

# HIV PEP and Nursing Scholarship: A Review of Critical Theory and Social Justice

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## Abstract

Research studies are not often considered a form of social justice. However, I put forward an example about how I used a grant to provide nursing care to patients who could not otherwise afford the required medication. Specifically, this was the provision of HIV medications in the form of post-exposure prophylaxis (PEP). In doing this, I attempted to use my position as a nurse researcher to address a social justice issue (i.e., the inaccessibility of PEP for those with lower socioeconomic status) and to concurrently alleviate moral distress among the nurses who provide care to these patients. After presenting this project, I reflect on how this helps us reframe nursing scholarship and critical theory. In short, I argue that we need broader definitions of both, so as to better capture what nurses do and to use our positions for social betterment.

**Key Words:** HIV, nursing, social justice, PEP, critical theory

## Introduction

Few items have a greater impact on people's overall wellbeing than the determinants of health, which can be defined as the broad and encompassing "personal, social, economic, and environmental factors" that surround people and influence their health (Health Canada, 2018). These determinants are not decisions by or characteristics of specific individuals, but persons' socioeconomic status, education, physical environment, culture, and gender, to name a few (Health Canada, 2018). That is, determinants of health produce the context within which people live, with some persons being healthier than others. A plethora of research has demonstrated that, among the determinants, socioeconomic status is central; as income rises, many health issues decrease in a stepwise fashion (Health Canada, 2018).

HIV is no exception. Compared to HIV-negative persons, HIV-positive persons have lower socioeconomic status and less access to resources and social supports; their self-reported health status is often poorer in comparison as well (Shokoohi et al.,

2019; Wheeler et al., 2017). HIV is thus an affliction of social power and standing, primarily affecting those who are marginalized and disadvantaged (O'Byrne, Orser, Jacob, Bourgault, & Lee, 2019). Indeed, in Canada, HIV disproportionately affects minority groups, such as men who have sex with men, persons who are Indigenous or of African, Black, or Caribbean descent, and persons who inject drugs (Bourgeois et al., 2017). While HIV prevalence is estimated to be 0.2% among the entire Canadian population (Public Health Agency of Canada [PHAC], 2018), it exceeds 12% among men who have sex with men and persons who inject drugs in Ottawa (Ottawa Public Health [OPH], 2016; PHAC, 2011). Higher prevalence exists among men who have sex with men in Montreal, Toronto, and Vancouver (PHAC, 2011). National HIV prevalence data thus signal that Canada has a concentrated HIV epidemic (i.e., >5% prevalence among "higher risk subpopulations" and <1% among pregnant women) according to the World Health Organization (2013), with over 80% of HIV prevalence being among minority groups (Bourgeois et al., 2017) who account for less than 25% of the Canadian population.

While traditional HIV prevention efforts have targeted the foregoing groups and focused on (a) behaviour change (e.g., limiting one's number of sexual partners and increasing condom use) and (b) healthcare utilization (e.g., facilitating access to testing and treatment), recent efforts have begun to include pharmaceutical prevention for HIV-negative persons (O'Byrne & Jacob, 2019). The first Canadian guidelines were published on this topic in November 2017 (Tan et al., 2017), and the two listed approaches involved HIV-negative persons using HIV medications as prophylaxis either before (pre-exposure) or after (post-exposure) potential contact with HIV. Known as pre- and post-exposure prophylaxis – PrEP and PEP, respectively – these interventions can prevent HIV acquisition by over 90% when used with condoms and taken as prescribed with appropriate clinical monitoring (Tan et al., 2017). Despite these interventions being efficacious, the cost of PEP and PrEP can impede uptake. PrEP involves the daily use of Emtricitabine/Tenofovir DF 200/300mg (FTC/TDF) at a cost, in Canada, of \$7.3035 per tablet plus an approximate 8% pharmacy mark-up and dispensing fees, totalling nearly \$3000 per person per year (Ontario, 2018). PEP, by comparison, being a 28-day course of three medications (oftentimes FTC/TDF plus another medication), costs about \$1000 for a single use. While both PEP and PrEP are covered by most private and public drug plans, as they are approved by Health Canada for this purpose (Gilead Sciences, 2018), many persons are uninsured and can only obtain these medications if they pay out-of-pocket (Noor et al., 2018; Grace, Jollimore, MacPherson, Strang & Tan, 2018). Because those who are most affected by HIV are often socially disadvantaged, PEP and PrEP are a luxury of the rich, which can create an even more marginalized subgroup among affected minority groups. A study from Toronto demonstrated this point: participants at greatest risk for HIV were the least likely to be able to afford PrEP (Noor et al., 2018).

