NURSES' PERCEPTIONS OF THEIR EMPOWERMENT TO BE PATIENT ADVOCATES

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NURSES' PERCEPTIONS OF THEIR EMPOWERMENT TO BE PATIENT ADVOCATES

by

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DEDICATION

This thesis is lovingly dedicated to my late husband of thirty-seven years, Robert Mathew Ruelokke (1927 - 1997), and to my dear and late parents Lydia (Squires) (1904 -1995), and William Earle Squires (1899 - 1983). Their never-ending faith, love, advice, encouragement, and example have been the major sources of everything good that I have to offer in my life.

This thesis is also dedicated to three of my special friends - Josephine (Mackenzie) Rossiter (1935-1998), Laura (Dowden) Cook (1925-1998), and Edith L. (Dale) Buffett, RN (1937 - 1998) - and to my nephew and godson, Michael Squires who will graduate from Memorial University of Newfoundland this year with my hope that he will be a lifelong learner.

ABSTRACT

A descriptive correlational survey was designed to investigate perceptions of autonomy and attitudes toward patient advocacy in a random sample (N = 183) of practising registered nurses in Newfoundland and Labrador. The effect of work-related variables and barriers/facilitators in the practice environment on nursing autonomy and enactment of the patient advocacy role was also explored. The conceptual framework for the study was based on Lydia Hall's model of nursing practice.

Most respondents had a RN diploma education (68%), worked in acute care settings (63.2%), were female (95.1%), and had ten or more years of nursing experience (60.5%). Data were collected over a two month period. Instruments used during data collection included the revised 47-item Pankratz and Pankratz (1974) Nursing Autonomy/Patients' Rights Questionnaire, and the modified Romaniuk (1988) Questionnaire on Patient Advocacy as a Nursing Role. The survey response rate was 23.8%.

Study findings indicated that most nurses had positive attitudes toward nursing autonomy and patient advocacy as a nursing role, and believed they were performing the patient advocacy role, were committed to it, and had peer support. Work-related variables had a minimal effect on nurse perceptions of autonomy and patient advocacy. Community health nurses and those with greater educational preparation had more positive views toward autonomous

practice and the patient advocacy role than other nurses. With regard to barriers/facilitators in the practice environment, emphasis was placed on the importance of administrative support, adequacy of knowledge and understanding of the advocacy role, and conducive work relations with peers and physicians.

The results of this study suggest that nurses are engaging in autonomous practice and acting as patient advocates. The factors found to affect autonomy and successful enactment of the advocacy role support some of the findings from previous research. There is certainly a need to conduct further research to examine the effects of the practice environment and adequacy of preparation on autonomy and patient advocacy.

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The Board of the Newfoundland and Labrador Nurses' Union readily gave approval for the use of their membership register to obtain the sample for this research. Many nurses throughout the province responded to my request for their opinions. I thank them for their input, and I hope that the results of the study will be of help to them as they endeavour to be patient advocates.

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Table of Contents

List of Tables

CHAPTER 1

INTRODUCTION

Advocacy is a central role of the professional nurse. The nursing literature usually identifies nurses as the *most* appropriate professional for implementing this important role (Curtin, 1983; Gadow, 1980; Snowball, 1996). There are a wide range of actions taken on behalf of patients that define the advocacy role. Some of the actions are proactive, such as assisting patients to understand illness meanings in order to help enhance their self-determination (Gadow, 1983), ensuring they are informed of matters concerning their care or treatment, or initiating steps to obtain sufficient staffing to give nursing care (Curtin, 1980; Zusman, 1982). In contrast, other actions are more reactive in nature, such as attempting to rectify discrepancies in patients' care because of colleagues' incompetencies (Winslow, 1984), or interceding when someone is critically ill (Benner, 1984). Still other actions are more narrowly focussed, for example, advocating on behalf of a particular patient and family (Starzomski & Rodney, 1997), while others are broader and at the societal level, such as, advocating for a particular health policy (Cowart & Reading, 1981). Whatever the nature of the advocacy role, nurses are expected to both protect and promote the welfare and rights of the patients under their care.

Documents from professional nurses' associations (Association of Registered Nurses of Newfoundland, 1984; 1991; 1995a; 1995b), nursing codes

of ethics (Canadian Nurses Association, 1991; 1997), and fundamental nursing textbooks (Craven & Hirnle, 1996; Dugas & Knor, 1995) all identify advocacy as one of the main roles of the nurse in practice. Advocacy is usually included with other roles such as direct care provider, teacher, and counsellor. As a central role for nurses, advocacy is not new. It has been promoted as an important nursing role since the 1970s in both the United States (Davis, Aroskar, Liaschenko, & Drought, 1997) and Canada (Lamb, 1980). What has perhaps changed is the form it takes; beginning with the nurse interceding on behalf of the patient, expanding to the nurse promoting the patient's autonomy (Nelson, 1988), and more recently extending to a social advocacy or promoting the needs of society as a whole (Fowler, 1990). Despite advocacy's prominence in the nursing literature it may not be as well understood or practised as the other central roles. The present study examines nurses' attitudes and opinions toward patient advocacy as a nursing role at a time when health care reform has assumed center stage, and when the need is great for nurses to understand and undertake this important role.

Problem Statement

Although advocacy is identified as one of the main roles of the practising nurse, there are a number of factors that may act as constraints or barriers to implementing this role (Davis et al., 1997; Feliu, 1983; Kohnke, 1980; Miller,

Manson, & Lee, 1983; Storch, 1982; Trandel-Korenchuk & Trande-Korenchuk, 1983). Paradoxically, an important constraint may be the patient's right to self-determination and autonomy. Research has shown that patients want to have control over people and events that impact their lives (Dennis, 1987) and thus may not perceive the need for an advocate. Indeed, many are capable of obtaining information, making independent choices about their health care, insuring their rights are not violated, or having family and friends intercede for them (Bernal, 1992; Copp, 1986; 1993). Other patients, however, for many reasons (e.g., illness severity, level of assertiveness or education, the institutional environment, etc.) either relinquish their self-determination or are not given the opportunity to participate in their own health care (Curtin, 1979; Dennis, 1987; Hall, 1969; Winslow, 1984).

A second barrier is the position of the nurse in the health care system and whether he or she feels capable of acting as an advocate for the patient in the true sense of the role (Storch, 1982). The heritage of health care and the traditional role of the nurse in large bureaucratic institutions may mitigate against the nurse performing the advocacy role (Blake & Guare, 1997; Woodrow, 1997). There are persistent debates about which health care professional is best suited to be a patient advocate or whether all could qualify equally well. Gadow (1980) and Curtin (1979) maintain that patient advocacy is the philosophical foundation of nursing. These authors clearly indicate that advocacy is a central role of the

professional nurse, while some suggest that other health care professionals are equally well qualified to be patient advocates (Bernal, 1992; Shannon, 1997). Some argue that nurses as institutional employees can not be patient advocates because this would place them in a conflict of interest situation (Anderson, 1990; Annas, 1974; Castledine, 1981; Sawyer, 1988; Sklar, 1979; Woodrow, 1997). Others feel it is fear of reprisal on the part of a nurse that may present the greatest barrier against speaking out on behalf of the patient in a health care facility where the nurse may not have a great deal of formal power (Davis et al., 1997). However, the lack of formal power, or authority, has also been seen as a strength for nurses to act as advocates. It is precisely this lack of power that may enable the nurse to more readily get to know the patients well and thus be in a better position to truly advocate for them (Quinn & Smith, 1987).

Advocacy is a broad concept and it is argued that it not only concerns patients' rights but nurses' rights as well (Annas & Healey, 1974; Cote, 1981; Fagin, 1975; Kelly, 1976; Pankratz & Pankratz, 1974; Prins, 1992). Fagin suggests that nurses' rights are a pre-requisite for feeling empowered to act as patient advocates. In other words, unless nurses have control over their practice and input into policies that affect them in the practice setting it is difficult to be an effective advocate. Nursing leadership plays an important role in creating supportive environments that foster autonomous decision-making and feelings of empowerment (McClosky & McCain, 1987; Prins, 1992; Trofino, 1989); all

prerequisites for successful implementation of the advocate role.

There must be clear definition of what this role entails if professional nursing associations are going to require nurses to be patient advocates (Miller et al., 1983). There may be a discrepancy between the profession's idea of advocacy and what nurses are actually able to do, or feel they can do (Romaniuk, 1988). Codes of professional ethics may not give the expected guidance or support to nurses' advocacy actions (Blum, 1984; Johnstone, 1989; Tingle, 1993).

Advocacy is a complicated process (Kohnke, 1982). Nurses require extensive knowledge of the process and the elements of each individual case, and awareness of their responsibility to all concerned when making a decision to become an advocate (Sawyer, 1988). With the ambiguities surrounding the role, nurses may not always be successful in solving the dilemmas that they face. Even very knowledgeable, capable advocates can get into situations where there is conflict because of differing perceptions or uncertainty about the conditions surrounding advocacy (Romaniuk, 1988; Stuart, 1986; Zusman, 1982). This uncertainty may be partly responsible for the limited progress in nurses' perception of themselves as autonomous professionals (Collins & Henderson, 1991).

Limited research findings document how nurses view the advocacy role and what they consider to be significant factors influencing successful role

implementation under variant clinical situations. There is an obvious need for more research on nurses' attitudes toward patient advocacy and autonomous practice, for attitudes could very well be the most important barriers to or facilitators of the advocacy role.

Purpose and Research Questions

The purpose of this study was to explore nurses' perceptions of the degree to which they feel empowered to be patient advocates in the Newfoundland and Labrador health care system. It explores nurses' attitudes toward advocacy and autonomy, and whether or not they feel adequately prepared to assume the patient advocacy role. It is anticipated that study findings will not only help nurses implement appropriate care in a time of increasing consumer interest and economic restraint, but also help those who are working on behalf of nurses to formulate clear policies. For example, the findings may be of assistance to nurse educators planning educational programs, nursing administrators setting nursing care standards, and professional bodies dealing with the practical issues constraining nurse advocacy. Finally, it is hoped this study will stimulate further research on the topic, especially regarding factors which enhance the feeling of autonomy and empowerment in the nurses who give direct care.

The research questions that are specifically addressed in this study are:

1. How do nurses in Newfoundland and Labrador perceive the patient advocacy role and nursing autonomy?
2. What do nurses feel best prepares them to be patient advocates?
3. Are nurses' attitudes toward autonomy and patient advocacy a function of key work-related variables (i.e., employing agency, years of nursing experience, educational preparation, and agency policies on patient/nurse advocacy roles)?
4. What factors in the practice environment impede or facilitate nursing autonomy and enactment of the patient advocacy role?

Rationale and Significance of the Study

Recent discussions on nurses' involvement in health and health care suggest that nurses ought to take on expanded roles and advocate more broadly than on an individual basis for patients (Starzomski & Rodney, 1997). In community health situations, nurses are urged to speak out on behalf of the population under their care to try and influence social policy and the type of health care that will be available to communities (Stanhope & Lancaster, 1996). However, it is not clear how nurses see their role as patient advocates, how well nurses feel prepared to advocate on behalf of individual clients much less groups, or whether or not they feel they have the autonomy to act as advocates.

Empowerment of nurses in these situations has not been explored. These are important questions that need to be addressed. While there is a fairly large amount of literature on the advocacy role in nursing since it was introduced in the 1970s, there is limited research on how nurses view this role and implement it in practice (Chafey, Rhea, Shannon, & Spencer, 1998; Mallik, 1997).

The term nurse advocate has been and continues to be widely used in the nursing literature, particularly in discussions on the roles of the nurse and ethical decision-making (Davis et al., 1997). Other discussions have centred around the appropriateness of the nurse advocate role (Curtin, 1983), the educational preparation of the nurse advocate (Gibson, 1991; Zwolski, 1989), how to advocate (Prins, 1992), difficulties associated with the advocacy role (Blum, 1984; Johnstone, 1989), and nurses' views of patients' rights (Astrom et al., 1993; Fromer, 1981). The major problem identified following an extensive review of the literature was the lack of consensus about what it means to be a patient advocate and how well nurses fulfill the role.

Patient advocacy has created particular challenges for the Association of Registered Nurses of Newfoundland (The Daily News, 1977; Joyce, 1977; White & Board of Trustees Sir Thomas Roddick Hospital, 1991). Definitions of the section of the Registered Nurses Act which pertain to the discipline of members give specific guidance for complaints regarding patient advocacy (Association of Registered Nurses of Newfoundland [ARNN], 1993). At the 1985 annual

meeting of the Association a resolution was passed to support members financially when they were dismissed from their positions because they followed the Association of Registered Nurses of Newfoundland guidelines on patient advocacy (ARNN, 1986). The Association revised guidelines for members to follow when they have concerns about patient care in institutions where they are employed (ARNN, 1995c). Despite these initiatives, no research has been done on nurse advocacy in the province, and therefore, there is no baseline data.

Nurse educators in the province have long considered patient advocacy an important component of the nursing curriculum. It continues to be one of the roles measured in clinical evaluation, as well as an expected role for the beginning nurse (ARNN, 1991; Memorial University of Newfoundland Calendar, 1998-1999). Given the importance attached to patient advocacy by the profession it would seem logical to consider that nurses feel able to take on this role. But is this really the situation? Do nurses feel able to take on this role? How do they view their autonomy? This study is an attempt to answer some of the questions raised about the advocacy role for nurses in a particular nursing jurisdiction - Newfoundland and Labrador; a jurisdiction that has long maintained that advocacy is a key nursing role.

Theoretical Framework

The theoretical framework guiding the study comes from the work of Lydia Hall at the Loeb Center in New York (Hall, 1963; 1964; 1969). The environment of the Loeb Center was one in which professional nurses were empowered, autonomous, and answerable for their practice. Although Hall did not use the term advocate or advocacy, she clearly saw the nurse in that role. This particular theoretical orientation is selected because Hall's work was demonstrated in a practice situation and clearly advocacy is, above all, about practice. It is about a particular type of practice; one that gives autonomy to the nurse and patient. Nursing as practised according to Hall's theory was, " to help the patient determine and clarify goals and, with the patient, work out ways to achieve the goals at the individual's pace, consistent with the medical treatment plan and congruent with the patient's sense of self" (George, 1995, p. 88). These activities are all congruent with models of nurse advocacy (Curtin, 1979; Gadow 1980; Kohnke, 1982; Lumpp, 1979). The components of Hall's model match a combination of definitions of advocacy.

Hall's model consists of three aspects of nursing (i.e., care, core, and cure) represented by three interlocking circles (George, 1995). Care consists of those nurturing functions which provide opportunities for comforting patients and developing a closeness that allows the nurse to get to know patients and explore their feelings. Knowledge of the patient is a necessary precondition for

advocacy. Equally important, is the presence of a strong theoretical base that enables the nurse to meet the caring functions required by patients. The care function is exclusively the domain of the nurse.

The core part of the model is the medium by which the patient is able to understand the effects of the disease process. It functions to promote the self-identity and maturity of the patient. In essence the core functions through interpersonal relationships to assist the patient to make conscious decisions about health. Hall believed that patients strive for their own goals, not the goals others set for them; important beliefs for patient autonomy. The challenge for the nurse is, through the process of reflection, to help the patient become aware of his or her own feelings. Although an important function of the nurse, this core may be shared with other health professionals.

