

ABSTRACT

ANALYSIS OF HOW STUDENTS LEARN PATIENT ADVOCACY

By Lori Dehnke

A descriptive research design was used to explore how students learn the patient advocacy role in the bachelor of science in nursing (BSN) program at a public college of nursing (CON) in the Midwest. Previous research primarily had focused on defining patient advocacy. The next step is to explore how student nurses learn patient advocacy roles, since nurses are in a pivotal position to provide information and support for patients in the fast-paced health care setting.

With Institutional Review Board (IRB) and CON approval, questionnaires were provided to all last-semester BSN senior nursing students to explore student thoughts and methods of how they have learned the patient advocacy role throughout their school career. Areas of focus for the study included: (a) students' definitions of patient advocacy; (b) first experiences with advocacy in nursing; and (c) patient advocacy learning experiences in lecture, clinical lab, clinical areas and their personal lives.

Data analysis created an awareness of some ways in which students learn the advocacy role. Themes from student definitions of patient advocacy were: (a) standing up for patient rights and wishes, (b) nursing as a voice, and (c) patients' best interests. Students identified areas of direct nursing care that assisted learning patient advocacy: (a) clinical rotations, (b) working as a certified nursing assistant (CNA) at a hospital or nursing home, and (c) in their personal lives as family or they themselves had exposure and experience in the health care setting. Indirect patient care experiences students identified were: (a) lecture, (b) class discussion in lecture and through case study analysis, (c) skills learning lab, and (d) discussion in clinical with students/instructors.

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by

Lori Dehnke

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APPROVAL

Rafaela H. Kuehner PhD Advisor

August 4, 2008 Date Approved

PROVOST
AND VICE CHANCELLOR

Laura E. Ems

8/14/08
Date Approved

FORMAT APPROVAL

Gloria Splittgerber

7/27/2008 Date Approved

This paper is dedicated to my daughter, Megan. Through hard work and her support my dream of teaching has happened. I would like to thank Dr. Roxie Huebscher, my clinical advisor, for all her support.

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CHAPTER I

INTRODUCTION

Patient advocacy is an essential component of the nursing process. Nurses and health care professionals define patient advocacy as the process of informing and supporting patients with their health care choices. (Bu & Jezewski, 2006; Foley, Minick, & Kee, 2002; Hanks, 2005; Mallik, 1997). Questions of how nurses learn the patient advocate role remain unanswered. Research to date focuses on defining patient advocacy rather than on the process of learning it (Altun & Ersoy, 2003; Bu & Jezewski; Curtin, 1979; Kohnke, 1982; Mallik, 1997). The purpose of this study was to discover how students learn patient advocacy as a senior level, bachelor of science in nursing (BSN) student.

Nurses have led the way for patient rights. Historically, patient advocacy was exemplified by Florence Nightingale's striving to create a safe, clean hospital for soldiers in the Crimean War. In 1896, standardization of care in the public health sector, hospitals, and in nursing education facilities led to the formation of the American Nurses Association (ANA). The ANA began creating standards of care through documents such as the Code of Ethics, which was revised in 1976 to include patient advocacy as a part of nursing (ANA, 1976). Currently, provision three in the Code of Ethics for Nurses states, "The nurse promotes, advocates for and strives to protect health, safety and rights of the patient" (ANA, 2005, p. 1). Identification of the advocacy role by the ANA illustrates the significance this role has in the health care system.

Dramatic technological advances are changing the way medical care is provided. Internet access allows the population at large to have a glimpse of potential treatments,

with no accommodations for their co-morbidities. Also, the possible outcomes of such treatments are not individualized, providing a false sense of hope for a positive outcome. Advancing and changing technology is a natural part of everyday medicine; however, patients and families often have minimal understanding of treatment consequences or outcomes (Becker, 1986). Lynn (2005), writing in a *Hastings Center Report*, provides a realistic look at the changing health care system: “The great success of modern medicine has been to transform acute causes of death into chronic illnesses” (p. S14). Complex medical terminology, treatment and insurance regulations leave patients and families searching for more understandable information, explanations and a caring and compassionate side of medicine.

The caring aspect of health care is being replaced with a business orientation (Bu & Jezewski, 2006; Becker, 1986; Curtin, 1979; Foley, Minick & Kee, 2000). Time constraints, advanced technology and increased complexity of care is creating an impersonal and distant treatment environment. Lynn (2005) writes: “Few initiatives have started to alter the dysfunctional financial incentives that favor medical, surgical, and pharmacological interventions over reliability, continuity, and comprehensiveness” (p. S18). This creates unrealistic expectations and outcomes for patients and families, since treatment choices often are not tailored to an individual patient.

Poor communication, time constraints, business orientation and provider discomfort in discussing both aggressive and palliative treatment and outcomes also perpetuate the problem, making patients feel they need to choose aggressive treatment or they will not be supported by the health care system (Rady & Johnson, 2004). The most aggressive treatment is not without costs for providers and patients. Health care dollars may be spent needlessly, since clarification of patient values and wishes may not

be obtained prior to treatment. Nurses are in the best position to be advocates and mediators between patients and health care team members. This communication and mediation among the health care team, as well as knowing patient values may assist a patient's movement through the health care system in an efficient, timely manner as well as ensure proper utilization of the system (Gaylord & Grace, 1995).

Patients older than 65 frequently view the physician as the expert, accepting whatever physicians prescribe as treatment (Mallik, 1997). Awareness of these patients' values and wishes is vital for providing patient-centered care. The nursing presence provides confidence and support, and assists in patient and families understanding of health care interactions as physicians spend less time at the bedside, but provide complex information. A personal account witnesses an example: The researcher's grandmother, 80 years old with many co-morbidities, was provided with only one treatment option, that of a coronary artery bypass graft (CABG) for 80% stenosis of her left main coronary artery. There was no discussion of medical rather than surgical management for the condition, or her wishes for end-of-life care. Yet, when the researcher spoke with her, she stated she did not want the surgical treatment offered by her physician; however, surgery was the only treatment the physician presented. Upon further discussion with the doctor, the researcher conveyed the grandmother's wishes for no surgery. The doctor acknowledged this information, stated the risks of not having surgery and stated he would follow her treatment medically.

A rather grim understanding of this data is expressed by Lynn (2005):

Most Americans will grow old and accumulate diseases for a long time before dying. Our health care system will cleverly supplement the body's shortcomings, making it possible to live for years "in the valley of the shadow of death," fearing

not only death but also all sorts of evil from the regular dysfunction of our health care and social systems (p. S14).

Physicians often continue aggressive treatment since that is what is expected. Also, discussion of end-of-life care is often avoided due to the physician's discomfort (Boyle, Miller, & Forbes-Thompson, 2005; Mueller, Hook, & Fleming, 2004). From this perspective, technology seems pushed upon patients. An example of this comes from Moran and Pouya (2004), both internal medicine physicians: "Resuscitation protocols have changed, eventually requiring CPR, regardless of underlying illness for all patients experiencing cardiac arrest" (p. 15). With such a description, one can sense the fear experienced by patients with chronic illnesses and the desperation felt by nurses who know potential outcomes of treatments.

Thus, learning patient advocacy is appropriate and necessary at the nursing undergraduate level in college; however, minimal nursing research exists to guide nurse educators in the process of how students learn patient advocacy. Advocacy is a broad, complex concept to teach students (Jones, 1982). Care must be taken to instill and solidify the values needed to fulfill this role. Jones (1982) elaborates on the components of her advocacy framework in which the nurse:

Is an intermediary for the client, ...bolster[s] individual independence..., [emphasizes]client uniqueness..., assist[s] her client in coping..., must be able to articulate on a practical as well as a theoretical level [as a team member], and creates through her actions, on behalf of the client, new patterns of health care delivery that are based on principles of client-centered care (pp. 41-42).