To address this situation, an approach I adopted was to use research grants to purchase and provide medications to uninsured persons. These studies involved securing external research funds to purchase FTC/TDF and to deliver it as PEP/PrEP in novel ways, for example by nurses in sexually transmitted infection (STI) clinics (O'Byrne, Holmes, & Roy, 2015; O'Byrne et al., 2019). In a purposeful effort to avoid exposing patients to experimental drugs (which is a longstanding ethical issue with drug studies involving minority groups), I evaluated PEP/PrEP delivery by nurses in STI clinics. As such, the risks and benefits of the medications were known; what was unknown was the uptake, delivery mechanisms, and outcomes

associated with nurse-led care. The benefit to uninsured patients who qualify for the studies was that they could obtain free medication.

In this paper, I overview how I used my position as a nurse researcher to secure funds to concurrently purchase medications for PEP so that persons at highest risk for HIV, but who were uninsured, could access this intervention, and to collect data about engaging in such care delivery to evaluate its outcomes and inform future HIV prevention efforts. My study, while generating new nursing knowledge, can be seen as a mechanism for social justice, that is, as a means to help those in need obtain access. Below, I discuss this project and reflect on how research projects could be a means for nursing professors to address inequity and social justice.

I structure this paper building upon the slogan of this journal (*Witness*, 2019), where I argue that it is not enough to witness, speak, or write about social injustice; one must also make change or risk being a hypocrite who accrues a researcher's salary while doing little to help the disadvantaged groups one purportedly strives to assist. This is not to say my approach is superior to others or that I am somehow on a pedestal; it is simply to raise questions about critique and inaction and offer one potentially less discussed approach: the use of research studies to affect change. I also use this reflection to posit that nursing is a practice discipline, and that our clinical training and work make us uniquely situated for innovative social justice strategies.

### **The Case: The PEP Project**

In Ottawa, the scenario of inaccessible PEP existed where patients were on the one hand, good candidates for PEP, while, on the other hand, unable to obtain PEP due to socioeconomic constraints. Nurses who worked in HIV case management in the local health unit and in the STI clinic also wanted to provide PEP to patients but could not because some patients could not afford the medications. The outcome was that only patients with private insurance obtained PEP, and could only do so via emergency rooms and infectious disease specialists. Unsatisfied with this situation and how it favoured those with (a) higher socio-economic status who could purchase medication and (b) the requisite abilities to attend and do follow-up with medical specialists (e.g., transportation, work, mental health, etc.), the HIV case management nurses came to me to discuss what could be done to improve access for marginalized individuals. I, in turn, used my position as a nursing professor to secure funds to study the

nurse-led provision of PEP.\* However, this process was not straightforward, and warrants further discussion as to how it unfolded. To do this, I make use of the journal's "see it, speak it, write it, change it" slogan.

### See It

The first step in the process that led to delivering nurse-led PEP was to identify an issue. Someone had to *see* the problem. This occurred when one public health nurse, who worked as an HIV case manager and a nurse in the local STI clinic, felt this was a service her patients could use; for example, when she would diagnose one patient with HIV, while his/her/their partner(s) would test HIV-negative, albeit with potential exposures within the timeframe when PEP was indicated. The issues at this point were that the only access point for PEP was the emergency department, and that PEP was only subsidized for three days, after which time patients had to pay through insurance or out-of-pocket for the remaining 25 days of medication. This left a subset of persons without access to an efficacious intervention that was clinically warranted.

To demonstrate the cost prohibitive nature of PEP further, the Canadian guidelines' recommended first-line drugs FTC/TDF and Raltegravir 400mg by mouth twice per day. The current cost of these medications without markup or dispensing fee for 25 days of PEP is \$884.10; with markup of approximately 8% and a \$10 dispensing fee, the cost of PEP is closer to \$1000. In 2013, when this issue was first discussed, generic formulations of FTC/TDF were not yet available, so the cost was closer to \$1500. This HIV case management nurse thus saw the issue: patients needed access to an intervention that is known to work, but which is impeded by clinical availability and cost. We suspected that many persons who accessed the STI clinic could not absorb such costs.

This situation created what can be described as a scenario of moral distress for this nurse, in that she identified patients who were good candidates for PEP but could not benefit from it due to resource constraints. She, and other nurses in the clinical setting, were distraught having to offer patients less efficacious interventions on the sole basis of socioeconomic status, not medical contraindications or patient preference. Many patients who wanted PEP did not obtain it simply due to cost (Goparaju et al., 2017).

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\* While not discussed in this paper, I undertook a similar process in 2018 to secure funds for, and open, the first nurse-led PrEP clinic in Canada.

This scenario was difficult for these nurses who could not help their at-risk yet disadvantaged patients (many of whom were younger, less employed, and non-white) obtain the same interventions available to those with more money and resources. This became an important social justice issue for nurses who undertake HIV prevention. Based on my reflection of the situation, the concept of moral distress applied well to what these nurses (including myself) experienced when we saw these patients clinically. For anything to change, however, one nurse had to *see* the issue.

### Speak It

The next step in creating a PEP program that addressed inequitable access was to raise the idea of this program to those with decision-making authority. We had to *speak* the issue. This first involved identifying who had decision-making authority, followed by the organization of meetings to discuss the issue. In this case, this included senior staff in the local public health unit, the clinic and medical directors at the STI clinic, chiefs of staff in the local emergency departments, and local infectious disease specialists who were involved in PEP delivery at the time. The goal was to amass support and buy-in from those with the authority to make decisions about whether a PEP program could operate. A key element to *speaking* was that fact sharing alone was insufficient. As with many decisions, while data about the need for an intervention or its efficacy are important, political factors must be also considered. Is the proposed idea a priority? How might its implementation be perceived? What would key partners think of action versus inaction? Who do the partners feel has responsibility for the issue?

A barrier we encountered at this stage can be described as the *purview paradox*, which is a situation when many parties agree that an intervention is warranted, but none believes it falls within their purview. All invited parties agreed that a PEP program was both important and needed; however, while the health unit, the STI clinic staff, the infectious disease physicians, and the emergency room staff supported the idea of giving PEP to those who need it, none assessed it to fall within their scope of practice or jurisdiction. The infectious disease specialists thought PEP should be initiated in frontline services; the emergency room staff thought PEP should be provided in STI clinics, as it "was not an emergency service"; the STI clinic thought PEP should be delivered in emergency rooms;

and the health unit thought PEP should be with primary care and emergency room services. There was agreement related to concerns about the cost of PEP medication and service delivery. This was particularly important for the STI clinic and public health nurses, who aim to provide services to those most in need.

Our main strategy at this point was to identify allies and to work with these decision-makers to sway opinion. For one, the hospital physicians (both emergency room and infectious diseases) agreed that PEP should be delivered in the community, specifically the STI clinic. The hospital administrators further agreed with this decentralization of services that were previously only available in already congested emergency rooms. Building on this common sentiment, our team capitalized on the motivation of the hospital physicians and had them agree to train and support staff in the STI clinic about how to delivery PEP, which included developing clinical pathways for PEP initiation and referral.

