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THE UNIVERSITY OF ALBERTA

PATIENT ADVOCACY: SURVEY OF NURSES' PERCEPTIONS

BY

CAMILLE JEWEL ROMANIUK

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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.....
Supervisor

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.....

Date : August 31, 1988

To

Gene, Karen, and Greg

You have been my inspiration

ABSTRACT

In recent years, there has been a proliferation of articles in the nursing literature on the nurse's role as a patient advocate. However, very little is known about how nurses who practice at the bedside view the topic. Therefore, a descriptive exploratory study was undertaken in which the perceptions of staff nurses regarding the nurse's role as a patient advocate were elicited. To collect the data, a questionnaire was developed and mailed to 200 registered nurses in Alberta who were randomly selected from among those nurses employed in full-time positions as staff nurses. A response rate of 60.5% was obtained. The questionnaire, which was comprised of forced-choice items and a Likert scale, elicited biographic data as well as opinions regarding patient advocacy as a role for nurses, the preparation of nurses to act as patient advocates, and the implementation of patient advocacy by nurses. Before the questionnaire was used, it was pilot tested on a sample of 20 staff nurses. Content validity of the questionnaire was established by basing each of the items in it on relevant nursing literature. The reliability of the Likert scale was determined by computing its Cronbach alpha coefficient. A coefficient of 0.845 was obtained. The data were analyzed using descriptive statistics, as well as analysis of variance when appropriate.

The respondents were of the opinion that nurses should act as patient advocates. While acknowledging that other health care workers also have an advocacy role to fulfill, they indicated that there is not a need for an individual in the health care system whose only responsibility is patient advocacy. The respondents indicated that basic nursing education programs and employers were responsible for informing nurses about their role of patient advocacy. According to the respondents, activities undertaken by nurse advocates include informing patients about the treatments and medications which they are receiving, speaking to others on behalf of the patient, and ensuring that patients' rights are met. Respondents with 6-10 years of experience expressed more positive attitudes than those with 1-5 years

toward patient advocacy as a role for nurses, and toward the implementation of patient advocacy by nurses.

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CHAPTER I

THE PROBLEM

Background To The Problem

In recent years the concept of patient advocacy has generated much interest among nurses. Winslow (1984) has written that "no other symbol has so captured imagination or won acceptance within nursing as that of advocate" (p. 37). The extent of nursing's interest in patient advocacy is evident by the proliferation of literature on the topic which has appeared in nursing journals since the early 1970s. Citing moral and legal obligations, the majority of authors maintain that patient advocacy is an important nursing function. Professional nursing organizations are echoing the message. In 1983, the Alberta Association of Registered Nurses (AARN) published guidelines designed to assist nurses in acting as patient advocates. In 1985, the Canadian Nurses Association (CNA) stated that "the nurse is obligated to advocate the client's interest" (p. 9).

The need for a patient advocate has emerged in response to several developments which have affected the delivery of health care. Since the beginning of this century, but particularly in the last 30 to 40 years, societal attention has focused on human rights. Such attention has given rise to the consumer movement which attempts to provide protection for individuals who purchase products or require services (Annas & Healey, 1974; Storch, 1977, 1978, 1980, 1982). Paradoxically, a concomitant development in the health care system has been an erosion of consumer interests with patients experiencing increased vulnerability, powerlessness and, ultimately, dissatisfaction. The dehumanization of health care services has occurred due to growing bureaucratization within the health care system resulting in a loss of individualized attention, and increasing technological sophistication resulting in the specialization of health services and the fragmentation of patient care.

Fueled by their sensitization to human rights, and the consumer movement, recipients of health care as well as health care professionals have recognized the need for an individual within the health care system who has the responsibility of maintaining patients' rights (Annas & Healey, 1974; Storch, 1977, 1978, 1980, 1982).