Frequently, learning the patient advocacy role is done by trial and error, meaning time and experience is needed for student learning (Foley et al., 2002). Expanding a

theoretical basis and developing evidence-based methods for teaching and learning patient advocacy may have an impact for nursing educators, students, employers and most importantly, patients.

Research Question

How do students learn patient advocacy in a BSN program?

Definitions of Terms

Conceptual Definitions

Senior student nurse: College student enrolled in a CON, who is completing his/her final semester before graduation.

Patient advocacy: "A process or strategy consisting of a series of specific actions for preserving, representing and/or safeguarding patient rights, best interests, and values in the health care system" (Bu & Jezewski, 2006, p. 103).

Process of learning: "A process of understanding, clarifying and applying the meanings of the knowledge acquired (Billings & Halstead, 2005, p. 232).

Operational Definitions

Senior student nurse: Student who has been accepted into the nursing program, meeting all the requirements of the CON, and in his/her last level in the nursing program in a CON.

Patient advocacy: Defined by the student.

Process of learning: The steps of gaining knowledge or skills in the area of patient advocacy that will enhance knowledge and potentially change behavior.

CHAPTER II

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

The Sphere of Nursing Advocacy model (SNA) is a combination of work from three nursing philosophers: Curtin, Gadow and Kohnke (Hanks, 2005). Curtin's (1979) human advocacy model, Gadow's (1980) theory of existential advocacy and Kohnke's (1982) functional model of patient advocacy, provide a vivid explanation and image of nursing advocacy (Hanks). Bu and Jezewski (2006) advanced nursing advocacy through the development of a mid-range theory, utilizing the philosophical works from Curtin, Gadow, Kohnke, and Fowler who developed the social advocacy model. Fowler's social advocacy model incorporates the political side of advocacy, which works for social change and assists in decreasing the inequities of health care (Fowler, 1989). The mid-range theory by Bu and Jezewski (2006) defined patient advocacy as: "A process or strategy consisting of a series of specific actions for preserving, representing and/or safeguarding patient's rights, best interests and values in the health care system" (p. 104). Unique yet symbiotic relationships exist among the philosophers' models.

Curtin's (1979) human advocacy model is based on nurses' common humanity with patients. Illness can reduce the patient's independence and autonomy since the patient must seek outside assistance to deal with illness. Advanced technology and rushed health care provider visits have the potential to make patients feel that they are merely objects who are being treated or acted upon. These constraints do not allow for adequate time to assess the patient's understanding of treatment choices and obtain their wishes for care. Curtin's model represents the nurse as establishing a working

relationship with the patient. This relationship identifies and protects the patient's humanity and uniqueness (Curtin, 1979). The model is not focused on the legal aspects of patient rights, but rather the ability of the nurse to protect and support patient's values.

Gadow's (1983) theory of existential advocacy is based on the patient's right of self-determination. In Gadow's theory, advocacy is defined as a: "Moral commitment to enhance patients' autonomy and ... [provide] assistance to patients in giving voice to their values" (Gadow, 1989, p. 535 and p. 541). Through advocacy, nurses assist patients to find clarity about their health care and life choices while remaining steadfast in their own (patients') values. In this theory, nurses focus on the patient as a total person, incorporating a wide range of patient values. Constant adjustments and modifications are made in the patient's care due to lived experiences of the patient.

Kohnke's functional model of patient advocacy states, "Individuals have the right to self-determination" (Kohnke, 1982, p. 1). Nurses assist the patient in self-determination through information and support of their decisions. The patient advocacy role requires that the nurse have proper education and the attributes to make the role be effective. These attributes are: "Open mindedness and a broad knowledge of people, society and social order" (Kohnke, 1982, p. 315).

Permission to use the SNA model was granted by R. G. Hanks (personal communication, July 13, 2008) (Appendix A). The SNA model incorporated the theories of Curtin, Gadow and Kohnke by utilizing a grounded theory analysis of three acute care cases from Hank's personal experience in nursing. Through careful analysis, themes emerged from the data to form the following assumptions:

1. Clients need advocacy when they are unable to advocate for themselves.
2. Nurses need to advocate for clients.

3. Nurses should not doubt their actions when advocating for clients.
4. Nurses should not allow prejudices to interfere with advocating for clients.
5. Nurses should allow clients to self advocate when clients are able to do so.
6. Nurses should provide a sphere of advocacy for the client (Hanks, 2005, p. 76).

Through the analysis and formulation of assumptions, a better understanding is derived of the SNA model. As depicted in Figure 1, the SNA model is formulated with the client as the center of the model. The nurse provides a protective shield when needed as the patient interacts with the environment. If no shield is needed, the patient freely interacts with the environment independently through the pores or openings in the sphere (Hanks, 2005). From this model, the patient advocacy needs are dynamic and ever-changing, just as is the nurse-patient relationship.

Application to Theoretical Framework

The SNA model, incorporating a visual diagram of patient advocacy, lends itself to full utilization in the nursing profession, both in practice and student use. The SNA model depicts professional nursing values: altruism, autonomy, human dignity, integrity and social justice by placing the patient in the center and allowing them to freely interact within the environment, while protecting patient's rights and wishes, when needed. The SNA assumptions, as previously listed, remind nurses and students of the importance of being supportive of patients, providing a careful watch to ensure patient wishes and values are respected, rather than the nurses' or other health care team members values.

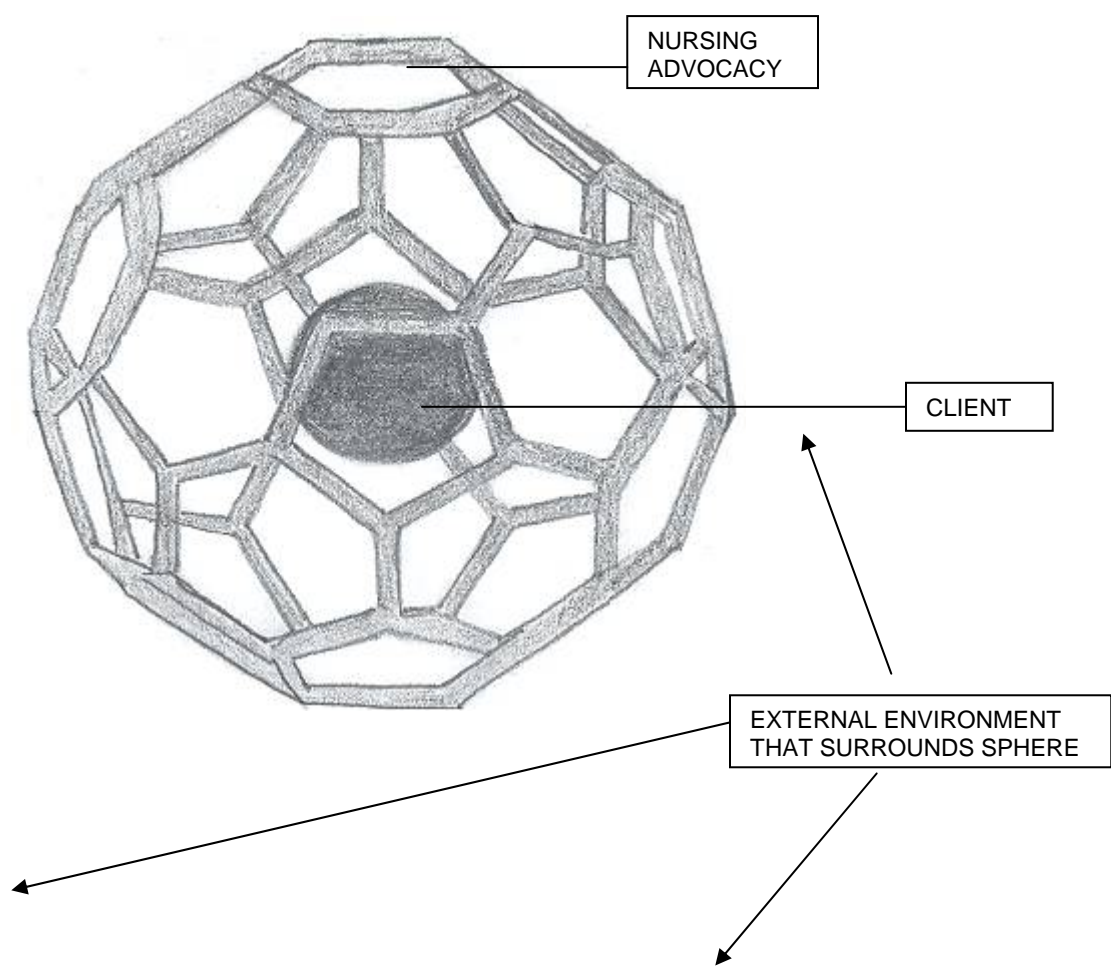


Figure 1. Sphere of Nursing Advocacy Model.

The concepts in the SNA model are the patient, the nurse and the external environment surrounding the patient or sphere. Nurses are vital in the SNA model, since they provide the “semi-permeable sphere” around the patient, allowing patients to interact with the environment if they desire (Hanks, 2005, p. 76). Utilization of the SNA model provides student nurses with a visual picture and summary of how patient advocacy is utilized in each patient interaction. Student nurses can use this model as they progress through school, learning and experiencing the basic foundation for advocacy in lecture and discussion groups, clinical lab and the hospital clinical setting.

Nursing students need the opportunity to experience, share and clarify their thoughts, feelings and values as they progress through their education. Study areas to advance value clarification include legal and ethical courses to create students' awareness of their own values that must be controlled and monitored as patients interact within the health care system. With increased knowledge and exposure to the concept of patient advocacy, students will be able to grasp the importance of patient advocacy rather than using what they think is good for the patient or paternalistic control of situations (Foley et al., 2002).

Becker (1986) informally surveyed 18 nursing students to illustrate the need for increased training in patient advocacy. When asked, all eighteen nursing students saw themselves as patient advocates; however, only 2 of the 18 surveyed felt they had the ability or autonomy to carry out this role. Both students who felt able to carry out this role were involved in the community setting, the rest were in the hospital setting (Becker, 1986).

In summary, patients are in the center of the sphere of patient advocacy and nurses provide a protective shield between patients and the external environment.

Learning patient advocacy as a student nurse is a vital part of the five core values of altruism, autonomy, human dignity, integrity and social justice that the profession of nursing holds.

Review of Literature

Introduction

Clarity in defining patient advocacy related to the nursing profession is needed; as well as the process of learning patient advocacy. For student nurses, learning the patient advocacy role is a complex process that has not been defined clearly.

Researchers agree that the advocacy role is essential for nurses to incorporate into their practices; however, numerous definitions and interpretations of this role have contributed to confusion of learning exactly what the advocacy role is (Altun & Ersoy, 2003; Bu & Jezewski, 2006; Snowball, 1996; Willard, 1996).

Proper education in the patient advocacy role is a serious undertaking, which should not be assumed as just another role nurses must perform (Kohnke, 1982).

Improper implementation of the advocacy role can be detrimental to both patients and nurses. Patient's independence and self-esteem may be at risk if the nurse makes an assumption of knowing the patient's needs and wishes (Mitchell & Bournes, 2000).

Without support and education, nurses may experience frustration and even burnout in attempting to learn and use the advocacy role.

Definition of Patient Advocacy

A simple and broad definition of the advocacy role is provided by Kohnke (1982), who stated the main role of an advocate is to inform and support the patient in their health care decisions. Curtin (1979) uses a philosophical approach by incorporating a

human advocacy model to explain the advocacy concept. The model focuses on human being similarities. Due to this common bond of humanity, all patients deserve to be treated with great respect and caring (Curtin, 1979). Similar to Curtin's theory of human advocacy model, Gadow (1983) defined the patient advocacy concept as the patient's right to self-determination. Patients deserve the right to choose treatments for themselves based on an informed decision (Gadow, 1983). Gaylord and Grace (1995) agree and advance the advocacy concept into a requirement for the nursing profession. They state, "Advocacy for nursing stems from a philosophy in which nursing practice is the support of an individual to promote his or her own well-being as understood by that individual" (Gaylord & Grace, 1995, p. 18).

In contrast to model development, O'Conner and Kelly (2005) reported "bridging the gap" between patients and a health care member was the prominent outcome of their research in defining the patient advocacy role (p. 463). These bridges are made as nurses support and educate patients as they move within the health care system.

Reasons for Advocacy

Patient Vulnerability

Patient vulnerability is often described as the predominant reason for developing the patient advocacy role (Becker, 1986; Foley et al., 2000/2002; Mallik, 1997; O'Conner & Kelly, 2005). In Ireland, using nursing focus groups to explore the perceptions of nurses' views of reasons for patient advocacy, O'Connor and Kelly reported patient vulnerability as a main theme of their study. Reasons for this vulnerability were that illness compromises the physical ability of patients to care for themselves and that patients have a knowledge deficit related to the medical system and technology (Foley et al, 2000; O'Conner & Kelly, 2005). Willard (1996) reports, in a concept analysis of

advocacy, when presented with illness, patients often relinquish power and control of their own health. In addition, disparities in income, education levels, language barriers, or implications of medical diagnosis lead to patient vulnerability (Bu & Jezewski, 2006).

Protecting Patient Values

In Bu and Jezewski's (2006) mid-range theory of patient advocacy, protection of patient values and choices revealed three core attributes for advocacy: "Safeguarding patients' autonomy; acting on behalf of patients; and championing social justice in the provision of health care" (p. 108). Similarly, when interviewing forty-three military nurses during an overseas peace keeping mission, Foley et al. (2000) reported that safeguarding patients and patient values became a part of whom they were as nurses. From this pattern of safeguarding patients, several themes emerged: "...protecting, ... attending the whole person...being the persons' voice...preserving personhood" (Foley et al., 2000, pp. 500-502). Foley et al. (2000) go on to write, "...perhaps advocating is becoming increasingly important in a dehumanizing, impersonal, and profit-driving health care system" (p. 505)

In a qualitative study by Snowball (1996), respecting patient values, rights, and allowing patient decision making were shared by the many participants; however, the researcher reported that nurses who participated in the study, often went beyond many of these descriptions of advocacy. These nurses had moved beyond basic advocacy and were focusing on the patients as the main center of all care. Also, these same nurses were found to have a high professional identity and knowledge in patient care (Snowball).

Consumerism and Patient Rights Movement

Patient rights have been an issue in nursing starting with Florence Nightingale. She writes that medicine provides a treatment oriented approach to disease; whereas, nurses assist each patient to identify what is best for them and then plans nursing interventions (Nightingale, 1860/2007). Careful assessment of each patient is needed to fully understand health care needs and wishes.

The rise in consumerism and the self-care movement provided momentum and expansion for the advocacy role in nursing (Becker, 1986). Highly educated consumers and/or patients may be skeptical of prescribed medical treatments and request or demand an active role in their healthcare (Becker, 1986). However, even the highly educated consumer at times is challenged by the fast paced, highly technical health care system and media promotion.