As a result of this assistance and subsequent agreements by the hospital physicians to offer direct on-call support when clinical questions arose during PEP delivery, the STI clinic staff began to see themselves delivering PEP, although they remained reluctant to do so. The STI clinic staff did eventually agree to provide PEP with two conditions: first, the project would be a pilot that would be re-examined after a 12-month period, and, second, external funding was required to ensure equitable access to those without medication insurance.

### **Write It**

The next step in implementing PEP was to obtain funding as was stipulated by the decision-makers. Being a practicing nurse in the Ottawa STI clinic and a university professor, my options were limited. I could neither apply for Ministry of Health and Long-Term Care funding nor obtain money from local health agencies (e.g., the Board of Health, the Local Health Integration Network). Funds from these agencies were earmarked for public health units and healthcare facilities. What I could access, however, was research funding, and, being a professor who undertakes HIV prevention research, I could submit a grant application within this vein of work. This became a submission to the Ontario HIV Treatment Network (OHTN).

Consequently, I proposed a project which took an established HIV prevention intervention, that is, PEP, and transformed it into research. Specifically, I sought to implement PEP while answering two questions: (1) what are the outcomes of nurse-led PEP delivery in an

STI clinic, and (2) what is the uptake and HIV prevention and diagnosis outcomes associated with providing PEP free-of-charge to persons without medication insurance? This grant application was not to test if PEP worked (as it was already established as standard of care), but to evaluate the outcomes of nurses delivering PEP in a community STI clinic. As part of studying *who* would use PEP in our clinic, we wanted to know if subsidized medication would increase access to groups who are known to be excluded from these interventions, such as persons of African, Black, or Caribbean ethnicity, Indigenous persons, and persons who inject drugs (O'Byrne et al., 2019). This grant thus represented the stage at which we first formally *wrote* about the issue. Subsequent writing included publishing our results and co-authoring the first Canadian PEP and PrEP guidelines, which emphasized nurses' involvement in PEP. This work also led to a unique risk assessment model that has been shown to overcome identified barriers related to ethnicity and gender within the current Canadian PEP and PrEP guidelines (O'Byrne et al., 2019).

### **Change It**

Through this grant submission, three years of funding was secured to provide PEP medication to uninsured persons and for a research assistant to track the project. This grant responded to stakeholders' concerns about medication availability for marginalized patients. As an update to the published data on this study, over the five years of data tracking, 307 persons sought PEP, of whom about 56% were initiated on PEP and 12.5% were uninsured and required study-funded medication. This last group was precisely the subset of patients we sought to help with the grant: those affected by HIV who not only belonged to a marginalized group (mostly men who have sex with men and persons who inject drugs), but also were disadvantaged socio-economically and unable to afford PEP. Another noteworthy outcome was that 9.8% of the patients who sought PEP through our program were diagnosed with HIV, accounting for nearly 7% of HIV diagnoses that occurred in Ottawa during the study period (O'Byrne, MacPherson & Orser, 2018; O'Byrne, MacPherson, Roy & Orser, 2017). This finding further supported the importance of providing equitable HIV prevention to this small group of individuals who needed PEP. Indeed, it provided access to a much-needed and highly efficacious intervention for persons who otherwise could not obtain it, and it linked persons at risk for HIV to care.

In addition to these findings, having a funded research assistant helped us to explore and determine if the pilot project was worth continuing. Because (a) uptake was

reasonable (at a rate of about 1 patient per week), (b) the nurses were competent and comfortable doing PEP assessments and initiations, and (c) there was a nearly 10% HIV seroconversion rate in this study, the STI clinic decided to maintain PEP as a standard clinical service and the local health unit opted to dedicate funds to purchase medication for uninsured high-risk persons who warrant PEP each year. The main *change* that occurred from this project was that patients who need PEP can now obtain it from the STI clinic, and those who have no insurance to pay \$1000 for medication can obtain this intervention without financial barriers.

### Reflections on the Project

Using one's position as an academic to address inequity typically involves the production and dissemination of research findings to dispel myths, challenge assumptions, or shed light on a form of social injustice. It may also involve speaking on topics as an expert advisor, witness or consultant, or include efforts to reshape policy through a variety of advocacy methods. In this case, I present another approach: obtaining research grants to fund inaccessible clinical services. This approach raises a few points for discussion.

#### *Nursing practice as social justice scholarship.*

From a social justice perspective, the most profound outcome of the PEP project was that it increased access to a much-needed HIV prevention service and did so by addressing the determinants of health. Two major barriers to PEP access were physical location, in that people did not want to or were unable to travel to the local emergency departments, and cost, in that the over \$1000 cost for PEP was exorbitant for many people without insurance. This project may have also helped alleviate what could be understood as moral distress among a group of nurses (including myself) who, through this project, became able to provide PEP to all appropriate patients, irrespective of their socioeconomic status. Using grants to study how nurses can provide these services and to provide access without cost impediments at the point-of-care is a less discussed way to ensure the equitable provision of such clinical services.

This raises an interesting point about the uniqueness of nurses as researchers. In contrast to many other health researchers, such as epidemiologists or sociologists, nurses are licensed healthcare providers with clinical training – some of which is advanced practice training. Nurse practitioners, for example, can order tests, prescribe medications, and form and communicate

diagnoses (Canadian Nurses Association [CNA], 2019). Combining this clinical competence – defined as knowledge, skill, and judgment (College of Nurses of Ontario, 2014) – with research training, nurses and nursing professors can undertake studies which offer established prevention strategies, rather than exclusively producing results about care. These clinical studies collect data not only about what people say, think, or believe, but also about what they do – which can vary from what they report. People may report that they will use an intervention or that they want access to it, but never actually use it. While such clinical studies are an established approach in medicine (take, for example, the focus on such studies in the *New England Journal of Medicine* and other similar medical journals), they are less common in nursing. We should remember that clinical intervention research studies can and do fall within our scope of practice (Flynn, Scott, Rotter, & Hartfield, 2017). My main point is not that nurses can engage in intervention studies, but that this form of research can be one strategy for nursing's work to address social justice issues for those in need.

The example in this article highlights an additionally important point about nursing practice and research. While distinctions are often drawn between research, theoretical reflection, and clinical practice, advanced practice nursing should be recognized as a means of scholarship that can be used to achieve social justice ends. Intervention studies, being novel and unique, change the nature and scope of healthcare and nursing practice broadly, and can do so for the direct benefit of patients and populations (Hartjes, 2018). These nursing interventions should not be conflated with expert practice by an individual nurse at the clinical level, i.e., Benner's (1996) "expert"; rather, they should be understood as practice-changing initiatives that broadly affect the health status and healthcare access of multiple patients in diverse settings. In this way, these interventions serve as potential means to revolutionize nursing practice, healthcare, and patient outcomes.

These sorts of clinical practice activities, however, are not typically considered to be sufficiently "scholarly". Oftentimes, nursing scholarship is restrictively considered to be academic only if it replicates university-based definitions most often stemming from non-professional and non-practice disciplines. I question why, in many university settings, we do not value clinical practice as scholarship? I am further perplexed by this devaluation of clinical practice when it is ultimately the foundation and reason for our existence; see the legal definition of nursing in Ontario (1991), which reads as follows: "The practice of

nursing is the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative, rehabilitative means in order to attain or maintain optimal function". By failing to articulate the importance of clinical practice as a component of nursing scholarship, we ignore a key element that makes us unique and which can make our research exceedingly powerful.

The American Association of Colleges of Nursing (1999) agrees with this point, asserting that we should "embrace the full scope of academic work, moving beyond an exclusive focus on traditional and narrowly defined research as the only legitimate avenue to further the knowledge of the discipline, and to obtain rewards for professorial performance". In this way, nurses should be recognized and rewarded for their clinical practice, such as the project described here and, for example, the advocacy work of Gagnon (2017; 2014) related to supervised injection sites and HIV criminalization. Additionally, Jacob's (2007) work on clinical decision-making regarding seclusion in forensic psychiatry follows a similar vein. Clinical practice is central to nursing but is not well recognized or supported as scholarship. Here, I have shown an example of how this can in fact occur, and how such scholarship can fulfill the social justice elements contained in the Code of Ethics for nurses (Canadian Nurses Association, 2017),

### ***Applied poststructuralist research.***

Another key point from this case example is that the approach of using one's academic position and privilege can align with a poststructuralist theoretical perspective, even if it does not appear to do so at first blush. If critical theory is "action oriented" with the goal of raising awareness about the "contradictions and disparities in their beliefs and social practice and become inspired to change them" (Polit & Beck, 2012, p.506), then it is important that critical theory researchers and those who engage in critique include intervention design and implementation studies within the accepted repertoire. While critical theorists often critique postpositivist researchers for having created a hierarchy of knowledge that excludes diverse ways of knowing (Cheek, 2005; Holmes et al., 2006), they should also accept multiple approaches as falling within this paradigmatic perspective and approaches to science. Otherwise, such researchers risk contradicting

themselves by simply producing a new allegedly correct way to do things, to the exclusion of other approaches that can achieve the same ends and outcomes; i.e., emancipation and empowerment of disadvantaged persons. One must not allow critique to become dogma.

Accepting diverse ways of achieving these lofty goals aligns well with a poststructuralist perspective, which is based on multiplicity and difference (Williams, 2005). In other words, while it is important to accept that the world can be explained in many ways, one must not let this focus on critique become an unquestionable doctrine, so that the acceptance of many or the act of critique is seen as superior to other approaches. To do so is to replace one ideology with another. One should acknowledge, as well, that, as part of multiplicity, there may only be a singular truth and a hierarchy of knowledge. Those of us who believe in multiplicity may be wrong, in the same way we speculate that those who hold onto only one truth may be. Humbly accepting this paradox is an important, but often overlooked, component of poststructuralism.

One must also ensure that critique does not lead to inaction. While there is a fine line between choosing to "help" others and colonialism, there is an equally fine line between critique and inaction – which is the true form of conservatism<sup>†</sup>. While the ethical issues of colonialism have been well-detailed (Ashcroft, Griffiths, & Tiffin, 2006), there has been little attention given to addressing the link between critique and inaction, although this is not a new concept. According to Hubard (1898), one strategy to avoid criticism is to "do nothing, say nothing, be nothing". That is, if one does not produce anything, one's work cannot be criticized. While there are shortcomings to Hubbard's (1898) logic, for one that a lack of contribution is routinely criticized in society, it still leads to an interesting point about how the position of critique can impede one's ability to help.

To elaborate, because the position of critique shows there are flaws in everything, it can become debilitating when people cannot then produce anything out of fear of critique. That is, if one criticizes the violence of nursing practice for normalizing behaviour (O'Byrne & Woodyatt, 2011), how can one create an intervention, which, by its very nature, promotes a socially condoned outcome because it promotes the goals of the overarching and disciplinary state system?

wherein the array of what is legal is broad (as it is not acceptable to interfere with other's business), and support to those in need is similarly absent (Kekes, 1997).

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<sup>†</sup> While conservatism is often narrowly thought of regarding social policies, such as women's and reproductive rights and access, it is actually a view of non-intervention by states and governments. It is thus a live and let live perspective,

For example, how can I implement a PEP program after critiquing STI/HIV prevention nurses as often enforcing specific sexual and health practices because they are those that most closely align with established white, heterosexual hegemonic social norms (O’Byrne et al., 2015)? I appear to contradict myself.

I address this tension in a simple way. Because the goal of poststructuralism and critical theory is to challenge the status quo, which often maintains specific groups as disadvantaged (Williams, 2005), then the means to achieve such ends should not be restricted to status quo approaches, provided these alternative strategies are ethical. I challenge the rigid definitions of critical theory, which can limit this perspective to qualitative methodologies and theoretical reflection (Lincoln & Guba, 2003). This position of critique can consequently lead to seeing, speaking, and writing, but never changing, as putting in such effort is to expose oneself to critique. It is to become that which one posits as problematic: the socially constructed subject who is without autonomy and can only indiscriminately do as s/he/they have been trained to do (Holmes & O’Byrne, 2010). If the position of critique – as is central to critical theory – leads to the perpetual identification of social issues, including how interventions, such as PEP, can capture persons within a state system that maximizes biopower, then the outcome of a critical theorist’s work can become perpetual critique *without* action. It is akin to complaining without providing solutions. This is a safe position, but one that likely does not yield much benefit for those in greatest need.

I think, however, that we need to reflect on this idea of critique, particularly as it relates to social justice, and accept that, while unrestrained critique is essential to ensure nursing practice is well thought-out, safe, and ethical (Adam, van Daalen-Smith, & Juergensen, 2019), critique should not come at the cost of allowing others – many of whom are disadvantaged – to suffer while researchers and professors debate the esoteric minutiae of nursing as, for example, a mechanism of social control and Foucauldian discipline (Jacob, 2012). While these discussions are important, we should not let them immobilize action by other nurses and nurse researchers. To do so violates the social change principles that are central to poststructuralism and critical theory. It also likely violates the code of ethics that guides all nursing practice, whether clinical or research (CNA, 2017).

Again, this is not to say that action is superior. As a central tenant of poststructuralism is multiplicity, my point is that we should accept that there are many ways to engage in critical theory and poststructuralist work.

To narrowly define this work as one of critique, to the exclusion of seeing how action and implementation can coexist within this paradigm, is to reduce poststructuralism to postpositivism. In other words, defining the so-called correct way to engage in critical theory and argue that implementation work is less critical than theoretical or qualitative work is to violate the principle of multiplicity, and, instead, exclusively serves to institute a new single-view perspective about this paradigm. My ultimate point, therefore, is that, if a main goal of critical theory is to work toward social justice for marginalized groups, then researchers’ work should not only be judged as critical based on methods or theory, but also based on the outcomes and outputs of their work. That is, did researchers achieve any meaningful change or improvement in the determinants of health for a marginalized and/or disadvantaged group? I thus approach the definition of critical theory based on both ends and means. This is to partially redefine poststructuralism and include within it a branch of applied work: that which uses the research process to directly reduce pain, suffering, and social inequities.

### Closing Remarks

In this paper, I presented my PEP project, specifically focusing on how the utilization of a grant to establish a pilot study and provide access to much-needed services that were unjustly inaccessible to many due to their resource constraints. In this way, I combined my expertise as a nurse and researcher to address a situation of social injustice that was creating moral distress for frontline practicing nurses. This raises the point that nursing professors are uniquely situated to engage in such research, but that we often measure ourselves against the established academic metrics of publications, grants, and presentations. I argue that, while this is important, not all nursing researchers should be evaluated on these standards, as they ignore the basis of our profession: clinical practice and patient care. As a second point, this reflection highlights that while inaccessible writings about the creation of subjectivity are important aspects of critical theory and poststructuralist work, they should not be valorized as superior to work that helps persons access services that they want and need to stay alive and suffer less. Critique is important, but it should not lead to inaction. There are many ways to engage in poststructuralist work, and such multiplicity should be considered the power of this paradigm. Through this diversity, nursing research can grow and expand, and one key aspect I think is important is to not just witness, speak, or write, but to act as well for the benefits of those in need. At the end of the day, this seems to be basic nursing care and nursing principles: work to improve

the health and lives of our patients through clinical care and research, and do so using the skills, knowledge, and resources we possess, whatever they may be. If nothing else, I hope this reflection continues

the important debate and dialogue about critique and social justice and encourages researchers to continue their work addressing the determinants of health for disadvantaged persons.



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