Coincident with the above developments in society at large and the health care system, the nursing profession is also undergoing changes. It is moving away from its heritage of obedience and loyalty to physicians and striving to become a fully autonomous profession (Winslow, 1984). The role of patient advocacy is attractive to nursing because it provides a venue for asserting professional independence at the same time that it provides a means for reinforcing commitment to the patient. Furthermore, nurses have always interceded on behalf of patients (Brower, 1982; Donahue, 1985; Fay, 1978; Nelson, 1988; Sklar, 1979). Therefore, the terminology may be new to nursing, but the function is not. Given today's health care system and consumer expectations, however, the nurse's role as a patient advocate is probably more complex than ever before, and it will likely continue to grow in complexity. Thus, new implementation strategies may be required. Before they are developed, the current status and implementation of the nurse's role as a patient advocate should be determined.

Statement Of The Problem

Patient advocacy has become an ideal which epitomizes the highest standards of the nursing profession. As an ideal, it is difficult to question, yet it appears that the nurse's role as a patient advocate is difficult to articulate and to put into practice. It seems, for example, that several nursing models of patient advocacy exist. Therefore, the role may not be universally understood or interpreted by nurses. In addition, it seems that there is a lack of nursing practice standards for the implementation of patient advocacy. As a result,

it may be difficult for nurses to ascertain how to act as patient advocates, or to identify and to evaluate advocacy actions. It also appears that nurses who do act as patient advocates receive little support from their peers, co-workers, and employers. In a celebrated case in the United States, nurse Tuma lost both employment and licensure when she acted as a patient advocate by informing a patient about different forms of cancer therapy (Tuma, 1977). That nurse Tuma's licensure was eventually reinstated by the supreme court of the state in which she was employed when she was dismissed only serves to emphasize the confusion and problems associated with understanding and implementing patient advocacy. Perhaps, as has been suggested by Miller, Mansen, and Lee (1983), nurses lack the power and authority to act as patient advocates. In spite of the fact that the nurse's role as a patient advocate may be somewhat nebulous, undefined and controversial, a commitment to patient advocacy has been expressed by professional nursing organizations and by authors in the nursing literature. It may be, however, that there is a discrepancy between nursing's ideal of patient advocacy and what nurses are actually able to do. If nurses are to act as patient advocates, and if they are to do so in a manner that is sensitive to the needs of patients and nurses, and to the context in which nurses work, the confusion and ambiguity surrounding the role must be clarified.

Significance Of The Problem

As long as ambiguity surrounds the nurse's role as a patient advocate, it is possible that the implementation of patient advocacy by nurses will remain fraught with difficulties. In addition, nurses may be poorly prepared to advocate on behalf of patients and they may be unaware of the standards to which they may be held accountable. It is also possible that meaningful dialogue among nurses on issues relating to the topic of patient advocacy may be impeded. As a result, nurses may be unable to present a united front to other health care

professionals and the public in articulating their unique role as patient advocates.

Purpose Of Research

The purpose of this study is to enhance understanding of the nurse's role as a patient advocate by augmenting theoretical formulations of the role with information from nurses whose practice involves direct patient care. Information regarding the nurse's role as a patient advocate from practicing staff nurses would provide a practical counterpoint to a subject which has been dealt with primarily at the abstract level. Such information may be useful in identifying the skills nurses require in order to advocate effectively on behalf of patients, and in providing direction to those who are responsible for educating and assisting nurses to implement patient advocacy. It may also provide the basis for further research on the topic.

Research Questions

The questions investigated by this study were as follows:

1) What are the perceptions of registered nurses practicing in Alberta as staff nurses regarding patient advocacy as a role for nurses?
2) What are the perceptions of registered nurses practicing in Alberta as staff nurses regarding the preparation of nurses to act as patient advocates?
3) What are the perceptions of registered nurses practicing in Alberta as staff nurses regarding the implementation of patient advocacy by nurses?
4) Do registered nurses who are practicing in Alberta as staff nurses differ in their perceptions about patient advocacy as a role for nurses, the preparation of nurses to

act as patient advocates, and the implementation of patient advocacy by nurses according to the following biographic characteristics: type of employer, educational background, years of nursing experience, and exposure to information on patient advocacy since most recent graduation from a formal educational institution?

Definitions Of Terms

Throughout this study the following definitions were used:

Registered Nurse: a nurse who has an active membership in the Alberta Association of Registered Nurses.

Staff Nurse: a nurse who provides patient care and who does not have administrative responsibilities for other employees.

Assumptions

An assumption which underlies this research is that staff nurses are at least cognizant of patient advocacy.

Summary

In this chapter, it has been suggested that the implementation of patient advocacy by nurses, and the preparation of nurses to act as patient advocates, may be adversely affected by ambiguity surrounding the nurse's role as a patient advocate. In addition, several aspects of a study of the nurse's role as a patient advocate which was undertaken by the writer were also presented. A review of the relevant literature is presented in the following chapter.

CHAPTER II

LITERATURE REVIEW

The literature review which is presented in this chapter has been organized into several sections. The review begins with a discussion of the ways in which patient advocacy has been defined or described in the nursing literature. Subsequent sections focus on the need for a patient advocate, the category of professional who should advocate on behalf of patients, the attributes required by nurses in order to act as patient advocates, and the problems encountered by nurses who act as patient advocates. The review concludes with a discussion of the relevant research.

Patient Advocacy From A Nursing Perspective

In The New Webster Encyclopedic Dictionary (1984), advocacy is simply defined as "The act of pleading for" (p. 15). A logical corollary is that a definition of patient advocacy would be analogous to the above definition of advocacy, but somewhat more specific. From a nursing perspective, however, patient advocacy has become a complex concept with a number of descriptions. While it is true that several nursing authors do describe patient advocacy in terms similar to those used in the above dictionary definition of advocacy (Alfano, 1987; Brown, 1986; Christy, 1973; Fonesca, 1980; Jones, 1982; Van Kempen, 1979), other perspectives on patient advocacy appear in the nursing literature.

Some authors suggest that patient advocacy is something more than any act or set of actions. They suggest that patient advocacy represents a belief system which gives impetus to advocacy actions. For example, Namerow (1982) wrote that "Advocacy is an attitude" (p. 151). Thollaug (1980), who considers patient advocacy to be "a kind of reform

movement aimed at restructuring the relationship between providers and consumers according to the interests of the latter" (p. 37), states that the time is right for making patient advocacy the conceptual framework for nursing. Donahue (1985), who considers patient advocacy "as a dynamic process which underlies the entire care philosophy of nursing and which provides the very structure basic to the nurse-patient relationship" (p. 348), postulates that patient advocacy may be the theory for nursing. Curtin (1983), who has written that "the role of the nurse as patient advocate is to create an atmosphere in which something intangible (human values, respect, compassion) can be realized. From where I sit, that is plain, not-so-simple, good nursing practice" (p. 10), believes that patient advocacy is the philosophical foundation for nursing. Another author who believes that patient advocacy is the philosophical basis of nursing is Gadow (1979, 1980, 1983).

Both Curtin (1978, 1979) and Gadow (1979, 1980, 1983) have developed descriptive models of their perspectives on advocacy. Gadow's (1979) model, which is called existential advocacy, "is based on the principle that freedom of self determination is the most fundamental and valuable human right" (p. 82). According to Gadow, existential advocacy is

> the effort to help persons become clear about *what* they *want* to do, by helping them to discern and clarify their values in the situation and, on the basis of that self-examination, to reach decisions that express their reaffirmed, perhaps recreated, values. (pp. 82-83)

The existential advocate enables the patient to make authentic, self-determined decisions which are based on personal values derived from personal experiences by providing information that the patient has selected. The existential advocate assists the patient to select the information to be presented by alerting the patient, either directly or indirectly, about the relevant information that is available (Gadow, 1983).

Curtin's (1979) model of advocacy, which is referred to as human advocacy, "is based upon our common humanity, our common needs and our common human thoughts"

(p. 3). According to Curtin, the nurse-patient relationship should be based on the fact that both are humans and, therefore, have similar experiences. As with Gadow's (1979) existential advocacy, the advocate practicing human advocacy recognizes the patient as a unique individual and facilitates decision making through the provision of information. Both Gadow and Curtin believe that information should be divulged to the patient judiciously, that the patient's values must be respected during the decision making process, and that the patient's final decision must be respected. Both also state that advocacy involves assisting the patient to find personal meaning or purpose in the experience of living, suffering or dying.

From the preceding discussion, it is apparent that the provision of relevant information in a sensitive manner and self-determination of the patient are important elements of both the existential and human advocacy models. Allowing the patient to make informed choices assures humanism in the provision of individualized care (Curtin, 1978). Similar ideas are expressed by authors who do not define patient advocacy in broad philosophical terms. Smith (1979), for example, states that the patient advocate is "one who helps maintain individualization and humanism while providing expert nursing care" (p. 926). Nowakowski (1985) combines self care with self determination and writes that advocacy is "helping the client move from passivity to action in his own behalf - assisting him to become responsible for his own health and decisions about it" (p. 354). Other authors who describe patient advocacy in terms involving self determination and/or humanistic care are Casteldine (1981), Chapman and Chapman (1975), and Kohnke (1978, 1980, 1981, 1982a, 1982b), who has written extensively on the topic.

Kohnke (1980) defines patient advocacy as "the act of informing and supporting a person so that he can make the best decisions possible for himself" (p. 2038). According to Kohnke (1982a), patients should be informed about all the treatments, medications, and procedures which are ordered for them, and their ramifications, as well as available alternatives and their ramifications. Kohnke (1982b) clearly states that the nurse advocate

does not have to take on the patient's case; the nurse advocate needs only to support patients in their right to make their own decisions. Kohnke (1981, 1982a), also states that individuals who make decisions for patients are rescuers rather than advocates, and that rescuers are responsible for the decisions that they make. According to Kohnke, the only time rescuing is acceptable is when a patient is unable to make a decision, as in the case of an unconscious patient or child. Kohnke's definition of patient advocacy has been quoted by many authors including Barry (1982), Creighton (1984), Miller, Mansen, and Lee (1983), and the AARN (1983) in its publication, Guidelines for registered nurses as client advocates.

Another commonly held perspective of patient advocacy focuses on patients' rights. According to the proponents of this view, patient advocacy includes both ensuring that patients know of their rights and taking measures to ensure that they are met (Annas, 1974; Annas & Healey, 1974; Brower, 1982; Kosik, 1972; Sklar, 1979; Storch, 1977, 1978, 1980, 1982). While a list of legislated patient rights in health care does not exist, statements regarding the rights of patients have been drafted by interested groups, such as the Consumers Association of Canada which has formulated the following list of rights:

I. the right to be informed

II. the right to be respected as the individual with the major responsibility for his own care

III. the right to participate in decision making affecting his health

IV. the right to equal access to health care (health education, prevention, treatment and rehabilitation) regardless of the individual's economic status, sex, age, creed, ethnic origin and location.

(Canadian Consumer, April 1974, p. 1)

Nursing authors have identified different types of advocacy. According to Becker (1986), two types have been evident throughout the history of nursing: patient advocacy and social advocacy. While patient advocacy relates to patients' rights and the nurse-patient relationship, social advocacy involves general human rights and societal obligations. Becker also claims that there are two levels of patient advocacy, active and passive, which are differentiated by the origins of the actions of the advocate. The actions of the passive patient advocate stem from imposed expectations/obligations, while those of the active patient advocate stem from personal beliefs and standards. Copp (1986) has identified several types of advocacy which are relevant to nursing: human advocacy, system advocacy, individual advocacy, political advocacy, legislative advocacy, spiritual advocacy, and moral-ethical advocacy. Kohnke (1978, 1982a) states that advocacy exists on three levels: advocacy for yourself, advocacy for clients, and advocacy for the large community. According to Kohnke (1982a), an individual who has not learned to advocate for one's self cannot advocate for another. In addition, as professionals, nurses have an obligation to use their information to influence decisions made by community members. A common theme which appears in each of the above categorizations of advocacy is social activism. The notion that advocacy goes beyond the interpersonal level to include the system's organizational level has been repeated by many nursing authors (Brower, 1982; Christy, 1973; Chapman & Chapman, 1975; Kosik, 1972; Namerow, 1982; Storch, 1977, 1978, 1982). According to Christy (1973) and Donahue (1978, 1985), the precedent for this notion was set by early nursing leaders such as Florence Nightingale, Lillian Wald, Lavinia Dock, and Margaret Sanger who defied social convention by advocating on behalf of both patients and nurses.

In summary, it appears that patient advocacy is a multifaceted concept which is only partially defined or described by each of the perspectives described above. It may be that the various perspectives are not mutually exclusive and that together they describe patient advocacy as it pertains to nursing. Nelson (1988) states that while patient advocacy has

always been integral to nursing, the intent of the advocate has changed as the profession has evolved. If so, the various perspectives of patient advocacy which have been described above could represent an evolutionary history of patient advocacy within nursing. Because various perspectives on patient advocacy exist among nurses, it is difficult to know which perspective is intended by nurses discussing the topic unless they clearly state their position.

Need For A Patient Advocate

The need for an individual in the health care system who has the responsibility to ensure that the patient's perspective is taken into account during the administration of health care has been widely recognized in the literature (Annas, 1974; Annas & Healey, 1974; Chapman & Chapman, 1975; Copp, 1986; Curtin, 1978, 1979; Donahue, 1978, 1985; Jenny, 1979; Kosik, 1972; Storch, 1977, 1978, 1980, 1982; Thollaug, 1980). Such an individual has been given several titles including advocate, patient advocate, patient rights advocate, patient assistant, patient representative, patient hostess, and patient ombudsman (Annas, 1974; Robinson, 1985; Storch, 1977, 1980, 1982; Zusman,1982). The duties associated with each of the above titles range from welcoming and introducing a patient to the hospital to guaranteeing patients their rights.

The rationale cited most frequently for the need of a patient advocate is the vulnerability and powerlessness of individuals in relation to bureaucratic organizations such as hospitals or government systems (Annas & Healey, 1974; Chapman & Chapman, 1975; Christy, 1973; Copp, 1986; Curtin, 1978, 1979; Jenny, 1979; Kosik, 1972; Thollaug, 1980; Van Kempen, 1979). Other rationales for the need of a patient advocate reinforce the idea that patients are not being well served by the health care system. For example, Straus (1972) wrote that advocacy was necessary in order to overcome the fragmentation of health care. Chapman and Chapman (1975), Curtin (1978, 1979) and Donahue (1978) state that

advocacy is necessary in order to maintain humanism within the health care system. Annas (1974), Aydelotte (1978), and Walsh (1978) state that a patient advocate is necessary in order to ensure that patients' rights are not infringed upon, even in the interests of health.

Who Should Advocate For Patients

Although there is agreement among authors about the need for a patient advocate, there is a difference of opinion as to who should fulfill that role. Some authors believe that all health professionals, including nurses, should act as patient advocates (AARN, 1983; Chapman & Chapman, 1975; Kosik, 1972). On the other hand, at least one author believes that there is need for a health care worker whose sole responsibility is patient advocacy (Annas & Healey, 1974). Fonesca (1980) and Van Kempen (1979) disagree with this position and state that nurses can be patient advocates. According to Annas (1974), nurses with special preparation in psychology, patient interviewing, and the law as it relates to patient rights and its language, could act as patient advocates. Nurses, he notes, already possess the necessary knowledge of medicine, medical terminology, and hospital administration. Storch (1978) also believes that nurses, with additional preparation in law, organizational theory, health care delivery, and administration, could serve as formal patient advocates. However, she stresses that such a health care worker would not abrogate the nurse's role as a patient advocate. Nurses, she maintains, are well-suited to act as patient advocates because they have sustained contact with patients, they are attuned to total patient care, they have the potential for extensive family contact, they are distributed throughout the health care system, and because there are many members in their ranks. Many authors have noted that nurses are ideally situated to act as patient advocates because of their unique relationship with patients, their knowledge of patients' problems, and their proximity to the patient's environment for 24 hours per day (Altschul, 1983; Bandman, 1987; