Strengthening the Nurse's Role as Patient Advocate

by Susan Hackler Fetsch and Mary K. Mintun

Frequently nurses are called upon by situations, patients and other health care professionals to intervene when issues of health care ethics arise. As an agent in health promotion and by acting as an advocate to assure the patient's autonomy and power, the nurse is a vital link between patients and the decision making process. Many nurses however, do not confidently and/or willingly participate in these situations, yet most nursing curricula contend to teach critical and ethical decision making skills. This article will discuss the nurse's role as advocate, implications of nursing education in ethics and subsequent implementation in the service area. Proposed resolutions to such problems as communication barriers, confidence in one's ability and position, power and conflict will be addressed.

Health care as currently practiced is undergoing radical change in the way individuals and groups obtain and pay for health care services. The rise of consumerism and challenges by various rights movements make it likely that health care reform will include a consumer-driven system featuring individual responsibility for health care behaviors, illness prevention and health promotion.

In concert with this consumer interest, the individual will have increased responsibility to participate in decision making; that is, to be aware of available choices and to act on those choices. Patients seek health care expertise because they do not have the knowledge, skill, resources or power to resolve a problem on their own (Purtillo and Cassel, 1981). Such vulnerability, the absence of support and lack of what is needed and wanted (Copp, 1986), reduces the patient's capacity for self-determination. Because of physical, emotional and financial stressors, patients need assistance from health care professionals to balance the cost-benefit ratio of decisions against the patient's own beliefs, values and resources (Sullivan and Decker, 1992).

Patients are no longer satisfied passively receiving care, but want to participate actively in decisions affecting them. Reform of this kind requires more than legislation regarding access and affordability. It demands attitudinal shifts replacing the traditional, paternalistic relationship of patient and doctor with a shared decision making relationship between the consumer and the health care team (physicians, nurses, chaplains, social workers and allied health workers). Such a transition of power in health care will bring about an expanded role for patient advocates and will call for new values to be incorporated through health care education, administration and professional socialization.

Nurses as Patient Advocates

Nurses are frequently called upon by patients, families and, at times, other health care professionals to intervene as patient advocates. A nurse's role entails that he or she will come into contact with many people who are unable to exercise self-determination in treatment decisions due to their vulnerability, illness, impaired ability or age. As an agent in health promotion and by acting as an advocate to assure the patient's autonomy and power, the nurse is a vital link between the vulnerable patient and the decision making process.

An example illustrates the importance of advocacy in the clinical setting for facilitating the patient's involvement in decision making. Peter, an 11-year-old child diagnosed with Wilm's tumor, was hospitalized on a pediatric school-age unit to receive antibiotics through an infusaport (an im-

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planted central venous access device) for an infection related to chemotherapy. The physician wrote orders for the nursing staff to obtain a timed antibiotic level directly from the child's vein to assess the effectiveness of the therapy. Knowing how Peter hated to be stuck by needles, other nurses had avoided collecting the specimen for the previous two shifts. The child's nurse, Karen, however, questioned the physician regarding the order for direct venous access, which would involve the child being stuck with a needle. The physician informed Karen that because she was concerned that previous antibiotic levels obtained from the indwelling access port had not been accurate, she believed that direct venous access would provide the necessary information to adjust the antibiotic dosage.

Knowing Peter's fear of needles, Karen entered his room and explained that she would need to obtain a sample of his blood and that it would involve a needle stick. Peter protested and said, "No way. You're not going to . . . I want to talk to the doctor!" Acknowledging the child's concerns, Karen responded to his request saying, "That's fine. You have every right to talk to the physician yourself about this." As a result, Karen paged the physician, explained the situation again, and then had Peter talk directly to the physician. "I'm running out of veins," Peter cried, "and don't want to be stuck! I don't understand why you have to stick me if I have a port!" The physician listened, respected the child's concerns, and ended up concurring with Karen that the sample could be obtained from the access device using the appropriate collection technique.

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This nursing intervention, while not dramatic, takes into account respect for patient involvement in clinical decision making. Karen empowered Peter—vulnerable and powerless as a result of his illness and age—to achieve his desired end by facilitating communication with the physician. Although this decision may not seem important in the broader scope of Peter's problems, avoiding a needle stick was paramount to him at that particular point. In addition, this type of participation in decision making helps prepare the child for active involvement in more critical issues.

The American Nurses Association *Code for Nurses* articulates the standards of practice for guiding the nurse's commitment to advocacy:

> As an advocate for the client, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practice by any member of the health care team or the health care system, or any action on the part of others that places the rights or best interests of the client in jeopardy (American Nurses Association, 1985, 7).