The American Hospital Association (AHA) Patient's Bill of Rights was developed in 1973 to assist and protect patient rights as an outcome of this consumerism (AHA, 1973). This Bill of Rights also allows for the protection of other populations, such as the elderly or mentally ill, who are challenged by the complex health care system. Shortly after the development of the Patient's Bill of Rights, the ANA's 1985 Code for Nurses with Interpretive Statements provided the nursing framework for protection of patient advocacy and rights.

Gaylord and Grace (1995) state that patient rights are merely a part of patient advocacy in nursing. They view advocacy as a requirement for patient care since, "Failing to advocate is synonymous with failing to practice well" (Gaylord & Grace, 1995, p. 13). Furthermore, practicing well in nursing is: "The support of an individual to

promote his or her own well-being as understood by that individual” (Gaylord & Grace, p. 18).

Professional Identity

Throughout the history of the profession of nursing, professional identity can be strongly linked to patient advocacy (Gaylord & Grace, 1995; Kohnke, 1982; Wheeler, 2000). Nurses are the champions of the sick and those who are unable, or unwilling, to speak for themselves. Nurses help “bridge the gap” between the health care system and the patient (O’Conner & Kelly, 2005). Patient advocacy is: “An ethic of practice” (Gaylord & Grace, p. 11).

In contrast to humanism, Mallik (1998) has reported from interviews with nurse leaders that nurses may be trying to advance their own professional nursing identity by laying claim to the advocacy role. With this new role, increased authority and autonomy may be gained (Hewitt, 2002; Mallik, 1998; Willard, 1996).

Currently, many nurses may lack support from administrators and physicians who may suppress the ability of nurses to act as advocates (Bu & Jezewski, 2006). In order for nursing to claim such a role, clarity in the definition and function of the advocacy role is needed.

Rather than the nursing profession claiming the advocacy role as their own, nurses in the research conducted by Snowball (1996) reported all members in the health care arena were valued and had equal consideration in patient care, making the patient the main focus. Uniting with other healthcare providers allows for a stronger influence on the bureaucracy of the health care system by the nursing profession (Snowball, 1996).

Negative Effects of Patient Advocacy

Advocating for patients is not without its risks or perils. Awareness of legal and ethical boundaries regarding disbursement of information and potential treatment options to patients must be fully understood by nurses. The ANA code of Ethics (2005) states: "Each nurse has an obligation to be knowledgeable about the moral and legal rights of all patients to self-determination" (p. 8). However, the nursing profession may not have the in-depth legal knowledge, autonomy, or support from institutions to fully carry out the legal patient advocacy role (Wheeler, 2000; Woodrow, 1997). Lack of legal knowledge for nursing is also supported by Priest, Carter-Kookken, Ealey, Holmes, and Hufeld (2007) as they write: "Most BSN students enter into practice without the foundational legal education necessary for safe and effective practice, let alone more sophisticated nursing functions such as advocacy" (p. 36). Closely tied to the legal aspects is the duty to first and foremost uphold the patient's values and wishes. Conflict may arise from a misunderstanding between patient and nurse or from the nurse's values being imposed upon the patient (Wheeler, 2000).

Nurses who actively participate as a patient advocate by speaking against the health care system have the potential to be ostracized by physicians and other staff (Bu & Jezewski, 2006). Questioning an order or treatment, even though advocating for patients, may be viewed as being insubordinate or a "troublemaker" by physicians (O'Conner & Kelley 2005; Wheeler, 2000; Woodrow, 1997). Also, negative effects from the advocacy actions may result in bad publicity and financial loss for the organization. In the worst case scenario, job loss or relocation can occur for nurses involved in highly controversial patient advocacy roles (Becker, 1986). This negativity and fear of reprisal

when advocating for patients may lead to silence or passive advocates who do not fully support patients.

Role strain or even moral distress was found to exist when staff had repeated unsuccessful attempts in the advocacy role (Sundin-Huard & Fahy, 1999). This qualitative study utilized unstructured interviews from a sample of 10 Australian critical care nurses to search for improved methods of nursing support for patient advocacy between the physician and organization (Sundin-Huard & Fahy). The researchers found that repeated efforts to advocate for patients with a self-perceived negative outcome can lead to moral distress or even burnout (Sundin-Huard & Fahy). The study indicated three possible paths of action when advocacy is unsupported: anticipate negative effects and do nothing, potentially leading to moral distress; use of covert nursing actions to advocate which perpetuated the doctor-nurse game; and direct confrontation, which in the study, showed unsuccessful results and also increased moral distress (Sundin-Huard & Fahy). The study did not elaborate on prior teaching about or awareness of patient advocacy that the nurses had experienced.

Learning Patient Advocacy

Methods of learning patient advocacy are often derived from work and life experiences making it: "Context based: that is nurses take different actions to advocate for patients in different clinical situations" (Bu and Jezewski, 2006, p. 103). However, with patient needs becoming increasingly more complex, other methods are needed to help student nurses and even practicing nurses become more familiar with the advocacy role. Researchers are beginning to become aware of the benefits of more ethics study, and experiencing the advocacy role through preceptorship or discussion (Kohnke, 1982). In a 4-year longitudinal study of nursing students in Turkey, Altun and Ersoy (2003)

reported advocacy traits can be learned and enhanced through the study of nursing ethics. Their study utilized questionnaires centering on patient's rights that were given to students in their first year of nursing school and then again in their 4th year of school. During the 4 years, nursing ethics was a common thread throughout the program. Overall, scores indicated students had learned more about patient rights, which is part of the advocacy role (Altun & Ersoy, 2003).

Development of the characteristics of being an advocate, as described earlier, will assist nurses and students as they learn the advocacy role. Narrative stories and experiences allow student nurses to actively engage in discussion of situations involving advocacy (Foley et al., 2002). These narratives will help create an awareness of the advocacy role as well as the ethic of care in nursing (Foley et al., 2002)

In contrast to learning patient advocacy as a new concept, Beckett, Gilbertson and Greenwood (2007), report that students have the relational awareness of patient advocacy that needs to be fostered and developed along with their technical skills as skills develop. Researchers gathered data from fourth-semester nursing students, who while applying principals of cultural safety submitted a two-part-reflective essay on the nurse-patient relationship. Students were acutely aware of their novice status in the technical aspects of nursing. These same students indicated an increased awareness of providing holistic patient care, by taking the time to understand the experiences from a patient's perspective: "Doing the right thing was clearly a concern; it was not only thought of simply in terms of clinical skill, but also, included preserving patients' dignity, protecting their rights and caring for them in profoundly meaningful ways" (Beckett et al., p. 32).

Knowledge and Confidence

Research has identified a clear sense of self-identity, confidence, therapeutic communication skills, and the ability to carry out the advocacy role in the health care setting as a common link to learning patient advocacy (Becker, 1986; Foley et al., 2002; Mallik, 1997; Snowball, 1996). Learning and development of these skills is vital to establishing a foundation for practicing the patient advocacy role.

Expertise in the clinical setting and ability to negotiate the health care system are a theme in the study by O'Conner and Kelly (2005). Along with expertise and knowledge, confidence in one's self and one's abilities as a nurse is paramount to the advocacy role. In a phenomenological study about how nurses learn advocacy, Foley et al. (2002), interviewed 62 active army and Army Reserve nurses. Results indicated having a strong sense of self, or knowing ones own values, is a major component to learning the patient advocate role. Other study results by Foley et al. (2002) indicated that confidence is gained by: watching others utilize the advocacy role in a positive manner, having a supportive mentor when one is new nurse, and ongoing discussions of the advocacy role. The majority of the participants stated that caring values were established early in life and became an innate part of their lives. Reinforcing this data, Becker (1986) discusses the need to know oneself or have self-advocacy, in order to be able to advocate for others.

Knowledge of and exposure to the legal ramification of advocacy was a method to supplement students' learning studied by Priest et al. (2007). In the study, sophomore II students were provided information about legal issues in their foundation in nursing course. Students posted questions on the internet the night before class; these were forwarded to a nurse attorney to answer. This interaction allowed exposure to the legal

side of nursing and collaboration of disciplines. Study results indicated students welcomed the interaction and gained much knowledge in the basic legal aspects of nursing and the advocacy role (Priest et al.).

Therapeutic Patient Interaction

Studies have identified that a therapeutic relationship is vital for the advocacy role (Bu & Jezewski, 2006; Beckett, et al., 2007; O'Conner & Kelly, 2005; Snowball, 1996). Through this trusting relationship, patient values and treatment choices are freely discussed and supported (Bu and Jezewski).

O'Conner and Kelly expand on the nurse-patient relationship to include the patient, nurse and all health care members, with the nurse bridging the gap among the members. Not only is communication important in nurse-patient relationship, it is vital among the health care team members (O'Conner & Kelly).

Summary

In summary, knowledge of learning the patient advocate role is at the beginning stages. Nursing staff are with patients 24 hours a day, 7 days a week and are supposed to support patient rights, human dignity and patient treatment choices. Advocacy actions benefit nurses as well as increasing a feeling of hope and personal satisfaction as they inform and support patients during their illness. In a broader sense, policy-making and human rights can be influenced through advocacy. Nurses seem to be in the best position in the health care system to advocate for patients.

Nursing students need to develop a basic knowledge of patient advocacy during their college years in order to enhance and expand their nursing skill and become competent practitioners. The literature supports learning ethics, therapeutic

communication skills, and developing a sense of self; however, the methods of learning patient advocacy are not definitive or guaranteed to enhance student learning. The importance of watching other nurses, faculty and health care members model the advocacy role also is vital to learning patient advocacy. This study explored how BSN nursing students learned the patient advocacy role.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this study was to explore how second semester senior nursing students learned the patient advocacy role.

Research Design

An exploratory design was used in this study. This design was appropriate because the process of learning patient advocacy as student nurses has little research data available. This design “provides an opportunity to examine all aspects of the problem” (Brink & Wood, 1983, p. 91). Exploratory studies help provide the data from which to build further studies. An attempt was made to discover what students know about advocacy and what factors influenced their learning patient advocacy.

Sample

Participants were students enrolled in a public college of nursing in the Midwest.

Participants met the following criteria:

1. Enrolled in the CON
2. Senior II level (prior to graduation in spring 2008)
3. Agreed to participate in the study

Sample Selection

A convenience sample of senior II nursing students in a Midwest CON was studied. All senior II students were given the questionnaire in a regularly scheduled class. This classroom method allowed for the complete senior II class (n= 66) to have

the opportunity to participate in the study in the most time-efficient manner. All students were in attendance per confirmation of the attending faculty.

Data Collection Instrument

After a literature review of patient advocacy, the researcher developed an open-ended questionnaire (Appendix B). The questionnaire contained seven questions in addition to a demographic sheet (Appendix C). The initial questions queried students' understanding of the concept of patient advocacy by asking for their individual definitions. Students were then asked about their first awareness and exposure to patient advocacy in their lives prior to starting at the CON. The remaining questions focused on lecture, clinical, and clinical lab at the CON that each student experienced. The demographic data included: age, sex, marital status, number of children, previous degree, race/ethnicity, current employer and if this employment is health-care related.

Data Collection Procedures

Approval was received from the University of Wisconsin Oshkosh Internal Review Board (Appendix D) and from the CON research committee.

To obtain permission to introduce and request volunteers for the study, the researcher submitted a study abstract, study information sheet (Appendix E), questionnaire and demographic sheet to the senior II faculty member. A brief presentation of the study's description, purpose and potential usefulness of data was provided. An information packet including a study information sheet, questionnaire, and demographic sheet were provided to all senior II nursing students in class. Students were instructed to read the information sheet, and complete the questionnaire and

demographic sheet if they chose to participate. Consent for the study was implied upon completion and submission of the questionnaire. Completed questionnaires were placed in an envelope and then in a sealed box in the CON office. This process allowed for complete student anonymity.

Data Analysis

The researcher completed data analysis by using interpretational analysis. Each questionnaire with demographic sheet was numbered to allow comparisons in the data analysis. The researcher reviewed all data, searching for themes and categories in each question and in the overall data. Once the first review was complete, the researcher reviewed the data again to verify the themes. Some answers fit into several themes. Then a general overview of the findings was developed, which allowed for data organization and presentation of results.

Study Limitations

The study was limited by time and a small number of participants. Student concentration and focus for completing the questionnaire may not have been adequate, since the students were approached after completing a 2-hour exam.

Open-ended questions provided very basic information and, after analysis, the researcher would have worded some questions differently. The questionnaire did not allow in-depth exploration for some answers that were provided. However, the questionnaire allowed for a moderate amount of students to participate, which provided a basic knowledge for future studies.

Representation was with a fixed group, obtained from only one senior class in one CON, making it difficult to generalize to other students. The majority of the students were female with only three male students participating. One student was Caucasian/Asian; all others identified themselves as Caucasian.

CHAPTER IV
FINDINGS AND DISCUSSION

Sixty-one students (92%) of the total 66, second semester senior students answered the questionnaire. Demographic data included ages and genders (Table 1), marital status (Table 2), number of children (Table 3), previous degrees (Table 4), and employment (Table 5).

Table 1

Ages and Genders

<i>n</i> = 61					
Age	Male		Female		Percent
	Number	Percent	Number	Percent	
21	0	0	4	6.90%	
22	0	0	25	43.10%	
23	1	33.33%	14	24.14%	
24	0	0	4	6.90%	
25	0	0	1	1.72%	
26	0	0	1	1.72%	
28	1	33.33%	0	0	
29	0	0	2	3.45%	
32	1	33.33%	0	0	
33	0	0	1	1.72%	
34	0	0	1	1.72%	
35	0	0	1	1.72%	
42	0	0	1	1.72%	
43	0	0	1	1.72%	
46	0	0	1	1.72%	
51	0	0	1	1.72%	

Table 2

Marital Status

<i>n</i> = 61	Number	Percent
Single	53	86.89%
Married	6	9.84%
Divorced	2	3.27%

Table 3

Number of Children

<i>n</i> = 61	Number	Percent
0	54	88.52%
1	3	4.92%
3	1	1.64%
4	2	3.28%
Pregnant	1	1.64%

Table 4

Previous Degrees

<i>n</i> = 61	Number	Percent
None	56	91.80%
Bachelor of Arts Degree	1	1.64%
Associate Degree in Arts/Other	3	4.92%
Associate Degree in Health Information Management	1	1.64%

Table 5

Employment

<i>n</i> = 61	Number	Percent
None	6	9.83%
Student	2	3.28%
Service industry	5	8.20%
Intern	23	37.70%
CNA	18	29.51%
Hospital	5	8.20%
Bank	1	1.64%
Medical Technician	1	1.64%

Results and Discussion

As students wrote about learning patient advocacy, centrality of the patient was a dominant theme. Throughout the data, actions of being a patient advocate were expressed in student statements: “standing up for,” “providing the client with the best possible care,” “observing nurses model advocacy,” and “informing my patients and portraying their thoughts and feelings regarding their care.” Another student stated “realization of if we as nurses don’t advocate who will?” Bu and Jezewski (2006) support this theme in the development of a mid-range theory of patient advocacy. Similarly, Hanks (2005) uses the centrality of the patient as a main focus in the Patient Advocacy Model. With such a focus on the centrality and actions of advocacy, establishment of a therapeutic relationship is a subtheme while students learned and provided patient care.

Standing up for Patient Rights and Wishes

The first common theme which emerged from the data as students defined patient advocacy was standing up for patient rights and wishes. Students used terms such as “standing up for” (n= 12), “speaking for” (n=10), “defending” (n=4), or “looking out for/protecting” (n=6) patient rights and wishes in their advocacy definition. Students used standing up for their patient in a multidimensional aspect such as: “attention to patient needs, increasing quality of life and care, treatment choices, and mainly patient rights and wishes.” Hanks (2006) encompassed this definition in the Patient Advocacy Model, with the patient as a the center and the nurse as the filter around the patient protecting or assisting the patient as much or little as they need. Snowball (1996) reported protecting or being a patient representative in findings for novice nurses in their study of patient advocacy. As nurses gained knowledge and experience, they: “focused on the centrality of the patient and on a view of themselves as nurses having a high level of professional identity, knowledge, skills and confidence through which to enhance the patient care experience. Thus their understanding of advocacy appeared to be firmly grounded in a well articulated notion of professional nursing practice” (Snowball, p. 70).

Lack of Knowledge of Legal and Ethical Aspects of Patient Advocacy

Advocacy is not only protecting the patient but having a solid foundation in the profession of nursing. This foundation allows for an awareness of self-protection or standing up for oneself. Students had a focus for patient advocacy that was very limited. Although not directly asked, students did not identify awareness of their autonomy and legal ramifications of being a patient advocate. Lack of understanding is shown by the low number (n=10) of students who directly identified legal and ethical class as increasing their awareness of patient advocacy. This lack of understanding is also

shown in one student's statement, "acting on a patient behalf without considering your own person implications." No other reference was made to the potential legal ramification of patient advocacy.

Nursing as a Voice

The second theme that emerged from the student's definition of patient advocacy was being a "voice" for the patient (n=11). A good example of this was shown in a student statement, "Using your professional role and knowledge as an RN to represent your patient's needs to other members of the care team in order to achieve optimal patient outcomes" and "allow patients voice to be heard." Awareness of the importance of communication as a voice for patients also was mentioned by four students. Students (n= 4) noted the importance of an indirect voice for patients through communicating with the health care team and making the patient values and wishes known. These wishes then can be communicated by patient or RN. Willard (1996), Jones (1982) and Gaylord and Grace (1995) support the nursing profession as being part of a team and collaborating to provide maximum benefit to the patient. This collaboration focuses back on the main theme of the patient being the central focus of care. Increased patient time and contact hours place nursing in a position to learn more about the patient and their health care needs and wants in order to advocate for the patient to other health care team members (Sutor, 1993).

Patient's Best Interest

The third theme from students' definitions of patient advocacy is supporting the patient best interest as they journey through their illness and the health care system. Student answers use words such as "best interest of the patient" (n=13), "meeting the patient's needs and desires" (n=5), "quality care" is provided (n= 10) and "support for the

patient” (n=3). As established early, patients may have many difficulties in navigating through the health care system. Empowerment and support for patient health care choices and decisions is needed to assist them in making their needs known. Gadow (1983) and Kohnke (1982) support this definition since it is the patient who needs to make the decision.

Learning to support patients’ treatment choices good or bad must occur in a nonjudgmental manner for nursing students. Simple statements such as “making sure their needs are met and wishes are being carried out,’ and “making sure all patient needs are met” does not define necessarily, whether it is the patient’s or nurses best interest for the patient. For example, due to intense pain, coughing and deep breathing is not a patient’s choice or desire after abdominal surgery; however, it is in the best interest of the patient for nurses to push the patient in completing this task to prevent complications. Patients may not always make the choice that is “best” for them. A student’s awareness of this is shown by the statement, “Ensuring that the patient desires and needs are met in a manner that is therapeutic and acceptable by the patient.” Exposure to patient options and dealing with situations that may be your patient’s choice but not in their best interest may add difficulty or stress to the advocacy role (Jones, 1982; Sundin-Hurd & Fahy, 1999; Wheeler, 1999). Pushing or assisting patients in the chosen way from treatment would be viewed as paternalistic, even though it may seem correct to the health care provider. Students must develop knowledge and experience to differentiate when it is in the patient’s treatment pathway and best interest and when it is in the nurse or health care provider’s best interest for treatment. This delineation is not clear from data received.

Students' First Awareness of Patient Advocacy

Students listed first awareness of the patient advocacy role as being primarily in the classroom setting, specifically in a foundation in nursing class (n=49), which is in the second semester of their sophomore year after acceptance into the CON. This class introduces students to core nursing principles and values. One student remembered advocacy as being introduced in their freshman year during the introduction to nursing class, prior to acceptance into the program. Other students answered: "nursing school" (n=5) and "legal and ethical class" (n=3). Legal and ethical class is a senior-level class. In hindsight, the question could have been asked differently to allow for improved clarity in student answers.

Even though the majority of students learned of patient advocacy in the classroom, ten students first became aware of patient advocacy as follows: in a clinical setting (n= 6), as a CNA (n=2), and with personal health experiences (n=2). Two of these students commented on their answer by writing: "First really understood the concept in Junior II."

Even though patient advocacy may be a new concept to students, care must be taken to cultivate and redefine past and present knowledge of "standing up for" others and incorporating that knowledge into a nursing perspective of patient care (Foley et al., 2002). Individual student growth is gained through a broader perspective of life events, the health care system and the nursing process, which comes both from the classroom and the clinical setting (Jones, 1982).

In summary, there were a limited number of students (n=27) who recalled a specific experience or event of patient advocacy, such as CNA, nurse intern or personal experience that assisted with learning the concept of patient advocacy. Students also

wrote of indirect care learning experiences (n=15) such as classroom discussion and nursing stories about advocating for patients as a first experience with advocacy.

Regarding this question, students may have felt they had no experience, too many experiences to list, or they may have chosen not to answer, since some wrote that they had no first-time experience (n=13) in the school setting. A small number of students (n=6) left the question unanswered.

Learning Patient Advocacy

Direct Patient Care

Students used words such as “observing,” “experiencing” or “actually seeing” advocacy in the hospital setting as methods of learning in the clinical setting. Both good and bad examples of patient advocacy were experienced in the clinical setting, ranging from “observing the nurses in the nursing home advocate for clients” to “patient stories of poor treatment and advocacy issues.” Nearly two-thirds of the senior students (n=45) utilized direct interaction with patients, staff nurses, physicians, and other health care team members to expand their awareness and experience in patient advocacy. Of the 45 answers students provided, working as a team member and communicating the patient needs (n=18) and utilizing their knowledge learned in lecture and clinical lab (n=11) to gain more knowledge in patient advocacy were the primary focus of answers. Patient teaching (n=5), comfort measures (n=6), medication administration (n=2) and addressing patient concerns (n=3) were answers students gave regarding learning patient advocacy in a direct patient care area.

Being able to learn about and experience patient advocacy outside of the education setting provides students with “real” world experience. Working as a nurse intern (n= 23) or CNA (n=18) placed students in direct patient care areas for learning

patient advocacy. Student comments included: "Seeing the nurses in the nursing home I work at trying to accommodate the needs of patients and working to individualize care helped me get a good picture of patient advocacy" and "within the workplace, [having] seen job[s] done incorrectly and done steps to correct it for the good of [the] client."

Learning patient advocacy requires increasing experience and exposure in clinical settings. Foley et al. (2002) support this learning by writing: "Students are eager to learn and much of their learning in clinical situations comes from watching how registered nurses practice" (p. 185). Classroom and clinical experience are vital, yet learning outside the school experience provides increased methods to gain confidence in nursing skills and tasks. Enhancing student confidence is a major part in learning patient advocacy (Foley et al., 2002).

Students had direct experience and exposure to patient advocacy as family members (n=14) or they themselves (n=3) encountered illness or hospitalization. Student examples of this direct experience of patient advocacy from the consumer side included: "Assisting family to speak up to doctors to get treatment. I helped my mom get her much-needed knee replacements" and "seeing other nurses advocate for their patients when they know the [patient] did/didn't need something." Foley (2002) reports, "Nursing students must experience these concepts in order to internalize them" (p. 185).

Indirect Care

Indirect patient care, which is learning away from the clinical or hospital setting, was another method of participants learning patient advocacy. Lecture classes are a method for hearing and reading about patient advocacy. Students (n=20) listed a foundations in nursing class that assisted advocacy learning. Students also listed a junior adult health class (n=12), which utilized critical thinking and application of

knowledge while discussing case studies. Senior-level lecture classes such as aging (n=5), in which the elderly population is studied, mental health (n=1), research (n=1) and legal issues and ethics (n=8) enhanced their patient advocacy learning. Students listed methods such as class discussion (n=16) and instructors' stories (n=5) regarding advocacy to expand their awareness of advocacy in the health care setting. The classroom setting can also be an important method to clarify and define advocacy, rather than teaching advocacy as a new concept (Foley et al., 2002).

Learning nursing skills in the lab also presented ways of learning patient advocacy. Students learned from: medication administration (n=7), procedures (n=15), comfort/safety (n=4) and discussion while learning skills (n=9). Student comments included: "The lab instructors challenging us to think about what we would do to help a particular patient"; "When we learned procedures/skills (IVs, blood draws, Foleys, NG tubes) the instructor always discussed being a patient advocate"; and "Lab instructors would ask questions as we were performing skills on how to be a patient advocate."

Nineteen students felt minimal or no learning of patient advocacy had occurred in the clinical lab. Responses included: not stressed in lab/not aware of any (n=8), no experience (n=10), and one student who felt more time should be spent on learning advocacy. Seven students left the question blank.

Discussion outside clinical experiences with students and instructors came from pre/post-conference as well as when students had questions while providing direct patient care. Students described watching patients, physicians, RNs and other health care members interact while discussing treatment and patient concerns or wishes. Student comments included: "Through seeing nurses not advocate in clinical, I've learned more"; and "Observing how nurses model advocacy." Students then shared

these events and experiences in post-conference so other students learned from their experiences. Other opportunities for learning in the clinical setting occurred as student and instructor interacted either by “quizzing you on keeping patient’s best interest when caring for patients” to “[learning] different patient needs and ways to advocate for them.”

Summary

In summary, learning patient advocacy is a complex process that requires time and experience; students begin to learn and experience advocacy as they progress through college. Recognizing and defining the concept of advocacy is the first step. Students incorporated both direct and indirect learning experiences of patient advocacy.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary/Conclusion

As a student, learning patient advocacy can be a challenging task. Numerous definitions and concepts of patient advocacy exist making it difficult to focus student learning. Also, patient advocacy is context based: "Nurses take different actions to advocate for patients in different clinical situations" (Bu & Jezewski, 2006, p. 103). An exploratory design developed a basic knowledge and understanding of the how student nurses learn patient advocacy. Utilizing a convenience sample of last-semester senior nursing students in a Midwest CON, the researcher had students complete an open-ended questionnaire and demographic data sheet. The researcher analyzed data by searching for themes in order to begin exploring the learning of patient advocacy.

Study findings indicated that most students have begun to learn about the patient advocacy role. An overall theme was the centrality of the patient while providing care and medical treatment. Students defined patient advocacy as standing up for the patients' rights and wishes, nurses as a voice, and nurses providing care and support for the patients' best interest in their health care decisions. Beginning awareness of patient advocacy mainly started in the classroom through lectures, discussion, case studies, and nursing stories of advocacy. Even though there was not a predominant experience which assisted with learning patient advocacy, direct patient care in clinical and as a CNA assisted their learning. Watching, observing interactions of staff, physicians and patients, as well as directly caring for patients advanced their learning. Indirect patient care methods of learning patient advocacy included classroom learning through

discussion and personal stories, as well as personal experiences in the health care setting.

Implications for Nursing Practice

Humanistic care and refocusing time and energy on the patient are needed. This group of students emphasized the centrality of the patient as they provided care. This centrality is shown in the comment of several students who wrote: "Students are willing to take more time to figure out/do something for patients that the busy nurse may not want to or can not do" and "realization of, if we as nurses don't advocate who will?" The awareness and focus on the patient is needed in "a dehumanizing, impersonal, and profit-driven health care system" (Foley et al., 2000, p. 505).

Students identified areas where learning patient advocacy may occur: learning and gaining confidence in the nursing process by classroom lecture and discussion, and learning therapeutic communication skills, nursing skills, and experience in both the clinical lab and hospital clinical setting. However, student answers indicated no uniformity in learning the patient advocacy role.

Student identification of practicing and gaining confidence in their nursing skills as part of learning patient advocacy is needed. Knowledge and self-confidence are needed to actively advocate for patients. Decreased awareness of the importance of confidence in nursing skills was indicated by the number of students who did not feel they learned about patient advocacy in the clinical lab. A greater focus on "real-world" situations is needed in the clinical lab to increase students' critical thinking and confidence, rather than just a focus on learning steps in a procedure.

Limitations are set by institutions and health care providers. Students showed a lack of awareness of such restrictions and implications of patient advocacy role; whether from their lack of knowledge or the question wording. The majority of students wrote about doing what the patient desired; however, they did not express implications for themselves. As a novice nurse, wanting to do the right thing for their patient is beneficial; however, students must learn self-advocacy or taking care of themselves while at the same time doing the right thing for patients. This type of advocacy comes from gaining confidence in their nursing and critical thinking skills whenever the situation arises.

Lack of understanding and awareness of legal and ethical issues is indicated by the few students that referenced legal issues and ethics as a learning point for patient advocacy. Although time and experience are the best opportunity for learning, legal and ethical issues can be emphasized throughout classroom lecture and discussion and through personal experiences of instructors and students.

Recognition of students' individual views and definitions of advocacy will help them as they formulate their knowledge specifically for their nursing career. With a poor understanding of limitations and restrictions, students and nurses potentially may become dissatisfied or frustrated in the nursing profession.

Teaching Recommendations

Learning patient advocacy may not be a new concept, but exploring what students know and filling in the gaps is important. To reform or reframe what students already know and feel about being a patient representative or advocate is the challenge for educators. Class discussions and clinical experience may be enhanced by making a

direct referral to patient advocacy, since educators may indirectly teach advocacy skills. Continued exposure and experience is needed to increase student knowledge of patient advocacy, since to develop a full understanding of patient advocacy takes time and experience. This type of learning is enhanced by students who immerse themselves in nursing through becoming a CNA prior to or during nursing school. Also, experience as a nurse intern year allows students to be more exposed to and experience “real world” situations in patient advocacy. Instructors then need to draw from this knowledge of patient advocacy through discussion and clinical lab to increase all students’ learning with real-life situations and learning experiences. For those students who do not choose to work as CNAs, learning patient advocacy may be advanced through case studies or simulations.

