered.

**Conclusions:** Implementation of a harm reduction philosophy in acute care settings has the potential to enhance access to health care for people who are street involved. However, explicit attention to defining the harms and values associated with harm reduction is needed. While nurses adopted values consistent with harm reduction and recognized constraints on personal responsibility, there was little attention to action on the social determinants of health such as housing. The individual and collective role of professional nurses in addressing the harms associated with drug use and homelessness requires additional examination.

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People who are homeless and using drugs are at risk for a wide range of physical and mental health concern (Wright & Tompkins, 2005). They experience higher rates of morbidity and mortality than the general population (Cheung & Hwang, 2004; Spittal et al., 2006; Wright and Tompkins). They also face significant barriers in accessing health care services including discrimination, lack of health care coverage, and transportation (for example, Barkin, Balkrishnan, Manuel, Andersen, & Gelberg, 2003; Butters & Erickson, 2003; Freund & Hawkins, 2004; Gelberg, Browner, Lejano, &

Arangua, 2004; Hwang & Gottlieb, 1999). Thus, those experiencing significant inequities in health often have reduced access to health care services (Hart, 1971; Starfield, 2006). Inequities in health and lack of access to health care are morally concerning as they are rooted in unjust social conditions that structure poverty, and homelessness and are potentially remedial (Starfield, 2006; Whitehead & Dahlgren, 2006). Such inequities are serious ethical concerns that are only beginning to garner attention in bioethics (Brock, 2000; Daniels, 2006; Sherwin, 1992).

Of particular concern is the lack of attention in bioethics to the dominant societal and organizational values that shape health care interactions and injustices in health care. Failing

\* Tel.: +1 250 721 6284; fax: +1 250 721 6231.

E-mail address: [bpaul@uvic.ca](mailto:bpaul@uvic.ca).

to attend to these values in health care delivery limits the achievement of fairness (justice) in allocation of resources and diverts attention away from the social determinants of health and the conditions that produce poor health outcomes for those experiencing disadvantage (Brock, 2000). The purpose of this paper is to describe the underlying value tensions that nurses must navigate to enhance equity in access to health care for those who are street involved, particularly those who are homeless and using drugs. The findings reported in this paper are drawn from a larger study of ethical nursing practice in the context of homelessness and substance use (Pauly, 2005).

## Background

### *Inequities in health*

Those who are street involved, are at risk for increased health problems related to violence, accidents, substance use, lack of housing, poor nutrition, stigma and discrimination (e.g. Kreiger, 1999; Wright & Tompkins, 2005). Specific health problems differ according to individual circumstances, age, gender and ethnicity (Hwang, 2001, Cheung & Hwang, 2004). For example, women are at higher risk for depression, sexual abuse, HIV and sexually transmitted diseases than men (Cheung & Hwang). Men are more likely to experience substance use, and older men are at greater risk of hypertension and other cardiovascular disorders (Hwang). Those who use drugs are further exposed to multiple drug-related harms including HIV/AIDS, Hepatitis C, bacterial infections, cellulitis, endocarditis, abscesses, overdoses and addiction (Hunt, 2003). Not surprisingly, people who live or work on the street do not have a life span similar to other groups. People experiencing homelessness are at risk of premature mortality as a result of HIV/AIDS, overdoses, accidents and suicide (Barrow, Herman, Cordova, & Struening, 1999; Cheung & Hwang; Hwang, 2000; Spittal et al., 2006). Spittal et al. found that women who use injection drugs had a mortality rate of 50 times that of the general female population in British Columbia. This elevated rate was associated with unstable housing and HIV infection. The increased risk of mortality applies to men, women and youth who are homeless and/or street involved. At the same time, those who are street involved face a myriad of barriers in accessing existing health care services further limiting the resources available to address health needs (Aday, 1993; Hall, 1999; Hall, Stevens, & Meleis, 1994; Stevens, 1992).

### *Inequities in access to health care*

Stevens (1992) argues that for nurses to work towards the goal of enhancing access, equitable access to health care must be framed within a broad sociopolitical context that includes attention to financial, geographic, qualitative and interactional barriers to accessing health care. Lack of health

insurance, lost or stolen health care cards, transportation, pharmaceutical costs, lack of eye or dental care are structural barriers to accessing health care (Barkin et al., 2003; Butters & Erickson, 2003; Freund & Hawkins, 2004; Hwang & Gottlieb, 1999).