This commitment requires participation in highly personal matters such as quality of life and death, liberty and rights. Kosik (1972) described patient advocacy as ". . . seeing that the patient knows what to expect and what is his right to have, and then displaying the willingness and courage to see that our system does not prevent his getting it" (694). Karen demonstrated her commitment to advocacy by her intervention for Peter.

Nurses have traditionally acted on behalf of patients, redistributing power and resources (Brower, 1982). Indeed, nurses are well-suited for the advocacy role because they are people

> . . . who could take the time to explain a patient's rights to him or her, and to whom the patient would feel comfortable asking questions or making needs known. Health professionals who have considerable patient contact may be in an excellent position to function as patient advocates (Purtillo and Cassel, 1981, 131).

This does not imply that only nurses are able to be patient advocates. However, Peter's situation, where he found confidence and trust in the relationship with his nurse, shows how nurses can facilitate inclusion in the decision making process.

While other nurses ignored his wishes which ultimately could have harmed Peter by failing to obtain the diagnostic information necessary for appropriate treatment, Karen chose to intervene and assist the child's participation in his care. Yet other nurses would have forcefully restrained him to obtain the sample based on their perceived obligation to the "physician's order," without critically examining available options and their impact on the patient as an individual.

If nurses are to empower patients through advocacy in the health care setting, it is important to look at factors that facilitate advocacy. In an interview about this situation, Karen said that she be-

came involved in the child's cry for help because she believed it was her professional responsibility to "bridge the gap between the patient and physician." She also believed that the chronicity of his disease and familiarity with the health care system helped to educate Peter about his options.

Several distinctive factors contributed to the favorable outcome for this child. First, Karen's basic education included an introduction to critical thinking and bioethics. Second, the practice setting supported the nurse's advocacy role through its mission that the treatment of children (patients in general) be based on humanistic values such as caring, autonomy and equality. In addition, the practice setting provided ongoing education that related ethical issues and nursing responsibilities within its humanistic framework. Finally, to assure optimal patient care, the relationship between the physician and nurse was collegial, working as a team without territorial boundaries.

Reform of Nursing Education and Practice

The remainder of this paper will offer recommendations for how nursing education and health care administration can prepare and support nurses to change processes that do not contribute to optimal patient care. In 1993, the National League for Nursing (NLN), the American Association of Colleges of Nursing (AACN), and the American Organization of Nurse Executives (AONE) developed position statements for nursing education reform. Each organization has suggested that along with the federal initiative for health care reform, schools of nursing need to re-examine their missions of education, research and service. With expanding technology and the potential for nursing's role to change dramatically, nursing education and practice must prepare to train nurses who can function effectively in an ever-changing and diverse environment. In such a climate, nurses must be able to discern clinical and ethical issues and find appropriate resolutions through critical thinking skills, pattern recognition and innovative response (Gould and Bevis, 1992; NLN, 1993). For example, while the nurse appreciated the clinical importance of the child's treatment needs, she also recognized the issue of patient rights in treatment decisions.

The explosion of technology, plus a health care system that will increasingly focus on the delivery of care at preventive and community levels through health promotion and maintenance, have necessitated that the traditional approach to nursing education be altered. Specifically, the current content-driven, behaviorist paradigm focusing on technology and technique must be replaced by a concept-driven curriculum that includes critical thinking, ethical decision making, and professional socialization (AACN, 1993; Gould and Bevis, 1992; NLN, 1993). These issues will be discussed below, including implications for education and practice.

Currently, neither nursing education nor the health care environment truly supports nurses' use of the proposed skills. Although the rhetoric of nurse academicians includes ideals of advocacy, autonomy and assertiveness, the traditional nursing academic structure does not support the development of these skills. In fact, the approach most common in nursing education today leads students to passively accept that (a) the teacher is the authority; (b) students can be dominated easily; and (c) the status quo can be maintained (Gould and Bevis, 1992). If graduate nurses are to communicate with other health care professionals as effective members of a coordinated health care team, students must share power with faculty and be encouraged to engage in activities that facilitate critical thinking and professional socialization. Such activities could include argumentation and debate, ethnographic experiences that enhance the ability to elicit, comprehend, analyze and evaluate the perceptions of health care consumers, structured controversy, and ongoing discussion of ethical issues, principles, and resolutions (AACN, 1993; Gould and Bevis, 1992; NLN, 1993; Pederson, 1992; White, Beardslee, Peters and Supples, 1990).

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Development of critical thinking skills must incorporate learning activities related to ethics offered in an environment that supports autonomous thinking and student-initiated change. Frequent group discussions of live moral issues, as well as opportunities for role modeling in dealing with ethical dilemmas, can facilitate learning (Cassells and Redman, 1989). Traditionally, most baccalaureate students enroll in a basic didactic philosophy course early in their college career. However, in most cases this classroom experience is not accompanied by clinical exposure that would enhance application of theoretical principles to everyday practice.

Because empowerment for self-determination is grounded in a recognition of autonomy and respect for individuals, a strong foundation in liberal arts and sciences is required. Nursing professionals, administrators and educators should demand beginning entry into practice at the baccalaureate level. Health care will increasingly require appreciating the interdisciplinary impact of psychological, philosophical, sociological, economic and biological forces on individual welfare. Capstone seminar courses that use collaborative interdisciplinary problem-solving experiences can generate mutual respect for the unique qualities each discipline possesses.

The presence of nurses who are willing to intervene as patient advocates is most often found in environments where nursing leadership values patient rights. To foster such an environment, health care managers need to determine their own values, demonstrate respect for staff, and foster an expectation of quality patient care. In this way a healthy, ethical practice setting can prosper. The necessary resources and support can be provided through staff education, ethical rounds, consultation and ethics committees.

A decentralized and participatory system of nursing management encourages autonomy and active decision making. However, as patients become more empowered, conflicts may arise when patients make decisions based on information provided by a health care professional that do not support the care plan developed by other team members. In such situations nursing leadership must offer support.

Active patient involvement in decision making may cause conflicting loyalties and subsequent employment risks. A nurse who fails to intervene on behalf of the patient risks acting unethically (ANA, 1985). However, the nurse who fails to follow a physician's orders may also experience employment risks. These risks can result in employment loss or in more subtle difficulties such as non-cooperative working relationships with physicians. Generally speaking, however, the nurse's role as patient advocate will be supported by the institution if nurses meet patient needs and are accountable and responsible in doing so (Becker, 1986).

Within the current health care structure, the relationships between physicians and nurses and the responsibilities assigned to each group imply unequal decision making capacity. For too long, nurses and physicians have been engaged in a "game" to protect the physician's authority to make all suggestions and decisions (Stein, 1967; Stein, Watts and Howell, 1990). The early women's rights movement changed the nurse-physician relationship, thereby adding conflict and confrontation. An adversarial relationship was found in practice and education arenas, leading to management programs that focused on assertiveness training, conflict resolution and empowerment of the female nurse. It is time that both nurses and physicians view their roles as collegial, bringing expertise and background that complement one another's efforts to produce optimal patient outcomes.

Nurses tend to avoid physicians who convey a superior attitude. In addition, fear of not being right or having less knowledge than the physician have been described as barriers to patient advocacy (Fetsch, 1991; Stein, 1967). At the same time, nurses do not always take the responsibility to be available and to participate in patient care conferences that can facilitate decision making.

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Many opportunities exist to improve nurses' ability and willingness to collaborate with other health care professionals and support patient involvement in health care. Through mission statements and staff orientations, administrators can promote the view that patients should be treated as persons, not as diseases or treatment modalities; and, consequently, patients should interact with the health care team as treatment decisions are made. Further, as nurses enter the service arena, an expanded orientation should be offered that includes not only skills, technique, policy and procedures, but also accentuates the nurse-patient-physician relationship in terms of communication, ethics and decision making. For example, it has been reported that some form of ethics is included in the orientation of only 33 percent of nursing graduates (Cassells and Redman, 1989). Therefore, ongoing staff development, including recognition of moral issues and decision making models, should be available to provide additional support and education in the ever changing health care environment.

Another way to facilitate critical thinking, decision making and professional socialization of the graduate nurse is to offer paid internship programs in cooperation with education and service. Through such internships, graduate nurses could work with experienced nurses who, presumably, would have

insight into decision making, empowerment and working relationships with other health care professionals.

Further, patient benefits would also result from experienced nurses actively participating in patient care conferences, ethics committees, and committees which set policy and procedures. Joint practice committees could support the notion that health professionals make equally significant contributions in the health care system. While institutions must provide the resources necessary for nurses to participate in and assume leadership roles on these committees, nurses themselves must take the initiative to secure these opportunities.

Conclusion

As was the case with Peter and Karen, nurses are frequently called upon to intervene as patient advocates when issues of health care ethics arise. However, many nurses do not confidently or willingly participate in these situations, although most nursing curricula claim that they teach critical thinking skills, ethical decision making, and professional socialization. This article has discussed the need for increased emphasis in these areas and the implications for nursing education and subsequent implementation in the service area. The NLN, AACN and AONE have developed position statements for nursing education reform. Each organization has suggested that the federal initiative for health care reform will require schools of nursing to re-examine their missions of education, research and service. With growing technology and the potential for nursing's role to change drastically, nursing education and practice must work together to ensure that graduate nurses are competent to carry out the ethical responsibilities mandated by professional standards and by patient involvement in health care decisions.

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