The cure part of the model is also shared with other health professionals. It functions to help the patient through their treatment process and as George (1995) states, "During this aspect of nursing care, the nurse is an active advocate of the patient" (p. 90). However, without the other components the nurse would not be in a position to take on this advocacy. Hall believed that the three components were interrelated and this was her reason for depicting the model as three concentric circles.

The philosophy underlying this model, particularly in relation to the role of the patient and the nurse, make it a strong nursing care delivery model within

which to view advocacy. Hall (1969) believed that patients' goals could be in conflict with the goals of bureaucratic hospital services which are usually set up to efficiently accomplish tasks. It is the role of the professional nurse to ensure that the patient is able to achieve his or her goals through receiving the required teaching and having individual needs met. Hall was not in favour of a team approach to nursing and felt only the professional nurse could deliver the type of patient care she envisioned. The professional nurse accepted the accountability and opportunity to give and coordinate total patient care and form a relationship with the patient that was germane to his or her recovery. Through critique, Hall's theory has been found to address the issues of advocacy: accountability, responsibility, and professionalism (Fakouri, Grandstaff, Gumm, Marriner-Tomey, & Tippy-Peskoe, 1998).

Definitions

Three definitions are important to the present study. These are advocacy, autonomy, and professional nurse practice. The definitions and operationalization of these concepts are outlined as follows:

Advocacy. A definition of advocacy is: A process through which the professional nurse and the patient work towards achieving the patient's self-determination. Advocacy was measured by the Romaniuk (1988) Questionnaire on Patient Advocacy as a Nursing Role (QPANR).

Autonomy. A definition of autonomy is: "A personal liberty of action, or that state in which an individual charts, and is capable of following the course of his/her own actions with self-determined plans" (Fromer, 1981, p. 285). Autonomy was measured by the "nurse autonomy" and "patient rights" subscales of the Pankratz and Pankratz (1974) Nursing Autonomy/Patients' Rights (NAPR) questionnaire.

Professional nurse practice. A definition of professional nurse practice is: "The practice of nursing is a synthesis of attitudes, competencies, and knowledge applied to all aspects of caring for the client's health (promotion, protection, maintenance, restoration and palliation). It is a goal-directed, continuing and comprehensive service. This service is carried out through collaboration with the client, who is an active participant, and with other health care professionals" (ARNN, 1998, p.1). The collaborative component of professional nurse practice was measured with the "nurses' rejection of traditional role limitations" subscale of the NAPR.

CHAPTER 2

REVIEW OF THE LITERATURE

The literature review is divided into three sections. The first section presents an overview of models of advocacy for nurses. The second section reviews some of the barriers confronting nurses in the advocacy role and the negative consequences that nurses experience when taking on this role. The final section summarizes relevant research on nurse advocacy and autonomy.

Models of Advocacy for Nurses

Advocacy has been variously defined as: activities protecting the rights of others and supporting client's rights to self-determination (Kohnke, 1980); assuring receipt of the appropriate social and medical benefits with the least cost (Zusman, 1982); assisting individuals to authentically exercise their responsibilities to themselves and others (Taylor, 1985); or any nurse-patient relationship which promotes the informed patients' health care goals (Copp, 1993). Some authors have developed a nurse advocacy model (Curtin, 1979; Gadow, 1980; Kohnke, 1982; Lumpp, 1979). Benner (1984) identified advocacy as one of the six different "qualities of power" in her model of excellence and power in caring. These models are influenced by whether advocacy is perceived as a focus of care within the nursing role or a relatively unique action of nurses. The following is an overview of each of these models.

Curtin's Model of Human Advocacy

According to Curtin (1979) the welfare of other human beings is the goal of nursing and gives the profession a moral rather than a scientific purpose. Rather than being defined by its functions, nursing should be guided by its philosophy of care. Curtin suggests that both the "philosophical foundation and ideal of nursing is the nurse as *advocate*" (Author's italics) (p. 2). The role of advocacy incorporates all other roles that have been previously ascribed to nurses, such as, caretaker, health educator, champion of the sick, healer, and parent-surrogate. This proposed ideal is based on attributes common to both nurses and patients: humanity, needs, and rights. Curtin makes it clear that she is not suggesting a legal or health advocacy but rather a human advocacy in which the nurse views the patient in his or her unity as a human being. Awareness of self unity and uniqueness of personhood are requirements for the human advocate role. They enable the nurse to understand and appreciate the effects of illness and hospitalization on the patient, and how the patient's unique self-unity can be fragmented by these experiences. In responding to the patient as a unity the nurse is able to meet the patient's unique needs.

Illness and disease, situations in which the nurse comes to know the patient, infringe upon the patient in four important ways. First of all, patients' autonomy may be threatened when they are forced to seek help from health professionals and thus relinquish some of their independence. Second,

restrictions may be placed on patients' freedom of action by the limitations imposed on the body by illness and disease. The more serious the illness, the greater the limitations. Third, illness and disease place the patient in a vulnerable situation by making him or her, to some extent, dependent on health professionals at least for information. However, patients still retain the right to make choices. Fourth, by virtue of becoming patients, individuals find themselves under the power of health professionals for treatment and care. In human advocacy, the nurse who comes to know the patient as a unity can transcend any of these limitations and work with the patient to preserve his or her humanity. This transcendence is the advocacy role in action.

Gadow's Model of Existential Advocacy

Similar to Curtin (1979), Gadow (1980) based her model on a philosophical definition of nursing, one defined "by the ideal nature and purpose of the nurse-patient relationship rather than by a set of specific behaviours" (p. 80). With advocacy viewed as the ideal of nursing, Gadow believes that nursing should be defined in terms of its philosophy of care rather than discrete functions. It is clear that the type of advocacy being proposed is not the same as a patients' rights approach. Nor is there any room for paternalism in her model. Gadow's position on advocacy is consistent with an existentialist approach based on the patient's own decisions about the meaning of an experience. Essentially,

it is aimed at resolving two conflicts that have been problematic within nursing. The first, a nurse conflict, is the dichotomy between the personal and the professional involvement in patient care. The second, a patient conflict, is the discrepancy between what the person experiences versus what is observed, or the "lived" versus "objective" body of the patient.

Advocacy helps to transcend these dual conflict situations by letting the nurse see both his or her own humanness and that of the patient. Advocacy as suggested by Gadow (1980) is based on the principle that the patient is an authentic being with the right to self-determination. In this model the nurse assists individuals to, "*authentically* exercise their freedom of self-determination" (p. 85). (Author's emphasis). Patients are assisted to clarify what they want to do, not what they should want to do, in a given situation. The type of assistance required is best given by the professional nurse who has the most comprehensive view of the experience because of an in-depth relationship developed with the patient. This overall action on the part of the nurse, coined "advocacy" nursing by Gadow, is to help patients reach what they value. Believing that her model only covered patients who could readily communicate with others, Gadow (1989) extended her discussion of existential advocacy to include "silent" patients, that is, those who are elderly and confused or have illnesses that interfere with verbal communication. The nurse ought to, in as far as she is able, learn to help silent patients with self-determination.

Lumpp's Ethical Relationality-Responsibility Model

Although not as well known as the previous models, and rarely discussed in the literature, Lumpp (1979) proposed an applied model for the nurse in bioethical decision-making that could be useful for dealing with advocacy issues. As defined by the model the nurse-client relationship is one in which the nurse acts as an advocate for the patient, that is, "one who speaks on behalf of another; one who has the other's interest and needs foremost in mind" (p. 17). Lumpp presents two components of the advocate relationship: reverence and fidelity. Reverence refers to the attitude of the nurse towards the patient, in particular, towards the dignity of the patient. A nurse does not have reverence for the patient's dignity if his or her freedom is not considered. In any care decisions the patient must have the freedom to choose. The second component, fidelity, implies an agreement with the patient. In order to advocate for the patient the nurse is required to clarify this agreement; an agreement based on trust and truthfulness.

Kohnke's Pragmatic Model of the Process of Nurse Advocacy

A somewhat different model of nurse advocacy, although based on similar beliefs about the rights of individuals, was developed by Kohnke (1980; 1982). Kohnke offers a pragmatic view of advocacy which is defined as, "an act of informing and supporting a person so that he [sic] can make the best possible

decisions for himself [sic]" (1980, p. 2038). As opposed to a philosophical basis for nursing, advocacy is viewed as a process whereby the nurse acts as an advocate by informing, supporting, and affirming the patient in his or her choice. The informing process consists of three sub-processes - assessing the patient's needs, developing a common understanding of meaning, and establishing accuracy. The supporting process also consists of sub-processes - upholding the patient's rights regarding his or her decision, and assuring patients of these rights. At times when supporting patients, the nurse needs to help them maintain a decision in the face of opposition. The final process affirming involves working with the patient to ensure that the decision made is consistent with his or her values.

Benner's Advocacy Power in Nursing Practice

In a study on excellence and power in clinical nursing practice, Benner (1984) identified "six different qualities of power associated with the caring provided" (p. 209). One of these qualities of power, "advocacy power", occurs when patients need nurses to defend them in select situations. Sometimes patients are inhibited by fear or some other emotion and are unable to understand what is happening in clinical situations. Other times patients do not understand what is being communicated to them because of their lack of familiarity with medical terminology. It is in these instances that the more expert

nurse is able to grasp what is occurring and use her power to interpret for the patient to the doctor, as well as to interpret in the reverse direction. Benner proposes that this type of power helps nurses remove barriers or facilitate understanding in an enabling way.

Summary

The models of advocacy for nurses that are presented in the literature are "normative" models (i.e., what the nurse ought to do to fulfil the advocacy role, or descriptive of the process the nurse would follow in the role). While these models provide a moral framework for the nurse to understand the advocacy role, the components of the concept do not have sufficient conceptual clarity to identify appropriate empirical indicators for model testing. Thus, it is extremely difficult to use these models as frameworks for research inquiries.

Barriers to and Consequences of the Advocacy Role

There was limited discussion of the barriers affecting nurse enactment of the advocacy role in the literature reviewed. A few authors examined possible barriers that nurses have to overcome before they can effectively act as patient advocates (Davis et al., 1997; Kohnke, 1980; Reverby, 1990; Storch, 1982; Trandel-Korenchuk & Trandel-Korenchuk, 1983; Winslow, 1984). Other authors have examined the consequences for nurses who have acted as patient

advocates and were not supported by their peers or employing institutions (Cowart & Reading, 1981; Flaherty, 1981; Smith, 1980; Rowden, 1992). This section reviews some of the theoretical literature on barriers to and consequences of the advocacy role.

Barriers to Advocacy

Kohnke (1980) felt that institutions and their organizational structures impose constraints on advocacy, especially when recommended nurse advocate processes are in direct opposition to institutional values. In order to function effectively, health care institutions with bureaucratic organizations require that workers follow a rational plan. Patient advocacy situations usually occur when institutional plans are not appropriate for a particular patient. Thus, when nurses take on the advocacy role in such situations, they may find it somewhat daunting to take on an institution in order to promote patients' rights.

In a descriptive study on patients' rights, Storch (1982) identified a number of social-behavioural (i.e., poor nurse-physician relationships and a female dominated profession) and structural (i.e., division of labour, organization of nursing services, and size of health-care organizations) factors that pose barriers for nurses acting as patient advocates. Storch noted that the imbalance of power in the health care system, with physicians maintaining control, present difficulties to nurses advocating for patient rights. Another significant barrier

singled out by Storch, and supported by Kohkne (1980), was that large organizations "are designed to provide service according to universal rather than particular criteria" (p. 163). Thus, patients who require an advocate need help against these universal criteria which do not permit individualized care.

Trandel-Korenchuk and Trandel-Korenchuk (1983) analysed the advocacy role and some of the difficulties encountered by nurses. The authors were especially critical of the gender influence on role socialization in nursing. While medicine is male-dominated and its members are better educated, nursing is female-dominated and its members are less well-educated. Trandel-Korenchuk and Trandel-Korenchuk argued that this factor creates inequalities in how physicians and nurses carry out their respective roles. In institutional settings, the nurse-patient relationship is often characterized as one of physician power over the nurse in many decisions involving patient care. Nurses often find themselves caught between physicians and patients. In addition physicians function as a more cohesive group than nurses, leading the latter to be more vulnerable in specific advocacy situations.

Winslow (1984) also identified the nurse-physician relationship as a barrier to nurses acting as advocates. Nurses frequently experience "divided loyalties" between patients, who are generally in an institution and under their care for short periods of time, and physicians and other colleagues with whom nurses have a longer standing relationship. When nurses choose an advocacy

role their actions might jeopardize physician-nurse working relations, especially if these actions oppose physician decisions about patient care.

Reverby (1990), like Storch (1982) and Trandel-Korenchuk and Trandel-Korenchuk (1983), argued that the gendered nature of nursing has presented powerful barriers to nurses acting as patient advocates. Storch and Trandel-Korenchuk and Trandel-Korenchuk perceived it as a question of power, fuelled by the predominance of women in nursing and the profession's mirroring women's position in society as less powerful than that of men. In contrast, Reverby's feminist critique is of a more fundamental nature and related to the caring aspect of nursing. She claims that the conflict between the "duty" versus the "right" to care has created much of the difficulty. Historically, nursing was organized with an expectation that nurses would have the duty to care, however, they were not given the right to determine how to carry out this duty. In other words, they were expected to be altruistic without being autonomous, and indeed were not given any autonomy within organized nursing. This longstanding situation has created a secondary dilemma for nurses because they have been "forced to act as if altruism (assumed to be the basis of caring) and autonomy (assumed to be the basis for rights) are separate ways of being" (p. 133). Reverby claims that nursing has not changed in many ways from its historical roots. Nurses still have not been totally successful in redefining the rights involved in the caring aspect of their work. Reverby argues that until nurses

redefine caring and integrate it with autonomy, they will continue to struggle with the dichotomy between being able to care and being autonomous. It is this dichotomy that will affect their position as advocates.

Davis et al. (1997) present four issues that constitute barriers to advocacy. The first issue is whether or not nurses are assertive enough to take on the advocacy role. The second relates to the organization of the nursing profession and whether there is support for patient rights. The third involves the educational preparation of nurses and whether they actually learn how to be patient advocates. The fourth stems from the power structure of health care facilities which pose important barriers to nurses taking on advocacy roles. For example, fear of reprisal is a real threat for nurses who take on this role.

Negative Consequences of the Advocacy Role

The decision to be a patient advocate, apart from facing the ambiguities of what it means, exposes the nurse to potential professional and employment difficulties (Winslow, 1984; Davis et al., 1997). The risks could be extremely grave for nurses who choose to act on behalf of patients whose rights are in conflict with the interest of the institution. There are a number of actual situations documented in the literature which capture the difficulties experienced by nurses when they take on the advocate role. An example of the difficulties posed when the nursing community fails to support its members is provided by

Smith (1980). In her position as a director of nursing in a community health center, Smith discovered information which indicated that the care of mothers and newborns in the local hospital was far below the national standard. She was not supported in her advocacy efforts by her nursing and other colleagues when she tried to rectify the situation, and eventually felt she had to resign from her position.

Another situation is presented by Flaherty (1981) who described an instance where a nurse refused to give preoperative preparation to a patient who she felt had not been fully informed of the scheduled surgery by the surgeon. As a consequence the nurse was reprimanded by her supervisor, received no peer support for advocating on behalf of the patient, and was subsequently overlooked for promotions.

Cowart and Reading (1981) cite an example of a nurse who was sued by a physician for disrupting the traditional physician-patient relationship because she acted as an advocate by providing information on alternate types of treatment for cancer to a patient. The physician saw this kind of information as a threat to his control over patient treatment. The patient had been told her leukemia was terminal and she wanted to know about other forms of treatment than chemotherapy. In this 1976 case the state board took away the nurse's licence to practice, a decision later reversed by the Supreme Court which ruled that providing a patient with information was not unprofessional conduct. This

instance, now a patient teaching situation, demonstrates how the role of the nurse advocate has changed.

Although nurses are less likely to be reprimanded for acting as patient advocates today, negative consequences still surface. Rowden (1992) described the animosity that he experienced in the early 1970s when he spoke out on the poor care patients received in a hospital familiar to him. Rowden felt pressured by nurse colleagues not to voice his concerns publicly. His experience was mirrored twenty years later in another British hospital when nurses went public to bring attention to the level of patient care in the institution where they worked. These nurses were also abandoned by their colleagues, as well as intimidated and harassed (Rowden).

Summary

The historical roots of nursing stressing subservience, lack of assertion, and a service ideal have created an impression among peers and other health care professionals that nurses should not act as patient advocates. Collins and Henderson (1991) argued that these roots do not provide adequate role models for nurses wishing to be autonomous practitioners. The literature identified a number of barriers which stem from the traditional role of the nurse, the nurse-doctor relationship, and the organization of health care. The Royal College of Nurses (1995) stated, "Nurses are not always necessarily placed to be patient

advocates, as it has been argued, they lack sufficient independence and objectivity" (p. 1).

Research on Nursing Advocacy and Autonomy

Among the first to study the advocacy role of the nurse were Pankratz and Pankratz (1974). These authors argue that patient advocacy is dependent upon whether or not nurses feel they can influence the system, are clear on what they should advocate, and are cognizant of the knowledge that patients require about their illness and the degree to which they should participate in their own care. Using this conceptual base, these researchers developed the Nurses' Autonomy/Patients' Rights (NAPR) questionnaire to assess nurses' views, "regarding dependence versus independence for both nurses and patients" (p. 212). The resulting 69-item NAPR was administered to staff nurses working in two community hospitals, two university hospitals, a large psychiatric hospital, and a sample of 206 nursing leaders, for a total sample of 702 participants. Principal component factor analysis was used to assess the construct validity of the NAPR. Three factors emerged from this analysis: 1) nursing autonomy and advocacy which measures flexible attitudes toward nursing, patients, and the hospital milieu with emphasis on nurses' competence and accountabilities as an autonomous professional; 2) patients' rights, which measures nurses' hypothetical concession of certain rights to patients; and 3) rejection of traditional

role limitations, which measures nurses' willingness to openly disagree with the doctor and become involved in the personal matters of patients.

Pankratz and Pankratz (1974) also examined the differences in sub-scale scores between the samples of nurses. Higher sub-scale scores were positively associated with higher educational qualifications. Leadership, setting, and non-traditional social climate were also significantly associated with scale scores. Nurse leaders had higher scores on all three sub-scales than staff nurses. Study participants from psychiatric settings had the next highest scores on the sub-scales measuring nursing autonomy and advocacy and rejection of traditional role limitations, while those from university hospital settings had the second highest score on the sub-scale measuring patients' rights. Age and work experience were not correlated with any of the sub-scales.

Murray and Morris (1982) designed a study to investigate how well nursing students practised professional autonomy. The revised 47-item NAPR questionnaire was used to compare graduating senior nursing students in diploma, associate degree, and baccalaureate nursing programs. The findings indicated that students from the baccalaureate program scored significantly higher on the autonomy and advocacy sub-scale and the patients' rights sub-scale than their colleagues in the diploma and associate degree programs. There was, however, no difference on the rejection of traditional role sub-scale. The implications of the findings are that baccalaureate nursing education

inculcates professional autonomy. The authors cautioned against generalizing study results to other baccalaureate programs since the presence or absence of leadership courses may produce different findings.

Pinch (1985) used the shortened version of the Pankratz and Pankratz NAPR to compare autonomy, promotion of patients' rights, and rejection of the traditional nursing role among freshmen and seniors in an approved baccalaureate program and graduate baccalaureate nurses with three to four years nursing experience. Information was also collected on participants' decision-making skills through the use of hypothetical examples of ethical dilemmas. The sample consisted of a total of 294 participants. The questionnaires and case examples were administered to the students face-to-face but mailed out to the graduates for their completion and return. A response rate of 21% was obtained from the mailed portion of the study. Freshman scored significantly lower on the sub-scales measuring attitudes toward autonomy, promotion of patients' rights, and rejection of the traditional role of the nurse than both the senior students and graduates. Pinch argued that freshmen are uninitiated in relation to professional nursing education and, therefore, the results reflect the traditional image of the nurse obtained from family, school, and society. The findings illustrate that desired changes have taken place in senior students. Despite the adjustments and realities of practice the graduates continue to increase a little in autonomy. Pinch felt these attitudes and the

intellectual foundation of the concept of autonomy could be built upon through in-service and continuing education experiences to enhance the nurses' abilities in the advocacy role. A limitation of the study was the low return rate from the graduate nurses.

The 47-item Pankratz and Pankratz NAPR was used by Wood, Tiedje, and Abraham (1986) to assess autonomy in a sample of nurses and student nurses. The sample consisted of 18 community health nurses who had a baccalaureate degree, 13 registered nurses completing their first practicum in a BN program, and 14 senior level students in a baccalaureate program who were completing a community health practicum. Community health nurses scored significantly higher on the autonomy and rejection of traditional role subscales than the other two groups. No differences among the three groups were found on the patient rights subscale. The authors concluded that the setting made a difference to autonomy and rejection of the traditional role, and could also be a factor in attitudes toward patient's rights. Community health nurses have a more autonomous practice. Similar to Pankratz and Pankratz (1974), age was not significantly related to autonomy, but baccalaureate prepared nurses' scores were higher than those with less education. The small, non-random sample limits the generalizability of study findings.

In a survey of nurses ($\underline{N}$ = 386) working in a large hospital, Collins and Henderson (1991) investigated perceptions of autonomy. Autonomy was

measured with the Pankratz and Pankratz NAPR Questionnaire. Two Likert-style questions were used to assess the degree to which respondents were expected to practice autonomously and whether support was received for autonomous practice. Data were also collected on select demographic factors (i.e., nursing education, age, gender, years in practice, clinical speciality, and job role). Study findings indicated that 51.4% of respondents felt that they were expected to practice autonomously, while only 45.7% reported receiving some support for autonomous practice. The obtained mean scores on the nursing autonomy and advocacy, patients' rights, and rejection of traditional role limitations sub-scales were 86.88, 59.82, and 50.88, respectively. These mean scores were similar to those of Pankratz and Pankratz (1974), thus indicating that nurses' perceived levels of autonomy had not changed appreciably in 15 years. Collins and Henderson concluded that, "the lack of progress toward increased perceptions of autonomy by nurses has serious implications for the profession as well as employers" (p. 28). Significantly, Collins and Henderson found that nurses with advanced preparation scored higher on the patients' rights sub-scale than those with less education, whereas nursing administrators and emergency nurses scored higher on the rejection of traditional role subscale than staff nurses in other clinical areas (e.g., psychiatry, maternal-infant, critical care, etc.).

In a descriptive exploratory survey, Romaniuk (1988) explored staff

nurses' (N = 116) perceptions of the nurse's role as a patient advocate. Data were collected using the Questionnaire on Patient Advocacy as a Nursing Role (QPANR); a researcher developed questionnaire to measure nurses' opinions, preparation, and role implementation of nurse advocacy. A response rate of 60.5% was obtained to the survey. The findings indicated that respondents believed nurses should be patient advocates, initially prepared for this role through their educational programs, and further prepared through inservice or continuing education. Some of the advocate activities identified by study participants included being a spokesperson for patients, looking after patients' rights, and giving information on treatment regimes. Although participants felt there was no need for a category of employee whose sole responsibility was advocacy, they did agree that other health care workers besides nurses could also act as patient advocates. Among the demographic characteristics studied, nurses with more years of experience (i.e., 6 to 10 years) had more positive attitudes toward acting as an advocate than those with five years or less experience.

In a comparative study of critical and non-critical care nurses working in a large federal hospital (n = 29) and smaller community hospitals (n = 35), Wlody (1993) investigated perceptions of the advocacy role, how it is practiced, and the influence of health care infrastructure and socio-demographic factors on role implementation. Study participants were working in clinical, educational, or

managerial positions and attending an educational program on ethics. A researcher-developed instrument, the Ethics Advocacy Instrument (EAI), was used to collect data at the end of the educational session. The content of the EAI addressed perceptions of advocacy, advocacy behaviours, health care infrastructures, and select sociodemographic factors (e.g., education, current position, employment type, nursing speciality, etc.). Data were analysed using both descriptive and inferential statistics. Content analysis was used to code the open-ended questions on barriers and supports. Study findings indicated that masters prepared nurses had higher advocacy scores than those with less education, federal hospital nurses selected advocacy behaviours significantly more often than their counterparts working in community hospitals, and critical care nurses had higher advocacy scores than those working in non-critical care areas. Critical care nurses also used significantly more support infrastructures than non-critical care nurses. The strongest support for the advocacy role came from peers, whereas physicians were most frequently identified as barriers to advocacy. The preferred model of advocacy was the patients' rights model. A major limitation of this study was the self-selection of nurses, that is, the sample consisted of those who opted for continuing education credits in ethics.

Snowball (1996) reported on the first phase of a larger study designed to explore the perceptions, understanding, and experience of acting as patient advocates in a small group of registered nurses working in general medical and

other clinical areas. Key individuals in a large teaching hospital were asked to provide a list of nurses who were practising at least one year and the nurses identified were sent an introductory letter explaining the research. Fifteen participants with nursing experience ranging from three to twenty-five years (mean of nine years) were recruited for the study. All participants had completed some post-basic nursing courses. The researcher used an interpretative qualitative research paradigm. Audio taped semi-structured interviews were used to elicit a narrative account of participants' perceptions, beliefs, and values related to acting as a patient advocate. Content analysis was used to identify emergent themes.

Snowball (1996) reported that some of the participants' descriptions of advocacy were congruent with the literature, such as, respecting the rights of the patient, representing or speaking up for patients' point of view in the decision-making process if the patients were unable or unwilling to speak up for themselves, and informing patients of their care options. Significantly, a few participants moved beyond these descriptions of advocacy and presented a view of the concept which was based on their philosophy of nursing and the centrality of the patient. These nurses stressed the importance of building a therapeutic relationship with the patient, being able to pick-up non-verbal cues, being a partner with the patient, sharing a common humanity, and promoting a humane environment to enhance their ability to advocate for patients. Some of the

participants felt that the risk inherent in the advocate role was positive as it provided the impetus for a change in the traditional views on nursing care. They were realistic about what nurses could achieve in the current political climate and voiced concern about what they could do in a system where they had strong business management responsibilities.

Although participants in the Snowball (1996) study were mainly advocating reactively, that is, responding to a risk type situation for the patient, they did feel they ought to be more proactive as part of their professional duty and advocate on a broader scale than the individual or ward level. They identified a need for nurses to have a strong professional identity, a high level of self-esteem, and self-confidence as necessary preconditions to advocate for patients in a potentially risky situation. Clarity about the focus of nursing accountability toward the patient and awareness of the potential impact of their actions were also important. The researcher acknowledged that study findings may be limited by the select group of participants (i.e., furthering their education, and working in a teaching hospital where advocacy issues may have been promoted) and planned to conduct a comparative study in a non-teaching hospital.

Using a qualitative research design, Chafey et al. (1998) examined how nurses define and characterize advocacy and barriers to role implementation. Seventeen nurses, who were either working in a hospital or community setting,

were asked whether they had acted as advocates, what they did as advocates, and what conditions, events or values facilitated or prevented them from assuming this role. A standardized open-ended interview, consisting of 12 advocacy questions, was developed to guide data collection. Study findings indicated that participants' advocacy actions could be collapsed into four major areas: coordination with the system, intervening for the patient, interpersonal relatedness, and empowerment. Interpersonal relatedness was the predominant action. Self-confidence and strength of conviction were important factors influencing participants' decision to take on the role, as well as situations where patients' rights were not being protected. Major barriers to assuming the advocacy role were intimidation through lack of support or threats to job security and safety. Nurses working in hospitals, in contrast to the community health nurses, identified time and economic constraints, greater acuity of patients, and the hierarchal structure of the institution as barriers. In contrast to other findings reported in the literature, physician intimidation was not identified as a key barrier. The authors conclude that characteristics of the nurse, patient, and environment are important determinants affecting nurses' willingness to take on the advocacy role. The authors also emphasize the need for further research on these determinants.

Summary

It is apparent from the studies reviewed in this section that theoretical and methodological variations, as well as small and/or non-probability samples, limit the conclusiveness of the findings on nurses' perceptions of the patient advocacy role. Despite these limitations consistent findings were observed on the important influence of educational background, clinical speciality, work setting, and current position on nurses attitudes toward nursing autonomy, rejection of the traditional role, and patients' rights. Furthermore, the qualitative studies reviewed had similar findings on facilitators of and the barriers to nurses acting as patient advocates.

Discussion

The conceptual ambiguity surrounding the concept of advocacy has created problems for nurses who are committed to the patient advocacy role. One significant problem is the absence of adequate understanding and practical knowledge to implement the advocacy role in different settings and under variant clinical situations. Although some research efforts have been directed towards operationalizing the key components of advocacy, limited progress has been made in this area. It is obvious that more research is needed to clarify what is entailed in the concept of advocacy, and also to identify key facilitators of and barriers to successful implementation of the role in nursing practice situations.

From both a clinical and research perspective, interdisciplinary teams would achieve greater progress with clarifying the advocacy role and identifying acceptable processes of implementation than nurse scholars working independently from others. Significantly, interdisciplinary collaboration would foster proactive as opposed to reactive advocacy, as well as accounting for the realism of the changing health care environment (e.g., short-term stay, higher acuity, technological advances, nurse-patient ratios, socio-political factors, etc.).

CHAPTER 3

METHODOLOGY

A descriptive correlational survey design was used to investigate perceptions of autonomy and attitudes toward patient advocacy in a sample of practising registered nurses in Newfoundland and Labrador. This chapter provides an overview of the population and sample, setting and context, instrument reliability and validity, research procedure, data analysis, and ethical considerations.

Population and Sample

The target population was all practising registered nurses in Newfoundland and Labrador who were members of the Newfoundland and Labrador Nurses' Union (NLNU). The number of nurses in the target population was approximately 5,000. All nurses employed on either a full-time permanent, part-time permanent or causal call-in basis were eligible for inclusion in the study by virtue of their membership in the NLNU.

Systematic random sampling was used to select 768 participants from a membership list supplied by the NLNU. Ideally, it would have been more beneficial to divide the accessible population into meaningful strata (e.g., age, years of experience, etc.) prior to sample selection, however, time and cost prohibited the use of this approach. Based on consultation with a statistician a

decision was made to estimate sample size as if the population were divided into three strata. Using a power of 0.80 and an alpha level of 0.05, the minimal number of participants needed to achieve a small to medium effect was estimated to be 105 per group (Polit & Hunger, 1991). Factoring in a normally low response rate of less than 50 percent to mailed questionnaires, the minimal sample size required for the study was 700.

In total 183 completed questionnaires were returned and usable. The final response rate was 23.8%. Although the response rate was much lower than expected it is important to speculate as to why this was the case. One of the reasons could be the saliency of the topic; advocacy may not have been an important topic to the nurses surveyed. Perhaps these nurses felt they worked in a health care system where they could not make much difference. Another possible reason for the low return rate could be that nurses really felt they did not know enough about the topic to complete the questionnaires. Maybe they felt that in their particular nursing position they really were not taking on an advocacy role.

Setting and Context

The study was carried out in the province of Newfoundland and Labrador in 1993. In this setting nurses have historically perceived their responsibility to the public to be the provision of a high standard of nursing care. From the

beginning the Association of Registered Nurses of Newfoundland (ARNN) was clear that standards of nursing practice, including advocacy, and nursing education were primary missions. Just after advocacy became prominent in the nursing literature in the late 1970s (Lamb, 1980), the ARNN (1984) developed a document, the *Quality of Nursing Care Standards*, to address the issue. This document identified advocacy as one of the three main functions of nursing practice. The "advocacy function" was based on the definition outlined in Harmer and Henderson's 1955 *Textbook of the Principles and Practice of Nursing* and described as, "in this capacity [advocacy function] the nurse would intercede for, defend, and uphold the rights and best interests of the individual and the public" (ARNN, 1984, p. 9). Specific activities that were considered to be part of the advocacy function included: questioning and possibly refusal to carry out medical orders or policies thought to be injurious to the patient, active acknowledgement of the individual's right to consent, privacy, dignity, and information, protection of abuse and neglect situations, and a mandate to change when there is any threat to the public's health and well-being.

The ARNN has endeavoured to continually give attention to its mandate on advocacy and has authored many documents that facilitate members' practice (1991; 1995a; 1995b). As a member of the Canadian Nurses Association, the ARNN has adopted guidelines through the years such as the CNA Code of Ethics (1980; 1985; 1991; 1997). The ARNN has collaborated

with other health care organizations and with relevant government departments and has endeavoured to interpret the role of Registered Nurses in health care. The ARNN Standards were revised in 1995 and the *Standards for Nursing Practice in British Columbia* (1992) were adapted. Advocacy was used as an indicator for clinical practitioners, educators, administrators, and researchers under Standard 4, Code of Ethics: Adheres to the ethical standards in the nursing profession. An advocate is defined in the Standards as:

> A person who pleads for or who speaks on behalf of another (e.g., a client advocate is a person actively involved in the care of clients who will inform them of their rights; ensure that they have the necessary information to make informed decisions; support them in the decisions they make and protect and safeguard their interests) (Association of Registered Nurses of Newfoundland, 1995a, p. 14).

Other ARNN documents address the importance of the advocacy role for nurses. The *Standards and Criteria of Professional Competence for Beginning Practitioners of Nursing in Newfoundland* (ARNN, 1991) state under Standard 1: Knowledge areas that the beginning practitioner understands and applies: "advocacy functions in the nurse-individual relationship" (p. 2). Likewise, in the *Scope of Nursing Practice* (ARNN, 1995b) client advocate is listed as one of the roles that may be used in the provision of nursing care.

Professional documents, such as the ones described above, are designed

to give direction and guidance to the practising nurse. In Newfoundland and Labrador, at least at the professional association level, advocacy is promoted as an important role for the registered nurse. Nurses are encouraged to take on this role and are offered some protection as they act as patient advocates. The ARNN's support and promotion of advocacy provides an important context to the study.

Survey Questionnaires

Two questionnaires were used to collect the data for the study. These were the Romaniuk (1988) Questionnaire on Patient Advocacy as a Nursing Role (QPANR) and the 47-item revised questionnaire on Nursing Autonomy/ Patients's Rights (NAPR) by Pankratz and Pankratz (1974). Although the NAPR was developed almost 25 years ago, the questions are still relevant indicators of nurse autonomy and patients' rights. Furthermore, scores on the sub-scales obtained in other studies allow us to identify any changes in nurses' views on these important issues over time.

Questionnaire on Patient Advocacy as a Nursing Role (QPANR)

The QPANR was developed by Romaniuk (1990) to collect biographical data and opinions of nurses in three areas: their role as a patient advocate, preparation to act as patient advocate, and implementation of the role as patient

advocate. Questions were developed based on a literature review and the feedback received from a sample of 20 staff nurses who were part of the target group for the study. The final questionnaire consisted of 11 questions on attitudes toward patient advocacy, 12 opinion questions about preparation of staff nurses to act as patient advocates, and biographical information (see Appendix A). Permission was received from the author to use this questionnaire in the present study (see Appendix B).

Nursing Autonomy/Patients' Rights (NAPR) Questionnaire

The NAPR was the second questionnaire used. Pankratz and Pankratz (1974) administered the NAPR to a population of 702 nurses working in staff nurse or leadership positions in three community hospitals, two university hospitals and a large psychiatric hospital. Principal component factor analysis was applied to the initial 69 items. During this analysis, scale items lined up on three main factors: 1) nursing autonomy and advocacy which measures flexible attitudes toward nursing, patients, and the hospital milieu; 2) patients' rights which measure nurses' hypothetical concession of certain rights to patients; 3) rejection of traditional role limitations which measure the nurses willingness to openly disagree with the doctor and become involved in the personal matters of patients. The internal consistency of the three subscales was strong, generating reliability coefficients of 0.93, 0.81, and 0.81 respectively. The 69 item scale was

reduced to 47 items following factor analysis. The revised scale (see Appendix C) has been used to measure nursing autonomy and empowerment in additional studies (Wood, Tiedje, & Abraham, 1986; Murray & Morris, 1982). Permission was received from Dr. Lorne Pankratz by telephone to use the NAPR questionnaire in the present study.

Procedure

The NLNU was approached for co-operation in conducting the research and for contacting selected participants. Approval to assist the researcher with the study was granted by the executive of the NLNU (see Appendix D). A simple random sample was chosen from the NLNU membership. Following approval and sample selection, the researcher provided the NLNU office with copies of a cover letter (see Appendix E) explaining the purpose of the study and the steps taken to preserve anonymity, the questionnaires, and two stamped envelopes. One envelope was for mailing the cover letters and questionnaires to the selected participants and the second, a self-addressed envelope to the researcher, was for returning the completed questionnaire. Participants were given a four week period from the date of the initial mailing of the questionnaires until a follow-up reminder was mailed to all the study participants to achieve the highest response rate possible.

As each set of questionnaires for each respondent was received, they

were given an identification number. Data were then entered into a Statistical Package for the Social Sciences (SASS) file for analysis.

Data Analysis

Data were analysed using descriptive statistics. Frequencies and percentages were used to describe the characteristics of the participants, awareness of employer policies on patient advocacy and nurses's advocacy roles, actual performance of the patient advocacy role, preparation for advocacy role, and factors promoting awareness of patient advocacy roles. Means and standard deviations were used to describe attitudes toward patient advocacy and nursing autonomy and patients' rights. One-way analysis of variance (ANOVA) was used to examine group differences by work-related factors (i.e., employing agency, experience, education, patient advocacy policy, and nurse advocacy role policy) on the NAPR sub-scales, and Pearson's product-moment correlation coefficient examined relationships between the sub-scales of the NAPR and ATPA. For the open-ended question on nurse perceptions of the patient advocacy role, content analysis was used to identify major themes.

Ethical Considerations

The research proposal including the questionnaires to be used was submitted to the Memorial University of Newfoundland Faculty of Medicine

Human Investigation Committee (HIC) for their consideration and approval (see Appendix F). The HIC is the official Research Ethics Board for all research from the Faculty of Medicine and the School of Nursing and consists of faculty from medicine and nursing as well as lay representation. Permission was also obtained from the Board of the Newfoundland and Labrador Nurses Union (NLNU) to access the target population through its membership list. A letter of support from the NLNU president was enclosed with the questionnaires sent to selected participants (see Appendix D).

The questionnaires were anonymous. This anonymity was preserved by having a statistician select the sample from the target population based on Identification (ID) numbers. The NLNU staff assigned IDs to all the names on the NLNU membership list and provided the statistician with just the ID list. Following application of simple random sampling procedures to the list by the statistician, NLNU office personnel matched the selected IDs to members and mailed out questionnaires to the selected participants. As in a number of survey research studies, completion and return of the questionnaire by selected participants served as consent to take part in the study. This procedure, coupled with not having any code or names on the questionnaires, further ensured anonymity. Only the researcher and statistician had access to the questionnaire and the raw data which were stored in a locked file.

There were no or very low risks or immediate benefits for the participants. There was a minor inconvenience in the time that was required to complete the questionnaires; an estimated thirty minutes. One of the long term benefits is that both the NLNU and the participants will have access to the findings.

RESULTS

CHAPTER 4

Study findings are presented in four sections. The first section presents a descriptive profile of the sample and key variables. The second section examines the influence of select factors on perceptions of nursing autonomy and patient advocacy. Consideration is also given to the interrelationships among the variables measuring attitudes toward patient advocacy and autonomous roles for nursing. The third section discusses instrument reliability based on study findings. The final section describes the themes that were generated from an analysis of respondents' comments on patient advocacy.

Descriptive Profile

This section presents an overview of select demographic variables, awareness of agency policies on patient advocacy and nurses roles, and preparation for advocacy roles. Descriptive findings are also presented on major study variables - nursing autonomy, patients' rights, traditional role rejection, and attitudes towards patient advocacy.

Sample Characteristics

Table 1 summarizes select demographic characteristics of the sample. The majority of respondents had a RN diploma education (68%) and were

Table 1

Description of the Sample (N = 183)

	n	%
Employing Agency		
Acute Care	108	63.2
Chronic Care	47	27.5
Community Based	16	9.4
Education		
RN Diploma	121	68.0
RN & Speciality	28	15.7
BN or More	29	16.3
Nursing Experience		
≤ 5 years	36	20.3
6 - 10 years	34	19.2
> 10 years	107	60.5
Gender		
Female	173	95.1
Male	9	4.9

working in an acute care setting (63.2%). Most respondents were female (95.1%) and had 10 or more years of nursing experience (60.5%).

Patient Advocacy and Nurses' Advocacy Roles

In the current study, information was collected on awareness of employer policies on patient advocacy and nurses' advocacy roles, and actual performance of the patient advocacy role. A summary of these findings is presented in Table 2.

A significant number of respondents (48%) were not aware of the existence of patient advocacy policies in their agencies. For those with this information (n = 92), only 39.1% reported that their agency had a written policy. Of the 36 nurses working in agencies with patient advocacy policies, the majority (91.6%) were familiar with them.

Most respondents (55.1%) were not aware of any policies on nurses' advocacy role in their agencies. For nurses with this information (n = 79), only 27.8% reported that their agency had a written policy. All of the those (n = 22) working in agencies with nurses' advocacy role policies were familiar with them.

There was a considerable amount of missing data on the question addressing performance of the patient advocacy role. For the 124 nurses responding to this question, 87.9% reported that they have been patient advocates.

Table 2

Policies on Patient Advocacy and Nurse Advocacy Roles

	n	%
Patient Advocacy Policy (n = 177)		
Yes	36	20.3
No	56	31.6
Don't Know	85	48.0
Familiar with PA[a] Policy (n = 36)		
Very	8	22.2
Somewhat	25	69.4
Not at all	3	8.3
Nurse Advocacy Role Policy (n = 176)		
Yes	22	12.5
No	57	32.4
Don't Know	97	55.1
Familiar with NAR[b] Policy (n = 22)		
Very	5	22.7
Somewhat	17	77.3
Acted as a Patient Advocate (n = 124)		
Yes	109	87.9
No	7	5.6
Don't Know	8	6.5

[a] PA=Patient Advocacy; [b] NAR=Nurse Advocacy Role.

Preparation for Advocacy Roles

In the current study, respondents were asked to select those factors that they considered to be most influential in shaping nurses' awareness of and preparation for patient advocacy roles. In addition, respondents were asked to indicate the type of information received on this topic since graduation. A summary of these findings is presented in Tables 3 and 4.

The majority of respondents indicated that nurses should be aware of the patient advocacy role (98.9%) and learn how to be patient advocates (96.2%). A significant number (63.4%) reported having read some materials on the nurses' role as patient advocates since graduation from a formal educational institution. For those respondents who had read on the topic, 54.5% reported that they did so within the last six months. A considerably smaller number (14.4%) reported having attended information sessions on patient advocacy (see Table 3).

When asked to identify dominant sources influencing awareness and knowledge about patient advocacy roles, there were important distinctions in the rankings for other nurses as opposed to the self (see Table 4). While basic nursing education (69.3%) was identified as the dominant factor influencing other nurses' awareness, experience (67.3%) dominated personal awareness. Similarly, positive reinforcement (68%) was identified as the dominant factor facilitating other nurses' acquisition of the role, whereas acting as an advocate (50%) was identified as the primary factor in personal learning.

Table 3

Nurses' Preparation for Patient Advocacy Roles

	n	%
Should be Aware of PA[a] Role (n = 183)		
Yes	181	98.9
Don't Know	2	1.1
Should Learn PA[a] Role (n = 183)		
Yes	176	96.2
Don't Know	7	3.8
Postgrad Readings on PA[a] Role (n = 183)		
Yes	116	63.4
No	49	26.8
Don't Know	18	9.8
Time Since Readings on PA[a] Role (n = 110)		
< 3 months	34	30.9
4 to 6 months	26	23.6
7 to 12 months	32	29.1
> 12 months	18	16.4
Attended Formal Sessions on PA[a] (n = 180)		
Yes	26	14.4
No	147	81.7
Don't Know	7	3.9

[a] PA=Patient Advocacy.

Table 4

Factors Promoting Nurses' Awareness of Patient Advocacy

	n	%
Others Awareness of Role[a]		
Basic Nursing Education	124	69.3
Employer Inservice Programs	81	45.3
Experience	70	39.1
Professional Associations	61	34.1
Personal Awareness of Role[a]		
Experience	113	67.3
Basic nursing education	79	47.0
Nursing literature	62	36.9
How Nurses Should Learn Role[a]		
Positive reinforcement	119	68.0
Experience	115	65.7
Attending lectures	105	60.0
What Nurses Should Learn[a]		
Human rights	96	55.2
Communication skills	88	50.6
Individual differences	77	43.8
Personal values	69	39.7
What Facilitated Personal Learning[a]		
Acting as an advocate	86	50.0
Lectures while student	67	39.0
Positive reinforcement	64	37.2

[a] Numbers vary due to the selection of more than 1 response category.

Respondents were also asked to identify important content areas which nurses needed to learn about in order to adequately prepare them for patient advocacy roles. The most frequently identified areas were human rights (55.2%), communication skills (50.6%), individual differences (43.8%), and personal values (39.7%).

Attitudes Toward Patient Advocacy

The Attitudes Towards Patient Advocacy (ATPA) Scale assessed nurses' ratings of the advocacy role in terms of implementation (i.e., performance, commitment, comfort, and peer support), attitude towards the role for nursing (i.e., priority and understanding), and adequacy of preparation. Scale items were rated on a six-point scale, ranging from strongly agree (1) to strongly disagree (6). The possible score range for the total scale was 11 to 66, and the subscales 7 to 11, and 2 to 12, respectively. Lower scores reflect more positive attitudes toward the patient advocacy role. The means, standard deviations, and weighted means for the subscales and total scale are summarized in Table 5.

The weighted mean for the total scale ($\underline{M}$ = 2.83) is below midpoint of the rating scale ($\underline{M}$ = 3.5). This finding suggests that most respondents had positive attitudes towards patient advocacy as a nursing role. The normative value of 2.14 reported by Romaniuk (1988), in a random sample of 116 full-time staff nurses employed by different health care agencies, was also below the scale

midpoint, indicating a favourable disposition towards this role.

In the current study respondents scored lower on the implementation ($\underline{M}$ = 2.7) and adequacy of preparation ($\underline{M}$ = 2.73) subscales than on the attitude towards the role for nursing subscale ($\underline{M}$ = 3.46). Comparatively, Romaniuk (1988) reported similar findings. The weighted mean for the implementation subscale indicates that respondents believed nurses were performing the role, were committed to and comfortable with it, and had peer support. There were notable variations among the individual items comprising this subscale. Although most respondents (87.9%) felt that nurses were implementing the patient advocacy role, only 58.6% believed that it was being implemented in a proper manner. Further, most respondents tended to rate their commitment to and comfort with the role more positively than their colleagues (i.e., 95.6% and 91.1% versus 83.8% and 72.8%, respectively).

With regard to the adequacy of preparation subscale, most respondents reported that they, as well as other nurses, were prepared to act as patient advocates. As was observed with the implementation subscale, respondents reported feeling more prepared for this role than their colleagues (i.e., 85.1% versus 72.4%, respectively). Finally, the attitude towards the advocacy role subscale evidenced the most negative ratings by sample respondents.

Table 5

Attitudes Toward Patient Advocacy Subscale Results

	N[a]	M (SD)	Weighted M
Implementation	176	18.91 (5.01)	2.70
Attitude Towards Role	181	6.91 (2.14)	3.46
Adequacy of Preparation	181	5.45 (2.18)	2.73
Total Attitude Score	176	31.14 (7.18)	2.83

[a] Numbers vary due to missing responses to subscale questions.

Although the majority (60.2%) believed that nurses gave high priority to patient advocacy, only a small number (38.9%) felt that all nurses had a common understanding of the meaning of patient advocacy.

Nursing Autonomy/Patients' Rights

The Nursing Autonomy/Patients' Rights (NAPR) Questionnaire assessed nurses' attitudes towards an autonomous role in three dimensions (i.e., nursing autonomy and advocacy, patients' rights, and rejection of traditional role limitations). Scale items were rated on a six-point scale, ranging from strongly agree (1) to strongly disagree (6). According to the NPAR scoring guidelines, a weighted factor was subtracted from each subscale to remove the confounding effect of negatively worded items. The higher the subscale scores, the more positive were nurses' perceptions of autonomy. The means, standard deviations, and score ranges for the three subscales are summarized in Table 6.

The scores on the nursing autonomy and advocacy subscale ranged from 76 to 148. The mean score ($\underline{M}$ = 102.7) was within the range of means (i.e., 73.9 to 102) reported by Pankratz and Pankratz (1974) for a sample of 702 nurses working in various hospital settings (i.e., community, psychiatric, and university hospitals). The high mean score suggests that most respondents viewed nursing autonomy and patient advocacy favourably, and felt comfortable taking initiative and assuming responsibility.

Table 6

Nursing Autonomy and Patients' Rights Subscale Results

	N[a]	M (SD)	Score Range
Autonomy and Advocacy	166	102.65 (12.27)	76 - 148
Patients' Rights	178	70.92 (7.96)	51 - 84
Role Rejection	176	60.00 (7.23)	46 - 78

[a] Numbers vary due to missing responses to subscale questions.

The observation that sample subjects supported nursing autonomy and advocacy was conveyed in a number of ways. For example, the majority (78.6%) believed that nurses could and should answer patients' questions regardless of the attending doctor's plan for information release. In addition, a significant number (95.6%) strongly opposed physician attempts to direct or guide nurses' role in the delivery of health care. With regard to the patient's right for control, most respondents felt that patients should have the right to plan their own activities (73.8%) and choose preferred treatment types (88.5%).

The scores on the patients' rights subscale ranged from 51 to 84. The mean score of 70.92 was above the mean ranges (i.e., 53.8 to 61.3) reported by Pankratz and Pankratz (1974). The findings suggest that most respondents believed that patients should be informed participants and were willing to concede certain rights to them. Specifically, a significant number believed that patients should be informed about their medications (100%), have adequate understanding of changes in care before accepting them (98.9%), be told their diagnosis (96.7%), and have the right to refuse care (97.8%). With regard to nursing actions in facilitating patients rights, most respondents indicated that nurses should understand policy changes affecting patient care (100%), consider the influence of sociocultural factors on patients (97.8%), recommend available community resources (98.9%), and convey the message that they are willing to be patient advocates (99.5%).

The rejection of traditional role limitations subscale had scores ranging from 46 to 78. The mean score (M = 60.0) was above the normative mean ranges (i.e., 45.8 to 56.1) reported by Pankratz and Pankratz (1974). The findings suggest that nurses were willing to disagree with physicians and become involved in the personal affairs of patients. More specifically, the majority indicated that they would be willing to make consultations for patients independently (75.4%), question physicians' decision-making (94.5%), openly disagree with physicians (86.8%), and refuse to carry out physicians' orders (93.4%). With regard to becoming involved with patients' issues, a significant number reported a willingness to discuss highly personal matters with patients (81.3%), to talk to patients about their pasts (90.1%), to explain procedures and treatments before initiating them (98.4%), and to respond to patients' questions (78.6%).

Factors Affecting Nursing Autonomy and Advocacy Roles

This section examines the effect of key work-related variables (i.e., employing agency, years of nursing experience, educational preparation, and agency policies on patient advocacy and nurse advocacy roles) on attitudes toward patient advocacy and nursing autonomy. Consideration is also given to the relationships among the subscales scores of the ATPA and the NAPR. One-way analysis of variance (ANOVA), or the appropriate non-parametric test (i.e.,

Kruskal-Wallis), was used to identify group differences. Pearson's correlation coefficient (Pearson's r) was used to determine relationships among the study instruments' subscales.

ATPA and Demographic/Work-Related

The findings did not demonstrate any significant differences in the ATPA subscales or total scale scores for employing agency, years of nursing experience, or education. Further, respondents' awareness of the existence of written agency policies on patient advocacy or nurses advocacy role did not effect ATPA subscales or total scale scores.

NAPR and Demographic/Work-Related

The findings revealed few significant differences in the NAPR subscale scores for demographic/work-related variables (see Table 7). There were no significant differences for years of nursing experience, or awareness of the existence of written agency policies on patient advocacy or nurses advocacy role. Employing agency ($F = 5.92$, $p = .003$) and education ($F = 4.72$, $p = .010$) affected respondent perceptions of nursing autonomy and patient advocacy. That is, nurses working in community health tended to have more favourable views of nurses' and patients' rights and to feel more comfortable taking initiative and assuming responsibility than their counterparts working in acute and chronic

Table 7

NAPR Subscales by Work-Related Variables (ANOVA Results)

	Scales		
	Autonomy/ Advocacy	Patients' Rights	Role Rejection
Employing Agency[a]	F = 5.92** (p = .003)	F = .445 (p = .642)	F = 1.33 (p = .267)
Experience	F = .069 (p = .793)	F = .385 (p = .536)	F = .047 (p = .828)
Education[b]	F = 4.72* (p = .010)	F = .510 (p = .601)	F = 2.03 (p = .135)
Patient Advocacy Policy	F = 1.11 (p = .295)	F = 1.73 (p = .191)	F = .570 (p = .452)
Nurse Advocacy Role Policy	F = 2.92 (p = .092)	F = .280 (p = .598)	F = .700 (p = .406)

* $p < .05$ ** $p < .01$

[a] Community vs Chronic and Acute; [b] ≥ BN vs RN only.

care settings. As well, nurses with baccalaureate and higher degrees viewed nursing autonomy and patient advocacy more positively than those with diploma education.

NAPR with ATPA

Table 8 summarizes correlations among the subscales of the NAPR and ATPA. The reader is reminded that lower scores on the ATPA subscales and higher scores on the NAPR reflect more positive attitudes.

There was a significant negative relationship between the patients' rights subscale of the NAPR and the implementation ($r = -.17$, $p < .05$) and adequacy of preparation ($r = -.23$, $p < .01$) subscales of the ATPA. The findings suggest that higher nurse ratings of autonomy and advocacy were associated with a stronger belief that patients should be informed participants and a greater willingness to concede certain rights to patients. Further, the stronger the feelings about being prepared to act as patient advocates, the stronger the belief that patients should be informed participants and the greater the willingness to make concessions to patients.

A significant positive correlation was observed between the attitude towards the role subscale of the ATPA and the role rejection subscale of the NAPR. The findings indicate that greater priority and understanding of the

Table 8

Correlations of NAPR and ATPA Subscales

	Scales		
	Autonomy/ Advocacy	Patients' Rights	Role Rejection
Implementation	r = -.06	r = -.17*	r = -.08
Attitude Towards Role	r = .14	r = .06	r = .15*
Adequacy of Preparation	r = -.08	r = -.23**	r = .05

* $p < .05$ ** $p < .01$

patient advocacy role was associated with less willingness to disagree with physicians and become involved in the personal affairs of patients. This finding was opposite to what was expected, but may be explained by the contradictory results between the two items comprising the attitude towards the role subscale (i.e., nurses gave high priority to patient advocacy but did not believe that everyone had a common understanding of this concept).

Reliability of Study Instruments

The reliability of the Attitudes Towards Patient Advocacy (ATPA) Scale and the Nursing Autonomy/Patients' Rights (NAPR) Questionnaire were also examined in this study. Cronbach's alpha was used to assess internal consistency.

ATPA

Alpha coefficients ranged from .84 for the total scale to 0.64 and 0.85 for the subscales (see Table 9). The moderate to strong alpha values indicate that the ATPA scale and subscales have good reliability. Further, the inter-item correlations (0.33 to 0.61) suggest that scale items are neither redundant nor unrelated.

NAPR

Alpha coefficients ranged from 0.68 and 0.83 for the subscales (see Table 9). The moderate to strong alpha values indicate that the NAPR subscales seem to have good reliability. However, the inter-item correlations (0.10 to 0.29) suggest that the overall relationship among scale items is quite low.

Nurse Perceptions of the Patient Advocacy Role

Respondents to the survey were given the opportunity to comment on the topic of patient advocacy. Although only a small number (n = 45) took the time to share their views, the descriptive commentary was quite insightful and addressed a number of important issues. The majority of respondents either worked in long term care or acute care settings (84.4%), had a diploma education or certificate in a speciality area (84.4%), and had six or more years of nursing experience (91.1%).

Each response was analyzed for major content areas by the researcher and one other committee member. Following the initial coding, efforts were directed towards identifying common themes present in the data. In the final analysis, the data was collapsed into three major themes: importance of patient advocacy role, barriers to role enactment, and forces facilitating role enactment. The findings are summarized according to these major themes.

Table 9

Internal Consistency of ATPA and NAPR Subscales

	Scale M	Inter-item Correlations	Cronbach's Alpha
ATPA			
Implementation	18.91	.33	.77
Attitude Towards Role	6.91	.47	.64
Adequacy of Preparation	5.45	.61	.76
Total Scale	31.14	.33	.84
NAPR			
Autonomy and Advocacy	102.65	.10	.74
Patients Rights	70.92	.28	.83
Role Rejection	59.95	.14	.68

Importance of Role

Within the descriptive comments, frequent reference was made to the key position that nurses assume in promoting patient understanding of the information conveyed by physicians. One nurse who worked in long-term care expressed her views on the importance of the patient advocacy role in the following manner:

> I feel that if we, as nurses, do not advocate on behalf of our patients, who will? Half the time patients do not understand what the doctor has told them. Often the nurse has to translate in layman terms what was meant by the conversation.

Another nurse working in oncology highlighted the problems inherent in how physicians' communicate with patients and nursing's responsibility in facilitating greater understanding: "Often they *[patients]* are intimidated by the medical profession and are afraid to question reasons for medications, procedures and treatment. It is up to the nurse to find out how informed patients are, and intervene if necessary."

Besides the promotion of understanding, many viewed the advocacy role as an opportunity for nurses to empower patients. One nurse, who worked in community health, commented as follows: "My goal is always to give knowledge so they *[clients]* can advocate for themselves. I will advocate for them if need be, depending on the appropriateness." Another nurse working in acute care also stressed the importance of not only informing patients but also empowering them to take the initiative: "We will pursue something until it is corrected or at

least answered; and often times counsel patients and families re how to ask the questions needed to get the information they want and need." A somewhat similar perspective was echoed by a second acute care nurse:

> Many patients feel like specimens or numbers, and many. . . would be greatly relieved and thankful if nurses intervened on their behalf. Give the patient the chance to speak first and then if he doesn't speak up, do it for him.

Another nurse pursuing postgraduate education also emphasized the important role that nurses play in empowering patients: "Nurses must empower them *[patients]* to understand their treatment no matter what."

Many of the respondents indicated that nurses were in the best position to fulfill the patient advocate role. Although not always conscious about being an advocate, some felt that nurses perform this role on a daily basis. An intensive care nurse made the following comment:

> When we go to work we are always acting on behalf of our patients - making sure that they're getting the service they need and deserve from the health care system. However, we don't think about the fact that we have acted as a patient advocate. Maybe we should be reminded.

Some attributed responsibility for patient advocacy to extended contact and knowledge about patient needs. One nurse who worked in an acute care setting commented thus: "I feel a nurse acts as a patient advocate anyway, whether she wants to or not, because the nurse is the first person that a patient will contact regarding care, medications, etc." A similar perspective on the suitability of nurses for the patient advocacy role was expressed by another nurse who

worked in psychiatry: "I always felt that nurses are there with the patient 24 hours a day - who knows the patient better and who is more able to fill this role." Still another nurse working in community health commented on nurses' suitability for the role in terms of their educational base: "It is essential that nurses act as patient/client advocates because of their broad perspectives and educational preparation which are holistic in concept."

Barriers to Role Enactment

Although all of the respondents supported the patient advocate role, a significant number identified barriers to successful role enactment. The most common barriers included: physician influence/power, non-supportive administration, inadequate peer support, and nurses' knowledge.

The perceived dominant position of physicians was frequently identified as a significant barrier to successful implementation of the advocacy role. One nurse, with over 10 years experience and working in acute care, expressed her dissatisfaction with physician authority thus:

> Physicians have too much to say in nursing decisions, policies and discipline. We should be an independent profession. We should never be placed in a position, where we feel we have to beg or bargain for patients rights; although this seems to be the norm!

Another nurse who worked in psychiatry described the difficulties with performing the advocacy role because of physician influence and power in the following manner:

> Nurses can advocate all they want but as long as our government recognizes the powerful lobbyists in the medical profession and not nurses and how we can provide care, nurses are out in the cold. . . . Doctors have had control too, too long!

The diminished ability to act as a patient advocate due to lack of support for this role also was reiterated by a nurse working in obstetrics: "They *[supervisors/ doctors]* still think the doctor's word is law and should not be questioned. I have been reprimanded in the past for telling a doctor what I thought of his practices in the caseroom." A similar perspective was expressed by another respondent who worked in coronary care: "The hardest part of playing patient advocate is when you come up against the medical system. Once the doctor. . .has decided what he feels is best for the patient it is difficult to get past the 'brick wall'."