In addition to financial and geographic factors, the nature and quality of interactions with health care providers can affect access to health care (Stevens, 1992). In research exploring the experiences of individuals who are homeless, experiencing addiction or mental illnesses in multiple communities in the United States, United Kingdom and Canada, negative attitudes, judgements and perceived discrimination have been identified as important barriers to accessing health care (Butters & Erickson, 2003; Crockett & Gifford, 2004; Ensign & Planke, 2002; Gelberg et al., 2004; Napravnik, Royce, Walter, & Lim, 2000; Stajduhar, Poffenroth, & Wong, 2000). In particular, those who use illicit drugs felt that their past or current status as a 'drug user' was a barrier to accessing health care and affected the quality of care they received. Hepatitis C, HIV/AIDS and mental illness are prevalent among those who are street involved and have been associated with stigmatizing experiences for affected individuals (Bird, Bogart, & Delahanty, 2004; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Crockett & Gifford, 2004; Dinos, Stevens, Serfaty, Weich, & King, 2004; Valdiserri, 2002; Zickmund, Ho, Masuda, Ippolito, & LaBrecque, 2003).

Negative experiences, stigma and discrimination in health care reduce the likelihood of people accessing care in the future, and will affect patient outcomes (Browne, Johnson, Bottorf, Grewal, & Hilton, 2002; Kreiger, 1999; Stevens, 1992; Varcoe, 2004). Experiences of stigma may result in feelings of worthlessness, depression, isolation, anger, anxiety and fear (Dinos et al., 2004; Zickmund et al., 2003). Feelings of worthlessness associated with the stigma of having a socially unacceptable disease and illicit drug use may inadvertently be reinforced by the attitudes and responses of health care providers. In one study, perceived discrimination in interactions with health care providers by people with HIV and low socio-economic status was correlated with higher levels of depression and post-traumatic stress symptoms, an increase in AIDS-related symptoms, poorer physical health and less satisfaction with care (Bird et al., 2004).

Registered nurses have a professional ethical commitment to provide nursing care on the basis of need regardless of ethnicity, race or class and to promote social justice through the development of equitable health policy (Canadian Nurses Association, 2002). However, those who are homeless and using drugs are among those identified by nurses as 'difficult' (Carveth, 1995); 'unpopular' (Johnson & Webb, 1995), 'those that nurses do not like' (Liaschenko, 1994) or frequent flyers (Malone, 1996). Differences in the quality of care of those identified as 'difficult' include delaying care, avoiding patients, inaccurate assessments, withholding of treatment, providing limited care (e.g. physical care only), providing less information, inappropriate behaviours such as roughness in providing care and negative responses to patients

(Carveth, 1995; Corley & Goren, 1998; Johnson & Webb, 1995; Stevens, 1992). Such behaviours are inconsistent with ethical nursing practice. Several of these authors have identified that the context or culture of health care is an important factor in the development and communication of attitudes, stereotypes and judgements involving social criteria (Corley & Goren, 1998; Johnson & Webb, 1995; Stevens, 1998).

Registered nurses working in the community in primary health care centres and as street nurses are often a first point of contact for people experiencing marginalization associated with homelessness and substance use. Some authors have found that those who are street involved highly valued the respectful nonjudgemental care provided by street nurses and when care is delivered in primary health care settings (Hilton, Thompson, Moore-Dempsey, & Hutchinson, 2001; Politzer et al., 2001; Stajduhar et al., 2000). However, little is known about the values that are embedded in these cultures that serve to counter perceptions of stigma and discrimination and enhance access to health care. The primary aim of the larger study was to contribute to a better understanding of ethical nursing practice as a means of enhancing equity in access to health care for those who are street involved in the context of homelessness and substance use (Pauly, 2005). In this paper, the focus will be on the values tensions that nurses must navigate to enhance equity in access to health care.