Research Recommendations

Research is needed to probe further into the process of learning patient advocacy. Repeating the study would provide additional data related to how students learn patient advocacy. The questionnaire should be modified to include:

1. Define patient advocacy in the nursing profession.
2. While growing up, describe how you learned about advocacy.
3. When did you first learn about the patient advocacy role in nursing?
4. Describe a specific experience/event that increased your understanding of patient advocacy in nursing.
5. Describe and explain how experiences/events in the lecture portion of school increased your understanding/learning of the patient advocacy role.

6. Describe and explain how experiences/events in the clinical lab portion of school increased your understanding/learning of the patient advocacy role.
7. Describe and explain how experiences/events in the clinical setting portion of school increased your understanding/learning of the patient advocacy role.
8. Describe any other life events and/or personal experiences that have increased your understanding of the patient advocacy role.
9. What are the legal and ethical considerations when advocating for patients?
10. What are potential implications (positive or negative) of being a patient advocate as a nurse?

A few themes emerged from the data that need further definition and exploration.

Understanding and further discussion of what is meant by student statements of “standing up for,” “speaking for,” “being a voice,” or “the patients’ best interest” will help provide clarity on what students know about patient advocacy or have experienced. Also, learning what students meant by advocating prior to or during a procedure would expand understanding of student knowledge. This understanding can be gained by utilizing a focus group to explore how students define these terms and currently use them in their student nurse practice. Learning what students bring with them related to advocacy may provide building blocks to expand and refine this knowledge toward their nursing career. From this data, in-depth interviews and possibly a longitudinal study utilizing qualitative and quantitative research to discover the effectiveness of methods of learning and teaching patient advocacy can be initiated.

Learning advocacy is equated with gaining knowledge, confidence and skills in procedures and assessments to assist patients as they experience illness and journey through the health care system. The CON is able to provide a foundation for learning advocacy; however, as students graduate, orientation programs should include support for continued learning. Studies of various orientation programs are needed to provide graduates with optimal learning in the nursing profession, which includes patient and self-advocacy. Easing the transition from school to work may assist with job retention, satisfaction and increased patient advocacy skills.

With a better understanding of how students learn patient advocacy, focus can turn to methods educators and employees can use to teach, model and support methods of learning patient advocacy.

APPENDIX A

Permission to Use Sphere of Nursing Advocacy Model

From: rghanks@utmb.edu
To: bpositive10@hotmail.com; cooperconsulting@socal.rr.com
Date: Sun, 13 Jul 2008 15:37:14 -0500
Subject: RE: Re use of the Sphere of Nursing Advocacy Model

Dear Lori,

I am glad the model will be of use for your study. Please double check with Ms. Cooper about any copyright issues with Nursing Forum. If you don't mind, please let me know about the results of your study-I am very interested in hearing about it. My work email is rghanks@uta.edu<<mailto:rghanks@uta.edu>>

Take care,

Robert Hanks

COOPER CONSULTING

(cooperconsulting@socal.rr.com)

Sent:

Tue 7/15/08 5:52 PM

To:

Lori Dehnke (bpositive10@hotmail.com);
Hanks, Robert G. (rghanks@utmb.edu)

Cc:

nursing forum (nursingforum@gmail.com)

Dear Lori,

As long as Robert Hanks agrees, your request is acceptable under the publishing guidelines for Nursing Forum. Good luck with your work and please let us know the results.

Please note the nursing forum email address is changed to nursingforum@gmail.com

Sincerely,

Phyllis G. Cooper MN, RN
Editor, Nursing Forum

APPENDIX B
Research Questionnaire

Research Questionnaire

1. What is your definition of the patient advocacy role in the nursing profession?

2. When did you **first** become aware of the patient advocacy role in nursing?

3. Was there a specific experience/event that made you aware of the patient advocacy role in nursing?

4. Describe events/experiences in the **lecture** portion of school that increased your awareness/learning of the nursing patient advocacy role.

5. Describe events/experiences in the **clinical lab** at the university that increased your awareness/learning of the nursing patient advocacy role.

6. Describe events/experiences in the **clinical setting** in school that have increased your awareness and/or learning of the nursing patient advocacy role.

7. Describe any other life events and/or personal experiences that have increased your knowledge of the nursing patient advocacy role in nursing.

APPENDIX C
Demographic Data Sheet

Demographic Data Sheet

Age

Gender

Race/ethnic identity

Marital status

Number of children

Previous degree

Type of employment

Is type of employment health care related?

APPENDIX D

UW Oshkosh IRB Approval Letter



March 15,, 2008

Ms. Lori Dehnke
1681 Birchwood Dr.
Green Bay, WI 54304

Dear Ms. Dehnke:

On behalf of the UW Oshkosh Institutional Review Board for Protection of Human Participants (IRB), I am pleased to inform you that your application has been approved for the following research: Analysis of Learning Patient Advocacy.

Your research has been categorized as EXEMPT. This means you will not be required to obtain signed consent. However, unless your research involves **only** the collection or study of existing data, documents, or records, you must provide each participant with a summary of your research that contains all of the elements of an Informed Consent document, as described in the IRB application material. Permitting the participant, or parent/legal representative, to make a fully informed decision to participate in a research activity avoids potentially inequitable or coercive conditions of human participation and assures the voluntary nature of participant involvement.

Please note that it is the principal investigator's responsibility to promptly report to the IRB Committee any changes in the research project, whether these changes occur prior to undertaking, or during the research. In addition, if harm or discomfort to anyone becomes apparent during the research, the principal investigator must contact the IRB Committee Chairperson. Harm or discomfort includes, but is not limited to, adverse reactions to psychology experiments, biologics, radioisotopes, labeled drugs, or to medical or other devices used. Please contact me if you have any questions (PH# 920/424-7172 or e-mail:rauscher@uwosh.edu).

Sincerely,

A handwritten signature in black ink, appearing to read "Frances Rauscher".

Dr. Frances Rauscher
IRB Chair

cc: Roxana Huebscher
1258

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APPENDIX E
Information Sheet

UNIVERSITY OF WISCONSIN OSHKOSH
INFORMATION SHEET

Project Title: ANALYSIS OF HOW STUDENTS LEARN PATIENT ADVOCACY

Explanation of Procedures:

Lori Dehnke RN, graduate student of the University of Wisconsin-Oshkosh College of nursing is conducting a study of the patient advocacy learning process of senior nursing students. I would appreciate your participation in this study as it will increase awareness of the importance of student nurses learning patient advocacy. Also, this knowledge will benefit faculty and employers by defining what students know about patient advocacy and hence is needed to be taught.

As part of this study, I will ask that you complete a questionnaire. Subjective data, such as age, sex, race/ethnicity, and experience in the health care field (i.e., CNA, family or self chronic illness exposure) will be gathered in addition to the questions, and kept strictly confidential throughout the study. A questionnaire will be utilized to gather data regarding the process of learning patient advocacy as a student. Consent for the study is implied upon completion and submission of the questionnaire.

Risk and Benefit:

I do not anticipate that the study will present any medical or social risk to you other than the inconvenience of time required for the interview. Participation in the study may not directly benefit you, however, will benefit the nursing profession overall as described above.

Safeguards:

The information gathered through questionnaire and possible brief interview, will be recorded in anonymous form. I will not release information about participants in any identifying manner. Data, when not being used will be locked in a file cabinet.

Offer to answer inquiries:

Once the study is completed, results will be available. In the meantime, if you have any questions, please ask or contact:

Lori Dehnke
College of Nursing
UW Oshkosh
Oshkosh, WI 54901
920-424-1051

Third party referral: If you have any complaints about your treatment as a participant in this study, please call or write:

Chair, Institutional Review Board
For Protection of Human Participants
C/o Grants Office
UW Oshkosh
Oshkosh, WI, 54301
920-424-1415

Although the chairperson may ask your name, all complaints are kept in confidence.

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