Besides the physicians' power base, lack of support from administration was identified as an important barrier to enactment of the advocacy role. A nurse who worked in the medical/surgical area highlighted administrative barriers to self-directed practice: "I feel the time has come for employers to treat nurses as the intelligent care givers they are. We should not have to fear speaking up for patients." Another nurse working in long-term care indicated that she encountered major problems with supervisors while attempting to advocate for patients:

> I very seldom pass it up to act on the patients needs and communicate them through the proper channels. . . .I think I was looked at as a trouble maker by the supervisors. . . .Therefore I received very little positive feedback for my efforts.

The lack of support from administration for the advocacy role was also expressed in terms of inadequate staffing. One respondent who worked on a busy medical unit made the following comment: "As a staff nurse I do not have adequate time to be a patient advocate let alone complete my nursing duties." A similar perspective was expressed by a nurse working in surgery: "I feel the nurse is with the patient 24 hours and can quite fulfill needs as patient advocate. However on a busy surgical floor time is a problem."

The absence of peer support also was seen as a major barrier to implementation of the advocacy role. One nurse who worked in long-term care commented on the seemingly indifference or passivity of her colleagues: "Nurses, although not openly opposed, are most often passive." Another nurse who worked in the neonatal area expressed a similar perspective: "Personally, I feel that nurses who act as patient advocates are not always supported by their peers." Still another nurse who worked in an acute care setting identified the absence of peer support as the primary reason for reduced desire/motivation to implement the role: "I feel nurses are our worst enemies. They don't pick up for each other enough, they don't support each other enough, and they don't congratulate each other enough for a job well done."

Besides colleagues' attitudes toward advocating on behalf of patients, some respondents felt that inadequate knowledge about patient advocacy was part of the problem. One nurse working in an acute care setting made the

following comment: "I don't think many nurses are very knowledgeable regarding this role and what it entails." A similar perspective was expressed by another nurse working in long-term care: "Advocacy is a very difficult topic to understand. Many nurses act as advocates. . .yet do not know that they are doing so." Still another nurse working in acute care commented on the general lack of understanding of patient advocacy: "A vague subject which needs clarification."

Forces Facilitating Role Enactment

A number of respondents commented on what was perceived as necessary requirements for successful implementation of the advocacy role. Inservice education and information on advocacy, administrative support, nursing experience, and a conducive work setting (i.e., peer support, positive relations with colleagues, and recognition of nurse capabilities) were the dominant components of this theme.

Many of the respondents emphasized the important influence of inservice education and information provision on successful enactment of the advocacy role. A nurse working in an acute care setting made the following comment: "I feel more information should be given to nurses to aid in their accepting this *[patient advocacy]* as one of their roles." A second nurse who worked in acute care noted that newer graduates seem to be more prepared for the advocacy role than in the past: "I must also make note of one fact that I find pleasing. . .

new nurses. . .are much more assertive and knowledgable on patient advocacy . . .and are therefore better patient advocates." Another nurse working in long-term care felt that more inservice was needed on this topic: "I feel there should be educational inservices in each centre regarding same *[patient advocacy]*." A second nurse working in long-term care expressed a similar sentiment: "I think that it is vitally important to work as patient advocates, and there should be more workshops and seminars on this matter."

Many of the respondents commented on the importance of the presence of a supportive administrative structure and a conducive work setting. One nurse working in long-term care expressed her thoughts on this in the following manner: "Nurses spend more quality time with patients. . . .Patient advocacy should be a priority of care. As nurses we need more protection from hospital policy manuals, and we need more leeway for decision-making." Another nurse working in community health made a similar remark: "I feel that any form of primary care allows patient advocacy if we as nurses want to do so and the system or program is designed to let the nurse do so!"

One nurse working in acute care attributed greater acceptance of the patient advocacy role to the confidence derived from experience and positive interpersonal relations with others in the work setting. "I feel that experience, along with rapport with doctors and administration, aids in the nurses confidence in acting as the patient's advocate." A somewhat similar perspective on the

importance of colleague support was expressed by one nurse who was pursuing post-graduate education: "Nurses need ongoing positive acknowledgement for acting as patient advocates from colleagues - more peer support as well from non-nurse health care workers." Still another nurse working in acute care attributed greater willingness to enact the advocacy role to nurses' recognition of their capabilities and increased confidence in interpersonal communications with others: "Nurses tend to use their own knowledge when giving nursing care; and we tend more to approach doctors with a suggestion for treatment."

Summary

The current study findings suggest that the vast majority of respondents supported patient advocacy as a suitable role for nursing. The findings also indicate that most respondents supported more autonomous roles for nursing. There were few significant variations detected for demographic and work-related variables. Community health nurses and those with higher educational preparation had more positive attitudes toward patient advocacy and autonomous practice.

Despite the positive attitudes toward and acceptance of the patient advocacy role and autonomous practice, many felt that administration, as well as nursing and medical colleagues, posed significant barriers to successful implementation. The qualitative and quantitative findings supported this

observation. The absence of agency policies on patient advocacy and the nurse advocacy role, as well as limited inservice education and lack of recognition for being an advocate, were indications that administration was not encouraging nurses to be patient advocates or assume more autonomy in practice situations. Significantly, some participants identified demanding workloads and inadequate staffing as an indication that adminstration was not supportive of patient advocacy roles for nurses. Although most respondents felt strongly about placing patient preferences and needs above physicians, it was quite clear from the qualitative findings that physicians, as well as nursing colleagues' reluctance to oppose medical and administration authority, were perceived as major barriers to the patient advocacy role.

CHAPTER 5

DISCUSSION

The core, care, and cure model proposed by Lydia Hall (1963, 1964, 1969) provides a useful theoretical perspective for informing research inquiries on advocacy. The Hall model postulates that if nurses are to be effective promoters of patient self-determination they must be empowered and autonomous agents that are capable of providing timely and relevant interventions which address the care (the body), core (the person), and cure (the disease) needs of patients under their care. What is important about this perspective is that if nurses are to fulfill their professional responsibilities to patients they must be committed to working with the total person, as well as other health care providers, in a non-structured, supportive and nurturing environment. The current study was designed to document nurses' perceptions of the patient advocacy role, autonomous practice, preparation for advocacy, and barriers to and facilitators of autonomy and advocacy. The discussion is organized around the research questions investigated in this study.

Perceptions of Patient Advocacy and Nursing Autonomy

One of the research questions investigated in this study was how Newfoundland and Labrador nurses perceive the patient advocacy role and nursing autonomy. Most study respondents supported patient advocacy as a

nursing role. Similarly, many nurse scholars argue that advocacy is a central role of nursing (Craven & Hirnle, 1996; Curtin, 1979; Dugas & Knor, 1995; Gadow, 1980; Hall, 1964; Kohnke, 1980; Lumpp, 1979; Winslow, 1984). Other nurse scholars describe advocacy as putting the caring aspect of the nurse's commitment into action (Kraus, 1981), or as a quality of power associated with caring that helps restore and empower patients (Benner, 1984). There are also research findings which indicate that nurses view patient advocacy as an important nursing role (Chafey et al., 1998; Romaniuk, 1988; Snowball, 1996; Wlody, 1993).

Several respondents indicated through descriptive comments that nurses were more suitable than other professionals to be patient advocates. Conflicting perspectives have been presented in the nursing literature on whether this role is indeed unique to nursing. While some authors argue that patient advocacy is inherent in the caring functions of nursing (Curtin, 1979; Gadow, 1980; Kohnke, 1980; Lumpp, 1979; Snowball, 1996; Winslow, 1984), others view advocacy as an important role for all health care providers (Bernal, 1992; Shannon, 1997).

In the current study, most respondents believed that nurses should be familiar with the advocacy role and learn how to be patient advocates. Significantly, most respondents believed that nurses were acting as patient advocates, were comfortable with and committed to the role, and received peer

support when implementing the role. Romaniuk (1988) reported comparable findings.

The current study's findings also indicated that most respondents supported patients' rights to self-determination. For example, most believed that patients should be empowered to act as informed participants (e.g., adequate understanding of medications, diagnosis, changes in care, information communicated to them, etc.) who are involved in planning their care and choosing preferred treatments. Despite the many interpretations of the advocacy role, the theoretical (Benner, 1984; Curtin, 1979; Gadow, 1980; Hall, 1964; Kohnke, 1980; Winslow, 1984) and research (Chafey et al., 1998; Collins & Henderson, 1991; Millette, 1993; Pankratz & Pankratz, 1974; Snowball, 1996; Wlody, 1993; Wood, Tiedje, & Abraham, 1986) literature provides strong support for the belief that nurses should promote and protect patients' rights.

With regard to feeling autonomous enough to be advocates, the majority of respondents reported a willingness to question physician authority (i.e., openly disagree, refuse to carry out orders, question decisions, and make independent consults for patients) and to become involved with patients' issues (i.e., discuss highly personal matters, explain procedures before implementing them, and answer patient questions). Comparable findings have been reported by Collins and Henderson (1991), Murray and Morris (1982), Pankratz and Pankratz (1974), and Wood, Tiedje, and Abraham (1986).

Study findings also indicated that more positive views of autonomy and advocacy were significantly associated with greater support for patient's rights to self-determination. In addition, nurses who felt better prepared to act as patient advocates were more likely to support patients' rights to self-determination. Interestingly, no other studies were identified that examined the extent to which feeling prepared to be patient advocates or attitudes toward autonomy and advocacy affected nurses' level of support for patients' rights to self-determination.

Preparation for Patient Advocacy Roles

Several research questions investigated study respondents' opinions on how well prepared nurses were to assume patient advocacy roles. Although most respondents felt that nurses were prepared to act as patient advocates, most also felt that nurses did not have a common understanding of the patient advocacy role and were not implementing it in a proper manner. Study findings concur with the dominant position reported in the nursing literature that the ambiguity surrounding the term advocacy results in multiple interpretations of how to implement the advocacy role in practice situations (Chafey et al., 1998; Davis et al., 1997; Kohnke, 1982; Mallik, 1997; Zerwekh, 1992; Romaniuk, 1988; Sawyer, 1988; Snowball, 1996; Winslow, 1984).

Experience was identified as the dominant factor influencing personal

awareness of the patient advocacy role, whereas, basic nursing education was believed to be the dominant source of other nurses' awareness. With regard to currency of information, the majority of respondents reported reading materials on advocacy, with a significant number doing so within the past six months. Romaniuk (1988) reported similar findings. No other studies were identified which investigated the dominant factors influencing nurse awareness of the advocacy role or the currency of continuing education on the topic.

Factors Affecting Autonomy and Advocacy

One of the research questions in the current study investigated the influence of work-related variables (i.e., employing agency, years of nursing experience, educational preparation, and agency polices on patient/nurse advocacy roles) on attitudes toward patient advocacy and nursing autonomy. The findings provided minimal support for the effects of work related-variables on nurse attitudes.

In the current study, work setting and educational preparation affected attitudes toward nursing autonomy and patient advocacy. Community health nurses had more favourable views of nursing autonomy and patient advocacy than their counterparts working in acute and chronic care. Similar findings are reported by Wood et al. (1986). Current study findings also demonstrated that nurses with baccalaureate and higher degrees viewed nursing autonomy and

patient advocacy more positively than those with diploma education. Pankratz and Pankratz (1974) and Wlody (1993) also note the positive effect of advanced education on attitudes toward nursing autonomy and patient advocacy. In contrast, Collins and Henderson (1991) and Wood et al. (1986) failed to find support for the effect of educational preparation on attitudes toward nursing autonomy and patient advocacy.

Barriers to or Facilitators of Patient Advocacy Roles

Those respondents who elected to comment on patient advocacy identified several barriers to and facilitators of enactment of the role by nurses. The most frequent barriers identified were physician influence/power, non-supportive administration, inadequate peer support, and nurses' knowledge. Several scholars have identified the problems posed by the dominant influence and power of physicians within the health care system, especially with regard to nurses' abilities to act as effective patient advocates (Bernal, 1992; Blake & Guare, 1997; Chafey et al., 1998; Seley, 1992; Romaniuk, 1988; Storch, 1982; Trandel-Korenchuk & Trandel-Korenchuk, 1983; Winslow, 1984; Wlody, 1993; Woodrow, 1997).

There is much discussion in the nursing literature on how institutional structures and inter- and intra-disciplinary relations pose significant barriers to nurse enactment of the patient advocacy role. Several authors reference such

institutional constraints as non-supportive administrations (Anderson, 1990; Bernal, 1992; Blake & Guare, 1997; Chafey et al., 1998; Davies et al., 1997; Romaniuk, 1988; Reverby, 1990; Sawyer, 1988; Snowball, 1996; Woodrow, 1997). Other authors highlight the barriers posed by inadequate peer supports (Chafey et al., 1998; Trandel-Korenchuk & Trandel-Korenchuk, 1983; Winslow, 1984) and lack of knowledge of the advocacy process (Chafey et al., 1998; Davies et al., 1997; Mallik, 1997; Pierce, 1997; Romaniuk, 1988; Shannon, 1997; Snowball, 1996; Tingle, 1993).

With regard to positive forces promoting nurses' willingness to act as patient advocates, the most frequent facilitators were available information on advocacy, administrative support, nursing experience, and a conducive work setting (i.e., peer support, positive relations with colleagues, and recognition of nurse capabilities). Study respondents indicated that increased information and education on advocacy would promote more successful enactment of patient advocacy roles. Comparatively, Jecker (1997), Ryan and McKenna (1994), Sawyer (1988), and Tingle (1993) agree that knowledge of the advocacy process would enhance nurses' ability to act as patient advocates.

Study respondents indicated that the presence of a supportive administrative structure and conducive work setting were key factors in promoting nurses' ability to enact the patient advocacy role. Comparatively, a few authors emphasize the significant role that nursing leaders play in creating

supportive environment that facilitate nursing autonomy, an important requirement for patient advocacy (Chafey et al., 1998; Hall, 1964; McClosky & McCain, 1987; Prins, 1992; Snowball, 1996; Trofino, 1989). The importance of peer support (Stratton, 1990; Wlody, 1993), positive relations with nurse and other colleagues (Blake & Guare, 1997; Stratton, 1990; Wlody, 1993), and nursing experience (Blake & Guare, 1997; Chafey et al., 1998; Romaniuk, 1988) have also been identified as positive forces promoting effective enactment of the patient advocacy role.

Implications of Findings for Hall's Model

Data from the current study provide partial support for Hall's model of nursing practice. This model postulates that nurses must be empowered and autonomous if they are to effectively meet patients' needs. Study findings indicate that nurses with more positive views of nursing autonomy and patient advocacy were more likely to support patients' rights to self-determination.

Study respondents also indicated that a supportive administration, peer support, positive relations with nurses and other colleagues, and adequate knowledge were important forces facilitating nurses' willingness to assume the advocacy role and implement it in a meaningful way. These findings provide support for Hall's position that nurses require a supportive and nurturing work environment, as well as good working relations with nursing peers and other

health care providers, in order to meet their professional responsibilities to patients.

Summary

The primary purpose of this study was to explore nurses' perceptions of nursing autonomy and their ability to perform the patient advocacy role in the Newfoundland and Labrador health care system. A second purpose was to explore factors that impede or facilitate nursing autonomy and enactment of patient advocacy in practice settings. Study findings provided partial support for the Hall model of nursing practice which provided the conceptual framework for the study.

The findings indicated that most nurses had positive attitudes toward nursing autonomy and patient advocacy as a nursing role. Nurses' perceptions of autonomy and patient advocacy were influenced by the practice setting and level of education preparation. Administrative support, knowledge and understanding of the advocacy role, and work relations with peers and physicians were also identified as important factors influencing autonomous practice and effective enactment of the patient advocacy role.

CHAPTER 6

Limitations and Implications

The findings from this study on nurses as advocates have implications for the Newfoundland and Labrador health care system and for practising nurses, as well as the professional body of nurses. This chapter discusses study limitations, and implications of the findings for nursing practice, administration, education, research, and the professional association.

Limitations

The low response rate to the survey and small sample size limits the generalizability of study findings, although the use of random sampling techniques enhanced the representativeness of the sample. The use of the NAPR to measure nursing autonomy and patient advocacy is another limitation of this study. Despite the good reliability scores for the patients' rights and autonomy/advocacy subscales, the role rejection subscale had a less than desirable alpha value. Further, based on scoring procedures, some NAPR items were used to generate scores in more than one subscale. Limitations were also noted with the ATPA instrument, especially the low alpha value obtained on the attitude toward the advocacy subscale. It is possible that the use of instruments with stronger reliability and validity would decrease some of the contradictory findings observed in this study.

Implications for the Health Care System

The only purpose of a health care system is to provide optimum health care services to the public. Therefore, every action, all monies used, all plans made should focus exclusively on that objective. Registered nurses are probably the most valuable resource to the Newfoundland and Labrador health care system. Without detailing the reasons for this statement, one has only to focus on the knowledge, availability, flexibility, and potential of nurses to realize this is not an exaggeration.

The Government of Newfoundland and Labrador has enabled the implementation of programmes deploying nurses, such as the Primary Health Care Project, enacted legislation to facilitate the registered nurse practitioner role, funded various nursing research projects, and supported changes to nurses' basic education preparation. While these actions are commendable, this study has shown that there is an aspect of the professional nurse's role that is being either overlooked or at least not enabled. That is the unique ability of the nurse to foster the patient's self-determination or to empower patients (public) to take responsibility for decisions about and for their own health care. Many barriers have been identified that prevent nurses from making such a fundamental contribution within the existing health care system.

This study demonstrates that because of barriers such as inadequate staffing nurses say they do not even have time to answer patients' questions

about their illness. They are also saying that for various reasons such as lack of administrative support they fear reprisal if they attempt to be the patient's advocate. It is counterproductive and not a good use of resources to pay salaries to nurses and then not permit them to practice as they are educated to do. Likewise, it is wasteful to have professional nursing staff that do not have the time to get to know their patient's needs because of fragmentation of staffing. The evidence shows that the availability of time for nurses to be with patients is a factor in the quality of care patients receive and shortens their length of hospital stay (Henderson, 1964; Bower-Ferris, 1975; Stratton, 1990). The effect of lack of care, such as not having knowledge about one's preventive health care, can lead to repeated and costly re-admissions.

Implications for Nursing Practice

Study findings have implications for nurses practising in this province. The findings indicate that many nurses have problems administering the quality of nursing care they are qualified, prepared, and anxious to give. Many barriers to quality care were identified by study respondents.

Before considering what remedies are available to diminish these barriers, a very pertinent factor must first be stated. That is, with regionalization, rationalization, and consolidation of health care systems in this province nurses are no longer in the position to be selective of employers when they wish to

obtain a nursing position. This puts a different slant on problems, than if nurses were able to select the type of administration they would like to work with. That along with the temporary and part time aspects of positions that were first introduced into this province in the 1960's by grocery supermarkets, gives no security, nor does it foster an esprit-de-corps that a permanent position affords. Having observed these restrictions, what can the nurses of this province do to enhance care to their patients, while they gain satisfaction from their practice? Most people want to do the best work possible, including administrations of institutions.

The findings of this study revealed several factors that could assist nurses in their practice. One of the most evident problems was the issue of institutional policies relating to patient advocacy. Many nurses (55%) were not aware of whether the institutions in which they practised had policies related to patient advocacy. Although there are challenges for nurses in this province, employment even in the present situation should be a two-way street. The potential employer obtains information and the potential professional obtains information. Nurses, when seeking employment, should ensure they are familiar with all institutional policies. Where there are none on a particular and important aspect of the nurse's practice, the nurse should ask for them.

Another barrier noted was the lack of time to give the quality of care that nurses would like to give because of deficiencies in staffing. Nurses should

determine what institutional policies cover this situation, and if none exist, they should provide management with immediate documentation of every instance of staffing deficiencies. Nothing is as valuable to alter situations as accurate and persistent documentation to the appropriate persons - verbal complaints do not suffice. Furthermore this is a valuable recourse in legal situations. Co-operation amongst nurses, the only persons qualified to assess nursing needs, will facilitate change in this regard because administrations will be furnished with data to initiate change.

The lack of professional nursing power on the health care team was a barrier raised by the respondents to the questionnaire. The barriers already noted are factors that erode nursing power and influence. Several respondents indicated that they do not consider this issue problematic. They indicated that with sound nursing knowledge, supportive peers, assertive behaviour, and an understanding administration, they overcame this barrier. These appear to be the ingredients of registered nurses' autonomy, and factors that should be the objectives of every registered nurse.

Implications for Nursing Administration

The relevance of the findings of this study to the administration of nursing departments is quite clear. There are many barriers that are preventing nurses from fulfilling their central role of patient advocate in health care institutions

throughout this province. Nursing administrators should examine these barriers, to ensure patients are getting the maximum benefits from professional nursing care.

In an age of increasing public expectation and overt critical examination of nursing leadership, nursing administrators have a challenging task to mobilize professional nursing staff so that their knowledge and abilities are fully utilized. Registered nurses have a depth of knowledge about nursing that is unique. However, there is a danger that this uniqueness or distinctiveness will be lost if nursing becomes a blanket term for the care provided by other health care providers (e.g., LPNs, PCAs, etc.). Further, professional nurses' unique potential may be misunderstood, underrated, under-utilized, and finally lost. As their roles evolve there is the fear that nurses will shed the physical care component of their profession (Dunlop, 1985; Hall, 1966). If nurses choose to delegate responsibility for the physical care needs of patients to other health care providers, it will be extremely difficult to distinguish nursing from other closely related occupational groups (Dunlop, 1985).

Staffing nursing departments is what could at best be considered a very unstable ritual. Staffing needs depend on the unique daily needs of those entrusted to us - the patients - matched with the unique abilities of nurses and their assistants, whether they be licensed practical nurses (LPNs) or personal care attendants (PCAs). What is important though is that registered nurses

retain the responsibility and accountability for the assignment of appropriate personnel for delivering nursing care.

The use of part time and temporary nurses also has the potential to fragment nursing care. This has a deleterious effect on the recovery of patients, and can, in the long run, be a costly venture. While it is judicious to supplement a stable sufficient staffing pattern by such use of professional nurses, it can be carried too far. It is not enough to say that there are nursing care plans and numerous ways to communicate information about patients. That underestimates the value of the nurse-patient relationship and its effect on patient's progress. The analogy that could be used is to think of the effect if the same approach would be used by physicians, and the continuity of the physician-patient relationship be obliterated.

Although study respondents expressed a desire to use their abilities, in many cases they were thwarted because of barriers, such as lack of support from nursing administration, lack of time, and lack of power within the health care team. Nurses indicated that they were unable to perform advocacy roles in an effective manner, or to implement what they considered to be important nursing care; care only they could give.

Morse (1991), in her study of nurse-patient relationships, found that time was a factor in providing a high quality of care. She said that in this era of multiple care-givers and shortened length of hospital stay there is not sufficient

time for the development of effective relationships. She also said that administrators consider nurses to be interchangeable, comparing the idea to counselling centres who could operate on a "take a number basis", and that "nursing is the only care-giving profession that subscribes to the notion that the identity of the care-giver is insignificant"(p. 464). There are no easy solutions to the staffing dilemmas that nurses consider incompatible with professional nursing care. The Royal College of Nurses (1995) proposed that when an issue infringes upon nurses' ability to be patient advocates it may be time for nurses as a unified group, whatever aspect of nursing they represent, to take the political/legislative route to correct the situation.

Research has shown that where appropriately selected nurses are assigned patients, in supportive, nurturing environments and feel autonomous and empowered, they make a significant and positive difference patient outcomes. Patients also feel empowered, their self-determination is enhanced, they have a shorter length of hospital stay, and fewer re-admissions. In such environments, other levels of nursing staff are more effectively utilized (Henderson, 1964; Stratton, 1990). Nurses should have the time and resources to meet the individual needs of the patients during hospitalization and follow-up.

Implications for Nursing Education

The findings of this study have implications for the nurse educators of this

province. Basic education programs for professional nurses are very carefully planned to educate persons to meet the legislated requirements to practice in the jurisdiction and where there are reciprocal agreements in other jurisdictions. While educators have the freedom to establish the standards of academic education, the clinical experience depends upon the available resources. It is thought that the best teaching is by example.

Several issues were identified that influence the quality of nursing students' experiences in clinical areas. Significantly, many respondents were dissatisfied with staffing levels and their inability to achieve desired standards of nursing care. It is therefore incumbent on educators to select clinical experiences that give the best possible experience to nursing students. It is essential to the future of nursing that there is unity in the profession. Educators should endeavour to support nurses who are facing dilemmas daily and are frustrated by not being able to give the quality of nursing care they desire, and the patient needs.

The concept of advocacy is a central focus of a nurse's role, if patients are going to deal with the challenges of illness and maintain self-determination. Many respondents, while considering that they had been advocates, were not sure or did not understand the term. This is valuable information because of its importance in planning nursing programs and ensuring that future nurses do understand their various roles and responsibilities.

The lack of power on the health care team was cited as a major barrier to patient advocacy. However, one respondent did note that nurses who have graduated during the past five years are more assertive and seem to be more empowered to fulfil their nursing roles. That is a significantly positive comment for nursing and one that hopefully will be heard more and more.

Implications for Nursing Research

Findings of this study present a challenge for nurse researchers in this province. This is the first research on professional nurses' views on patient advocacy in Newfoundland and Labrador. The findings indicate that there is a critical need for more research on this issue so as to give a valid basis for planning nursing care services on provincial and institutional levels. The meaning and process of patient advocacy is a fundamental component of basic education programs for nurses. The lack of research on the topic will result in a lack of meaningful advocacy for the public needing the health care services.

Implications for the Professional Association

The Association of Registered Nurses of Newfoundland (ARNN) has historically been proactive in fulfilling its only legislated mandate, which is protection of the public in matters pertaining to the roles of registered nurses.

There are many sub-objectives to that goal, however the focus of the ARNN and the reason for its existence is that mandate.

The ARNN will be interested in the findings of this study because many concerns raised by the nurse respondents come under its jurisdiction. Especially disconcerting is the quality of patient advocacy that nurses feel they can give within the current health care system. Since the mid 1980's, the ARNN has had a protocol for members to follow when they have concerns about patient care in institutions where they are employed (1986, 1995). One of the Standards of Nursing Care (1995) approved by the ARNN directly expresses the advocacy role of the nurse, although there is no definition of the term in the latest documents reviewed. A recommendation would be for the ARNN to examine the operational value of its reference to advocacy. This is especially important given the fact that the majority of nurses felt they had been patient advocates but were not clear about its meaning and were not aware of employers' policies related to the matter or if they had any policies.

Summary

The results of this study suggest that nurses in Newfoundland and Labrador have positive attitudes toward nursing autonomy and the patient advocacy role. The findings also indicate that nurses are performing the advocacy role despite the barriers posed by administrative structures, physicians'

power base, and, to a lesser extent, non-supportive peers with limited interest in or understanding of the role. Although the results of this study are not generalizable, they do support some of the findings of previous research and have important implications for nursing practice, education, administration, and research.

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APPENDIX A

REVISED QUESTIONNAIRE ON PATIENT ADVOCACY AS A NURSING ROLE (QPANR)

This questionnaire is divided into three sections:

A) Attitudes Towards Patient Advocacy

B) Opinion of Staff Nurses About the Preparation of Nurses To Act as Patient Advocates;

C) Biographical Information

PART II A

ATTITUDES TOWARD PATIENT ADVOCACY

Indicate your opinion regarding each of the following statements by selecting one of the six possible choices. To make your choice, circle one of the numbers which corresponds to the following list:

1.	Strongly Agree (STA)	4.	Disagree (D)
2.	Slightly Agree (SLA)	5.	Slightly Disagree (SLD)
3.	Agree (A)	6.	Strongly Disagree (STD)

	STA	SLA	A	D	SLD	STD
1. In my opinion, nurses are acting as patient advocates.	1	2	3	4	5	6
2. In my opinion, nurses are implementing the role of patient advocate as it should be implemented.	1	2	3	4	5	6
3. I am committed to acting as a patient advocate.	1	2	3	4	5	6
4. I think that other nurse are committed to acting as patient advocates.	1	2	3	4	5	6
5. I am comfortable acting as a patient advocate.	1	2	3	4	5	6
6. I think that other nurse are comfortable acting as patient advocates.	1	2	3	4	5	6
7. In my opinion, nurses who advocate on behalf of their patients are supported by their peers.	1	2	3	4	5	6
8. Among all the roles that they assume, I believe that nurses give patient advocacy a high priority.	1	2	3	4	5	6
9. I believe that when the term patient advocate is used to describe a patient role, it is understood in the same way by all nurses.	1	2	3	4	5	6
10. I feel prepared to act as a patient advocate.	1	2	3	4	5	6
11. I think other nurses are prepared to act as patient advocates.	1	2	3	4	5	6

PART II B
OPINIONS OF STAFF NURSES ABOUT THE PREPARATION OF NURSES TO ACT AS PATIENT ADVOCATES

1. Do you think that nurses should be aware of patient advocacy as a role for nurses? (Circle one)

a. Yes **[Go to Item 2]** b. No **[Go to Item 3]** c. I Don't Know

[Go to Item 3]

2. Which of the following, if any, do you think should contribute to making nurses aware of patient advocacy as a role for nurses? (Circle **three**, no more, that are most important.)

a. Basic nursing education
b. Post basic nursing education
c. Graduate nursing education
d. Inservice programs conducted by employer
e. Workshops or conference not conducted by employer
f. Nursing literature
g. Other nurses
h. Public media
I. Nursing supervisors
j. Other members of the health team
k. Experience
l. Professional nursing organizations
m. None of the above

Go to Item 3

3. Which of the following, if any, have contributed to your awareness of patient advocacy as a role for nurses? (Circle **three**, no more, that contributed most.)

a. Basic nursing education
b. Post basic nursing education
c. Graduate nursing education
d. Inservice programs conducted by employer
e. Workshops or conferences not conducted by employer
f. Nursing literature
g. Public media
h. Nursing supervisors
I. Other nurses
j. Other members of the health team
k. Experience
l. Professional nursing organizations
m. Advocacy needs of patients
n. This questionnaire
o. I was not aware
p. None of the above

Go to Item 4

4. Do you think that nurses should learn how to be patient advocates? (Circle **one**.)

a. Yes [**Go to Items 5&6**] b. No [**Go to Item 7**] c. I Don't Know [**Go to Item 7**]

5. How do you think that nurses should learn to act as patient advocate? (Circle **three**, no more, that are most important.)

a. Attending lectures
b. Reading articles and books
c. Talking with other nurses
d. Watching other nurses
e. Following directions
f. Through experience
g. Receiving positive acknowledgement for acting as an advocate
h. Role playing

6. I believe that in order to be adequately prepared to act as patient advocates, nurses should learn about: (Circle **three**, no more, that are most important.)

a. their own values.
b. differing value systems.
c. individual differences.
d. moral principles.
e. the legal system.
f. human rights.
g. government policies.
h. communication skills.
I. channels of communication.
j. none of the above

Go to Item 7

7. Which of the following, if any, helped you learn to act as a patient advocate? (Circle **three**, no more, that were most helpful.)

a. Lectures attended while a student
b. Workshops and/or conferences
c. Articles and books
d. Talking with other nurses
e. Talking with non-nurse health care workers
f. Watching other nurses
g. Following directions
h. Acting as an advocate
I. Receiving positive acknowledgement for acting as a patient advocate
j. Role playing
k. I have not learned how to act as a patient advocate
l. None of the above

Go to Item 8

8. Since your most recent graduation from a formal educational institution (basic, post-basic, or graduate education), have you read anything on the topic of the nurses' role as patient advocate? (Circle **one**.)

a. Yes **[Go to Items 9&10]** b. No **[Go to Item 11]** c. I Don't Know **[Go to Item 11]**

9. Since your most recent graduation from a formal educational institution (basic, post-basic, or graduate education), how many years and months has it been since you last read anything on the topic of the nurses' role as patient advocate? (Count 12 months as one year.)