## Methodology

Ethnographic designs are particularly appropriate when the aim is to understand practices and experiences within a broader cultural context (Hammersley & Atkinson, 1995; Roper & Shapira, 2000). In particular, Hoffmaster (1993) has argued that ethnography is an important methodology for research in ethics with the potential to reveal the way in which ethical concerns are historically and culturally situated and yield important knowledge necessary to improve ethical practice within professions. The characteristic features of ethnographic work are participant observation, holism, context sensitivity, sociocultural description and theoretical connections (Stewart, 1998). In addition to these characteristics, this research project was informed by social constructionism (Crotty, 1998), critical theory (Lather, 1991) and feminist processes for doing research (Anderson, 1991).

Ethical approval for the study was granted by the sites where the research was conducted and by a University Ethics Review Board. Staff and clients in the sites were informed about the study through verbal presentation and/or posters. Written informed consent was obtained from all primary participants. Verbal consent was obtained from secondary participants.

Over a period of 10 months, data were collected in three sites including two primary health centres and one emergency department (ED). Both of the primary health care health centres and the ED were located in large Canadian cities and all were identified as serving an 'inner city' population charac-

terized by homelessness and substance use. Data collection methods included 203 h of participant observation and formal interviews with 26 primary participants including 13 registered nurses, 4 people accessing health care who had previous or current experience with homelessness and substance use and 9 other health care team members in the three sites. In addition, multiple informal interviews with nurses, other health care providers and people on street and in the clinics were a source of data. The study was conducted over 2 years and completed in 2005.

Data analysis proceeded concurrently with data collection. Insights from initial observations were followed up in subsequent observations and observations/hunches were shared and discussed with participants as the research proceeded. Data analysis was conducted using Lincoln and Guba (1985) approach to qualitative analysis. Immersion in the data was achieved by reviewing transcribed interviews and field notes systematically to be able to identify activities, events, and conversations that described ethical practice and interactions for insights into the social context. The operations of unitizing and categorizing, as described by Lincoln and Guba (1985), were employed in the analysis of the data. Consistent with feminist processes for doing research, the nurses involved as primary participants were invited to discuss the emerging findings during and at the end of the data collection and analysis. Feedback from participants was recorded and treated as an additional and valuable source of data rather than as validation of data.

The criteria for reliability and validity in feminist research include dependability, adequacy, reflexivity and catalytic validity (Hall & Stevens, 1991; Lather, 1991). Dependability was enhanced by documentation of methodological, analytical and reflexive field notes, discussing findings with the participants, and through feedback from members of the dissertation committee. In addition, it should be noted that dependability increases with prolonged engagement, persistent observations, use of multiple observers and comparison of multiple data sources in the analysis. All of these were integral to the design of this study. In order to achieve adequacy, throughout the process of the research, continual questioning by the researcher of methods and the impact of the study in a social and political context was a central activity (Hall & Stevens, 1991). In this study, field notes, discussions with dissertation committee members and opportunities to engage with people during observations and sharing of observations and findings were employed as strategies to enhance reflexivity.

Drawing on the tenets of critical theory, Lather (1991) proposes catalytic validity which "represents the degree to which the research process re-orient, focuses and energizes participants toward knowing reality in order to transform it, a process Freire (1973) terms conscientization" (p. 68) to enhance rigor. It was anticipated that participants in this study might gain insight into important and relevant aspects of their practice and the context of their practice. Nurses directly involved in the study commented on the value of the research

in highlighting their work and helping them to articulate what they do. In addition, there was an explicit intent to generate insights that could enhance the development of ethical practice of practitioners with those who are street involved. These have been shared with practitioners and policymakers.

## Findings

In fostering ethical nursing practice, nurses had to constantly navigate a series of value tensions that shaped practice with those who are street involved. These value tensions highlight dominant but often unattended values in health care that can both facilitate and constrain access to health care services. The value tensions identified in this study included shifting from an ideology of fixing to reducing harm; stigma to moral worth; and from focusing on personal responsibility to enhancing decision-making of individuals.