_____ Years and _____ Months

10. With reference to **Item 9**, what was the type of material you read? (Circle as **many** as apply).

a. Books
b. Popular magazine articles
c. Newspaper articles
d. Articles from nursing journals

Go to Item 11

11. Since your most recent graduation from a formal education institution (basic, post-basic, or graduate education), have you attended any information sessions on the topic of patient advocacy? (Circle **one**.)

a. Yes [**Go to Item 12**]
b. No [**Go to Part II - Section C**]
c. I Don't Know [**Go to Part II - Section C**]

12. What type of information session did you attend regarding patient advocacy? (Circle as **many** as apply.)

a. Course offered by an educational institution
b. Inservice presentation offered by employer
c. Workshop, conference, or seminar not offered by employer

Go to Part II - Section C

PART II C

BIOGRAPHIC INFORMATION

Instructions

Now that you have shared your opinions about patient advocacy with me, I am interested in knowing something about you. The information you give me about yourself will be useful in reporting the results of the study. Remember that you are not asked to reveal your name and that all information is anonymous.

Read each item carefully and circle the letter(s) that correspond with the best response(s).

1. Employing Agency: (Circle **one** only.)

   a. Active Treatment Hospital (Specify type of Unit) _____
   b. Rehabilitation Convalescent Hospital
   c. Extended Care/Auxiliary Hospital
   d. Psychiatric Hospital
   e. Nursing Home
   f. Home Care/Visiting Care Agency
   g. Business/Industry
   h. Physician's Office/Family Practice Unit
   I. Educational Institution
   j. Public Health Agency
   k. Other (please specify) _____

2. Gender:

   a. Female b. Male

3. Educational Background: (Circle as **many** as apply).

   a. RN Diploma
   b. Basic Baccalaureate Degree in Nursing
   f. Master's Degree in Nursing
   g. Master's Degree in another discipline (Specify)

c. Post Basic Baccalaureate Degree in Nursing

d. Baccalaureate in another discipline (Specify) _____

e. Post RN Certificate in a nursing specialty

h. Doctorate Degree in Nursing

I. Doctorate Degree in another discipline (Specify) _____

4. Total number of years of experience as a nurse after graduation from **basic** (initial) nursing program: (Full-time and permanent part-time position only.)

a. 1 year
b. 2 years
c. 3 years
d. 4 - 5 years
e. 6 - 10 years
f. > 10 years

5. Does your employer have any written policies regarding patient advocacy? (Circle **one.**)

a. Yes [**Go to Item 6**]
b. No [**Go to Item 7**]
c. I Don't Know [**Go to Item 7**]

6. If your employer has written policies regarding patient advocacy, how familiar are you with your employer's written policies regarding patient advocacy? (Circle **one.**)

a. Very familiar
b. Somewhat familiar
c. Not familiar

Go to Item 7

7. Does your employer have any written policies regarding the nurse's role as patient advocate? (Circle **one.**)

   a. Yes **[Go to Item 8]**

   b. No **[Go to Item 9]**

   c. I Don't Know **[Go to Item 10]**

8. If your employer has written policies regarding the nurse's role as patient advocate, how familiar are you with them? (Circle **one.**)

   a. Very familiar

   b. Somewhat familiar

   c. Not familiar

   Go to Item 9

9. Have you ever acted as a patient advocate? (Circle **one.**)

   a. Yes b. No c. I Don't Know

Please feel free to make any additional comments on the topic of patient advocacy that you wish.

Turn to last page

APPENDIX B

Letter of Permission to use the QPANR

476 Ronning street
Edmonton, Alberta
T6R 1Z3

April 25, 1993

Violet Ruelokke
P.O. Box 5692
St. John's, Newfoundland
Canada A1C 5W8

Dear Violet:

Further to our recent telephone conversations, you have my permission to use my survey tool, *Questionnaire On Patient Advocacy As A Nursing Role*, in your research for your master's thesis. In addition to acknowledgement of my work, I would appreciate a copy of your study when it is completed.

I have enjoyed speaking with you and sharing ideas. If I can be of further assistance, please do not hesitate to call again. Good luck with your thesis!

Sincerely,

Camille Romaniuk

APPENDIX C

Nursing Autonomy/Patients' Rights Questionnaire

General Instructions

Please read each of the items on this questionnaire and respond to them as requested. While you are responding to the items, please remember that there are no correct answers, and that you are being asked to express your opinions and ideas because they are important in assisting others to understand how you feel about this aspect of nurses' role in patient care. There is no way that your participation in this study can be identified.

PART I

NURSING AUTONOMY/PATIENTS'

RIGHTS QUESTIONNAIRE

Indicate your opinion regarding each of the following statements by selecting one of the six possible choices. To make your choice, circle **one** of the numbers which corresponds to the following list:

1. Strongly Agree (STA)
2. Slightly Agree (SLA)
3. Agree (A)
4. Disagree (D)
5. Slightly Disagree (SLD)
6. Strongly Disagree (STD)

		STA	SLA	A	D	SLD	STD
1.	I feel patients should plan their own activities.	1	2	3	4	5	6
2.	I've fulfilled my responsibility when I report a condition to a doctor.	1	2	3	4	5	6
3.	I'd feel free to try new approaches to patients' care without the "permission" of an administrative nurse.	1	2	3	4	5	6
4.	I feel free to recommend nonprescription medication.	1	2	3	4	5	6
5.	If I requested a psychiatric consult for a patient, I'd feel out of bounds.	1	2	3	4	5	6

		ST A	SL A	A	D	SL D	ST D
6.	I believe a patient has a right to have all his questions answered for him.	1	2	3	4	5	6
7.	If I'm not satisfied with the doctor's action, I'd pursue the issue.	1	2	3	4	5	6
8.	I'm the best person in the hospital to be the patient's advocate if he disagrees with the doctor.	1	2	3	4	5	6
9.	If a patient is allowed to keep a lot of personal items, it becomes more trouble than it's worth.	1	2	3	4	5	6
10.	I don't answer too many of the patient's questions because the doctor may have another plan in mind.	1	2	3	4	5	6
11.	I feel the doctor is far better trained to make decisions than I am.	1	2	3	4	5	6
12.	I'd never call a patient's family after discharge.	1	2	3	4	5	6
13.	Patients shouldn't have any responsibility in a hospital.	1	2	3	4	5	6
14.	Patients should be permitted to go off their units and elsewhere in the hospital.	1	2	3	4	5	6
15.	If a patient asks why his medication is changed, I'd refer him to his doctor.	1	2	3	4	5	6
16.	If a policy change affects patient care, I want to understand why the change is necessary.	1	2	3	4	5	6
17.	Patients should be encouraged to show their feelings.	1	2	3	4	5	6
18.	I should be able to go into private practice (like a doctor's) if I wish.	1	2	3	4	5	6
19.	I feel patients should be told the medications they're taking.	1	2	3	4	5	6
20.	I should have a right to know why a change is necessary before it's accepted.	1	2	3	4	5	6
21.	Patients should be told their diagnoses.	1	2	3	4	5	6

		ST A	SL A	A	D	SL D	ST D
22.	If I make conversation with the patient, there's no need to explain procedures and treatments before they're started.	1	2	3	4	5	6
23.	I generally know more about the patient than the doctor does.	1	2	3	4	5	6
24.	Patients in a hospital have a right to select the type of treatments of care they wish.	1	2	3	4	5	6
25.	If I disagree with the doctor, I keep it to myself.	1	2	3	4	5	6
26.	I feel the patient has the right to expect me, as a nurse, to effectively use my time in improving my skills by taking advantage of educational opportunities offered.	1	2	3	4	5	6
27.	I'd feel comfortable authorizing a patient to leave the unit to go to another part of the hospital.	1	2	3	4	5	6
28.	The patient has a right to expect me to regard his personal needs as having priority over mine.	1	2	3	4	5	6
29.	I feel the patient has a right to refuse care.	1	2	3	4	5	6
30.	It should be the doctor who decides if the patient can administer his own drugs.	1	2	3	4	5	6
31.	I'd never refuse to carry out a doctor's order.	1	2	3	4	5	6
32.	I feel patients should be informed about what constitutes quality health care.	1	2	3	4	5	6
33.	The patient has a right to expect me to accept his social/cultural code and to consider its influence on his way of life.	1	2	3	4	5	6
34.	Patients should be permitted to wear what they want.	1	2	3	4	5	6
35.	I'd never interact with a patient on a first-name basis.	1	2	3	4	5	6
36.	I rarely give in to patient pressure.	1	2	3	4	5	6

		ST A	SL A	A	D	SL D	ST D
37.	Nurses should be held solely legally, responsible for their own actions and shouldn't expect to come under the umbrella of the doctor or hospital in a malpractice suit.	1	2	3	4	5	6
38.	Doctors must decide what nurses can and cannot do in the delivery of health care.	1	2	3	4	5	6
39.	It's the nurse's prerogative to decide whether or not to wear a uniform.	1	2	3	4	5	6
40.	I'd give the patient his diagnosis if he asks.	1	2	3	4	5	6
41.	It should be the nurse's decision when to talk to the terminally ill patient about his condition.	1	2	3	4	5	6
42.	I think it's my responsibility to initiate public health referrals on patients.	1	2	3	4	5	6
43.	I feel I should suggest to patients, family, and doctors any community resources I know are available.	1	2	3	4	5	6
44.	Patients can expect me to speak up for them.	1	2	3	4	5	6
45.	I'd never ask a patient about his or her sexual life.	1	2	3	4	5	6
46.	I'd talk very little to patients about their pasts.	1	2	3	4	5	6
47.	I rarely ask a patient a personal question.	1	2	3	4	5	6

APPENDIX D

Letter of Permission from the NLNU

NEWFOUNDLAND AND LABRADOR NURSES' UNION

P.O. BOX 416 - ST. JOHN'S, NEWFOUNDLAND - A1C 5J9 - TELEPHONE (709) 753-9961 - 62
TOLL FREE 1-800-563-5100
FAX (709) 753-1210

To: NLNU Members

The Newfoundland & Labrador Nurses' Union is pleased to assist in conducting a study that will investigate whether nurses in this province feel empowered to be patient advocates.

Nurses are taught to be patient advocates by acting on behalf of their patients in health related matters and have been identified as the most appropriate professional for patient advocacy.

Unfortunately, nurses receive many mixed messages in carrying out this very important role.

This advocacy role can cause personal conflict for the nurse because it may jeopardize the relationship with the Employer. Nurses are advised to ensure that the obligation to the employer is not in conflict with the professional obligation to protect the public. This can be both extremely difficult and confusing for nurses.

The study, a Master's Thesis, is being conducted by Violet Ruelokke, a local registered nurse. Mrs. Ruelokke is a student in the Masters of Nursing Program at Memorial University of Newfoundland. Her Thesis Supervisor is Dr. Christine Way. The study will be carried out during the next few months. It will, for the first time in this province, give the nurse's view of patient advocacy and lay the groundwork for a better understanding and appreciation of patient advocacy.

Nurses are encouraged to participate in this study.

Sincerely yours,

_____

Joan Marie Aylward
Provincial President

/dmw

APPENDIX E

Cover Letters to Nurses

Dear Nursing Colleague,

I would like to introduce myself and explain the purpose of the enclosed Questionnaire. I am a Registered Nurse who practised in various positions in Newfoundland since my graduation. I am currently enroled in the Master's of Nursing Program at Memorial University of Newfoundland.

Because of my interest in the concept of the nurse as a patient advocate, I chose this issue as the topic of my thesis. You, and over 700 other nurses, have been randomly selected to participate in this study which is designed to investigate "Nurses perceptions of their empowerment to be patient advocates".

Your views are very important, and I am hoping you will assist me by completing and returning the enclosed Questionnaire. There are no correct or incorrect responses to the items on the Questionnaire. Your opinion, based on your own personal experience, is what I am seeking.

Your anonymity and confidentiality is assured. I have engaged an independent person who is a statistician, to assign an identification number to each name on the Newfoundland and Labrador Nurses Union membership list, and to randomly select a sample from the assigned numbers. Respondents will only be known to me in terms of a temporarily assigned number.

I am pleased that the Newfoundland and Labrador Nurses Union is endorsing this study in principle. I am making the results available to the Union with the hope that it will be valuable to them and to others interested in the practice of nursing. Little attention has been given to nurses' views about advocacy. It is anticipated the results will give a meaningful picture of how nurses view their ability to deal with the complex issue of patient advocacy in this province, at a time of increasing consumer interest and economic restraint.

Please return the completed Questionnaire in the enclosed stamped, addressed envelope before August 20.

Thank you for your anticipated co-operation and assistance,

Sincerely yours.

Violet D Ruelokke

Violet Ruelokke

August 14, 1993

Dear Nursing Colleague,

Due to summer vacations the members of the Human Investigations Committee (which approves all research proposals from the School of Nursing of Memorial University) did not meet as scheduled. This has caused a delay in mailing the enclosed questionnaire to you. It also means the return date has changed. I previously requested you return it by August 20. I am now requesting you return it by September 10, 1993.

Please remove the cover letters, the questionnaire cover and, if you have not used the last page for your comments, that page as well, before returning the completed questionnaire in the enclosed stamped addressed envelope.

With renewed thanks for your anticipated co-operation and assistance,

Sincerely yours,

Violet Ruelokke

APPENDIX F

Letter of Approval Human Investigation Committee

Memorial
University of Newfoundland

Human Investigation Committee
Office of Research and Graduate Studies (Medicine)
Faculty of Medicine, The Health Sciences Centre

August 18, 1993

Reference #1252

Ms. Violet D. Ruelokke
P.O. Box 5692
St. John's, NF
A1C 5W8

Dear Ms. Ruelokke:

At a meeting of the Human Investigation Committee held on August 12, 1993, your application entitled **"Nurses' Perceptions of Their Empowerment to be Patient Advocates"** was considered and approval recommended.

We take this opportunity to wish you every success with your research study.

Sincerely yours,

H. B. Younghusband, Ph.D.
Acting Chairman
Human Investigation Committee

cc: Dr. K. M. W. Keough, Vice-President of Research
Dr. Christine Way, Supervisor