### *Fixing/reducing harm*

In the acute care setting nurses repeatedly described the culture of health care as one in which they had to “fix” individuals who presented in the emergency department. An emergency department nurse describes,

“We have to fix them fast so we can take the next person or we end up plugged. And that of course is a frustration for us. What we ideally like to do is treat the acute and send them elsewhere. And as an ED nurses that is where our focus is. Let’s treat the acute, don’t dig too deep.”

Nurses in the ED described that their primary focus is to fix people as quickly and efficiently as possible so as to move them through the department ED. However, those who were experiencing mental health or substance use problems were among those whose health and social issues were not amenable to fixing easily or quickly. As one nurse said, “I can’t fix it in 15 min with a shot.” Another nurse indicated “I want to see people leave our department fixed and some of these at risk population you can’t fix.” Nurses were particularly frustrated by “fixing people up” only to have them return again and again. For example, people who repeatedly returned to the emergency department for treatment of multiple abscesses. “You pump them full of antibiotics, you cure their abscesses and they go back out and do it again. It’s very frustrating.” The dominant ideology of fixing in the ED left nurses feeling frustrated and with a sense of failure at their inability to fix the complex health and social issues of people experiencing homelessness, mental illness and drug use. Clients also recognized the limits of a health care system focused on fixing in responding to their needs. One woman with a long history of schizophrenia described herself as broken and said that health care providers could not fix her. A man with a history of substance use and repeated emergency department admissions

indicated that when “they can’t fix you, they give up on you”. These clients expressed a feeling of being ‘unfixable’ and abandoned.

The dominant ideology of fixing in the culture of the emergency department was in direct contrast to the dominant value of reducing harm described by nurses working in the primary health care centres. Both of the primary health care centres in this study had an expressed philosophy of harm reduction. In these centers, nurses were involved in the implementation of specific harm reduction strategies. Annie, a nurse, described,

Instead of saying, looking at that broken crack pipe, would you like a plastic tip for your crack pipe is what you say, that broken crack pipe, I’ll bet you that bothers you. I have a plastic tip in there. Would you like that for your crack pipe? You know, understanding that abstinence from drugs is often not an option in this drug saturated environment as we say. It isn’t even an option to get past that and to get on to the next thing that is, how can I make using drugs safer for you? You know. It’s acceptance isn’t it.

In the presence of a harm reduction philosophy and approach to care, there was a move from a focus on fixing people to accepting that people ‘fix.’ Nurses described harm reduction as associated with reducing the direct harms of drug use and sexual activity through needle exchange, distribution of safer crack kits and condoms. However, nurses also used the term harm reduction to describe their work in reducing a broad range of social harms such as homelessness, violence and poverty.

And obviously that’s the way you should be treating all your clients. You’re figuring out who they are, where they’re at at moments, and how to work together. So you meet whatever few little goals you have even if that’s you know, a good night’s sleep that night. It’s not about telling them what’s good for them. And so that definitely is absolutely relevant in my mind about what I think/see as harm reduction everywhere.

Working in harm reduction meant that nurses tried to consistently minimize harm for individuals not just harm of drug use, but social harms that were impacting health or well being. One nurse stated,

For example, if a woman was in an abusive relationship, how can harm be reduced if she is unable to leave her partner? If someone refused hospitalization, what could be done to reduce harm that was both safe and acceptable to the individual? In one situation, a nurse helped prevent the harms associated with a loss of housing for one man. She described the development of her relationship with him over time on outreach and his eventual willingness to seek services at the health care centre for multiple physical and mental health concerns. When he was in danger of being evicted due to the disorderly state of his apartment, she was able to help him maintain his housing by ensuring that his apartment

was cleaned. In this situation, she reduced the harm that might have arisen if he had been evicted and become homeless. Reducing harm was a primary moral imperative among nurses working in a harm reduction context that was used to guide their actions and decisions in providing care. While nurses supported strategies that reduced the harms associated with drug use, they moved beyond specific harm reduction strategies and worked to reduce the harms associated with the vulnerability of homelessness, violence and poverty. Nurses consistently asked the reflexive question, “What can be done to reduce harm for this person in this situation?”

While nurses and other health care providers in the primary health care settings endorsed and supported harm reduction as a philosophy, they identified situations when it was perplexing or difficult to discern whether or not they were reducing harm such as in the care of pregnant women who were using drugs or when someone might be putting the community at risk by not completing a course of antibiotic treatment. One nurse describes her process of reflection on such situations,

But that becomes hard when you have a woman who’s pregnant who comes in and asks for a rig. Because your instinct is, that first reaction is to say you shouldn’t be using; you have a baby. But the harm reduction would be, well, we could prevent that baby from being exposed to HIV into an infection and that the mom might end up being in hospital and needing antibiotics, a skin infection or something like that. The Mum becoming desperate and doing some kind of drug that’s more harmful for the baby lets say than what heroin is. By this attitude of ‘don’t harm the baby’ are we then actually putting the baby at more risk because then the Mum is also being judged when she comes in to health care so if something does come up, she’s not going to come back and see us because we’ve judged her and said no, we’re not giving you that needle. I think what happens then is that when you are practicing harm reduction and that people do have a right to health care, is that then people feel that they can trust you and fall back on you; that well, I will be treated with respect here and will be treated as a human being. So then they’re more likely to access care when they need it and if there is going to be a change in their life, they’re willing to walk through this door.

In this situation, protection of mother and child was seen to be enhanced by a harm reduction approach that would preserve access to health care and ensure an ongoing relationship of trust into the future. Preservation of a trusting relationship was often identified as an important priority and means for reducing harm both now and into the future. In addition, a shifting from fixing to reducing harm acted as an antidote to stress and burnout for health care providers.

#### *Stigma/moral worth*

In formal and informal interviews, all participants (nurses, clients and others) repeatedly described concerns about peo-

ple being treated as ‘not quite’ or ‘less than human’ in health care interactions. People who were street involved described feeling like an alien, a ‘piece of garbage’ or ‘a piece of shit.’ Some nurses acknowledged these kinds of concerns. One ED nurse said,

Oh well, if they come in complaining of pain, automatically they’re drug seeking. They’ve run out of their own drugs. They’ve run out of money to buy their own drugs so they have to get free drugs now. And they’ll just keep coming back in and you automatically just label them. I’ve done it myself and it’s a horrible thing but it does happen. You know. And you kind of brush them off. I find most street people here don’t get treated like people.

Feelings of ‘Being treated like garbage’ and labeling highlight concerns about lack of respect and worth and dehumanization of people who are street involved.

All participants spoke of their concerns about the verbal and non-verbal behaviours of health care providers that communicated a fundamental disrespect of the worth of people who are street involved and the underlying message, that those who are street involved are unworthy or undeserving of care.

On a day when I was doing outreach with a nurse, I heard a frontline worker refer to people being treated like a piece of garbage by ambulance personnel. So, I immediately asked her to explain it to me. She told me, she feels offended when she hears an ambulance attendant say, “Do you really want to go to hospital?” combined with a smile that says, “I don’t believe you.” She described that this can be translated to mean, “I don’t want to waste my time, you’re a piece of garbage.” She was quick to add that this did not apply to all ambulance personnel by saying, “Some have hearts and know how to relate to people in (this area).”

Such behaviors reflect a complex interplay of social, economic, political and historical forces that are enacted within health care interactions. One of the issues repeatedly encountered during this project was the view that people who were repeat users of the system are wasting time and resources. Some nurses’ raised concerns about the financial costs to the health care system generated by repeat “users”. This highlights the way that an ideology of fixing in combination with funding pressures and societal values related to worth may play out in allocation of health care resources.

Regardless of the nurses expressed the belief that all people including those who are street involved are worthy and deserving of health services proportionate to their needs. Such values are embodied in professional codes of ethics and are commonly expressed professional ethical values (Canadian Nurses Association, 2002). However, there was evidence in this study of care being rationed to those considered less deserving as result of their social status in the ED driven by an ideology of fixing, financial pressures and societal norms.

Those who were street involved described wanting to be treated as a “real person” when they accessed health care. One man, who had been coming to one of the primary health care centres for several years, described it as “the last chance café.” He explained,

I mean they’re the kind of folks who ignore their health [and] they maybe don’t take care of themselves because their life changes so erratically, radically. And but so a lot of people who normally wouldn’t bother with their health or the system. They have been seen as and treated as non-relevant, non worthwhile. You just disappear. We’re not on the radar but here we’re just [people, not street people] Word gets around, so you know.

His comments are reflective of many who identified that the centre as a place where they could access respectful nonjudgemental health care. Within the primary health care centres, nurses and others consistently resisted rationing care and strived to maintain their awareness of times when rationing based on social criteria was a potential concern.

Nurses and others in the primary health care centres described a variety of strategies for preventing rationing based on social criteria and ensuring access to health care for individuals often perceived as difficult or challenging. One nurse described constantly trying to be alert to of when she was “getting her back up” in response to particular clients. When clients were in need of acute care resources, nurses worked to disrupt negative chains of judgement to ensure that individuals received treatment appropriate to their needs. For example, a nurse might call the emergency department and alert them that a client was coming who was very ill and in need of resources even though the individual might swear at them. Nurses and other team members were encouraged to work with individuals with whom they had a good relationship and shared the care of individuals found to be difficult, demanding or challenging among the team. One nurse stated,

And so each one of us has a particularly difficult client that we really click with or that we go to bat for a lot. Or you’ll hear the voice and you’ll go out and see them or whatever. And that very same person may be somebody that everybody else doesn’t really relish seeing. So that can be changing, but it’s the same in any environment. If the negativity starts to get too big, and that gets in the way. It generally doesn’t. I think there are a lot of people with relatively like-minded philosophies.

This nurse highlights the importance of having shared values among team members. Nurses indicated that other team members often provided “a fresh perspective.” For example, one day, a nurse consulted a physician indicating that she was not sure if she believed the patient’s story, the physician indicated that he thought the patient was quite genuine and her symptoms were consistent with her diagnosis. After the nurse turned to me and said, “See when one of us writes some-

one off, somebody else sees something different.” Working as part of a team was a source of support and helped nurses and other team members to stay focused on shared values including the importance of ensuring that individuals who often have limited access to health care have access to health care resources proportionate to their needs.

In ensuring that everyone receives care proportionate to their needs, health care teams had to constantly balance access to health care against efficient use of resources and safety. Health care teams worked to ensure access to health care and manage resources, particularly human resources, wisely. The following example illustrates a case conference in which the team discussed concerns about a woman who has been repeatedly accessing the health care centre.

The team discussed the number of times each of them had seen Joyce over the past few days. They identified that in this situation, continuity of care with the same practitioner was needed. Since the centre often triaged anxious patients so they were seen quickly to prevent escalation among others, Joyce was being seen repeatedly several times a day by different practitioners. The team discussed the need to have her assigned to one practitioner only and restrict her visits to once a day. One of the staff indicated that once a day was a lot but someone else observed that once a day was better than the current multiple visits per day. Someone asked “are we willing to call the police if needed?” The manager indicated that she didn’t want to do that until Joyce had received a psychiatric assessment. They talked about precedence in which other clients had been restricted to one practitioner and a limited number of visits per day or per week. They recalled past times when they had needed to set limits with some violent and aggressive drug dealers. Through discussion, they determined which practitioner, given individual case loads, would be Joyce’s primary provider. In that discussion, the practitioner assigned to her care was asked if she would be able to set these limits with Joyce. She said she would have to.

The team through thoughtful and direct dialogue sought to preserve Carol’s access health care and manage available resources wisely. Together they agreed on and committed to a plan of action that could be followed up with the individual involved.

Second, health care teams in the primary health care centres had to balance access to health care with real or perceived threats to personal safety and security of team members. Team members were alert to potential threats to themselves and others and constantly talked through concerns to assess whether their feelings of being threatened were a manifestation of negative judgements or of substantive concern. There was a recognition that often an angry or aggressive response from an individual arose from their past experiences and was a manifestation of survival mechanisms needed on the street or in prison. Only rarely would an individual be banned from accessing services in one of the community health centres.

Banning only occurred in the face of serious threats to safety and after extensive team consultation. In the face of such challenges one nurse said that the manager helped to remind them of their values.

And I think those are things that [our manager] brings to the clinic. And not very often, but now and again she'll have to put down her foot in a staff meeting and say, we're not barring this patient because this is what we do and this is what we're about and we are here to serve that very type of person who is angry and you know, whatever. So she's good at keeping us on track.

This manager played a key role in ensuring that the team upheld shared team and organizational values. The nurses in this centre were consistently able to raise their concerns about the treatment and care of individuals to the manager and were supported to take actions that helped enhance equity in access to health care. For example, one nurse was able to have a ban lifted for a man who had been barred from a shelter. With the support of the manager, she fostered dialogue between the man and the shelter to address the behaviours that had led to the ban. Nurses consistently worked to resist negative societal values related to the worth of those who are street involved through a variety of strategies that were supported by other team members and managers in order to facilitate and preserve access to health care.

#### *Personal responsibility/enhancing decision-making*

Nurses and those who were street involved described the problem of individuals being blamed or found to be at fault for their poor health. One woman, who accessed care from nurses at a primary health care centre, described the attitude of some health care providers as “well why the hell are you here? You shouldn't be here, right, because you know, you do this to yourself.” Frequently, nurses espoused the view that individuals on the street are survivors. They acknowledged and respected their capacity to survive situations such as family dysfunction, abuse, traumatic injury and loss. Thus, implicitly recognizing the social conditions that shape their life situations and fostering respect and moral worth of individuals. In order to resist the view that individuals were not taking responsibility for their health, nurses expressed the view that individuals while responsible for their choices may have had limited opportunities to develop decision-making capacity.

In this study, nurses continued to offer and keep open choices even when individual behaviours were not consistent with what the provider might think was in the best interest of the person. For example, if a client decided to discontinue treatment such as antiretroviral medication for their HIV, if someone did not show up for an appointment or if they went on a drinking binge after going through detox, they were not labelled as making bad choices, noncompliant or failing to take responsibility. Rather nurses kept the door open by con-

tinuing to offer choices regardless of previous decisions or behaviours. They might describe the person as still precontemplative, meaning they are not yet ready to make a change but reinforcing that they need to keep working with the person. However, if a nurse perceived that the harm was life threatening and they were in need of care, they might say “this is serious, you have to go or you could die.” Nurses working in harm reduction worked to balance the client's right to say ‘no’ and encouraging but not coercing an individual to take action.

The shift from personal responsibility to enhancing development of decision-making capacity reflects a continuing value on autonomy rooted in liberal individualism but instead of expecting autonomy nurses focused on assisting individuals to develop the capacity for autonomous decision-making. In order to resist blaming individuals for failing to take personal responsibility for their health, nurses shifted to focus on the development of decision-making capacity in order to enhance access to health care. While nurses recognized the social conditions that constrained decision-making capacity, their actions focused on enhancing individual autonomy rather than effecting change in the social conditions.

#### **Discussion**

The ideology of fixing is consistent with dominant biomedical value systems that operate in health care that emphasize a focus on disease and cure of disease and illness as the measure of success (Storch, Rodney, Pauly, Brown, & Starzomski, 2002). The focus on reducing harm as a dominant value system that operated within a context of harm reduction helped to foster access to health care. Harm reduction has been described as being characterized by the key principles of pragmatism; humanistic values; focus on harms; balancing costs and benefits; and hierarchy of goals (Canadian Centre of Substance Abuse, 1996; Hilton, Thompson, Moore-Dempsey, & Hutchinson, 2001; Hilton, Thompson, Moore-Dempsey, & Janzen, 2001; Hunt, 2003). The findings in this study are consistent with the key principles of harm reduction. A focus on reducing harm may be viewed as a more ‘ethical’ approach to working with people experiencing social disadvantage because they are not forced to change and their choices are respected while trust and opportunities to access health care are preserved. Gunn, White, and Srinivasan (1998) state “harm reduction encompasses abstinence as a desirable goal, but recognizes that when abstinence is not possible, it is not ethical to ignore the other available means of reducing human suffering” (p. 1191). While a key priority of harm reduction, as described by nurses in this study, was to reduce harm associated with drug use, reducing harm became a moral imperative that propelled nurses to act to reduce the harms associated with social conditions affecting the health of those who are street involved such as assisting with access to housing, income or other health and social services. However, there were often sig-

nificant barriers encountered in attempting to mobilize such services and resources.

These findings suggest that the presence of a harm reduction philosophy fostered a focus on reducing harm as a key contextual feature of ethical nursing practice enhancing access to health care for those who are street involved. It may be that the adoption of a harm reduction philosophy created a safe climate for fostering a different set of values or that individuals with already established values were drawn to work in settings that serve those who are street involved. Regardless, these findings suggest the need to develop nursing curricula and practicums that enhance students' knowledge of the social conditions that shape the lives of those who are street involved and knowledge of harm reduction.

Expanding harm reduction approaches to hospital programs and services has been successful in several settings (Young, Fish, Browne, & Lawrie, 2002). Although such programs have not been rigorously evaluated, improvements in relationships with clients have been reported. Thus, pointing to the need for the development of harm reduction policies within acute care settings and increased understanding of the harms associated with street life among health care providers. While nurses and other health care providers in the primary health care settings endorsed and supported harm reduction in practice, there are significant ethical tensions associated with implementation of harm reduction. This is an area for future research and exploration to better understand and equip providers to respond to the perplexing issues raised by the adoption of harm reduction philosophy and policy.

While harm reduction may contribute to shifts in the moral orientation of health care providers, it has limitations. Harm reduction has been most often applied to reducing the harms of drug use, focusing on decriminalization of illicit drugs and preventing disease rather than the harms associated with homelessness, violence and vulnerability especially for women (Dykstra et al., 2007). Harm reduction shifts the line of personal responsibility for drug use to being responsible for safer drug use (Fischer, Turnbull, Poland, & Haydon, 2004; Miller, 2001). While harm reduction fosters social context that can enhance access to health care, it is not sufficient to address inequities in health that are deeply rooted in social conditions such as homelessness and poverty (Pauly, 2008). Harm reduction falls short of shifting the context from one of personal responsibility to social responsibility for reducing inequities. Thus, harm reduction is only a partial response to address inequities in health and access to health care for those who are street involved (Pauly).

While expanding harm reduction initiatives on the basis of reducing the consequences of drug use is well supported, an explicit ethical analysis of the values underpinning harm reduction is needed in order to ensure enactment of harm reduction in a manner consistent with ethical practice aimed at reducing inequities in health and access to health care. There is a need to link harm reduction with perspectives on social justice in order to redress injustices in social structures (Pauly, 2008). An ethical commitment to social justice by

nurses suggests that action which addresses the determinants of health inequities such as housing is needed. Nurses have the potential to play a key role in bringing issues related to consideration of a broader range of harms into harm reduction and drug policy debates.

In this study, nurses promoted autonomy of individuals within health care interactions and health care relationships by respecting choices and enhancing decision-making capacity. Nurses recognized that individuals may have had limited opportunities to develop decision-making capacity. The recognition of constraints on decision-making capacity is consistent with Sherwin's (1998) notions of relational autonomy. Autonomy was understood as a capacity to be developed and more consistent with notions of relational autonomy rather than autonomy informed by liberal individualism (Beauchamp & Childress, 2001; Sherwin, 1998). These findings suggest that opportunities to enhance decision-making capacity exist within health care interactions. When individuals made choices that were contrary to what providers perceived was in their best interest, nurses, working within a context of harm reduction, sought to minimize harm rather than abandon individuals on the basis that they were refusing care. These findings provide insights into the way that nurses working with individuals balanced one principle against another in everyday practice.

Some nurses in this study embraced actions to enhance autonomy and reduce harm for those who are street involved. Nurses were more likely to take such actions when they worked with a supportive interdisciplinary team and manager. Similar to other research, ethical practice was enhanced when nurses had strong leadership and were members of effective interdisciplinary teams (Rodney et al., 2002; Varoce et al., 2004). However, taking action was in the context of providing care to individuals. In this study, nurses did not take action to redress the broader social conditions that contribute to inequities in health and access to health care for those who are street involved. This raises questions for nurses about individual and collective roles in effecting justice in policy and practice to address inequities in health and access to health care and the role of policy in the enactment of social justice in nursing practice.

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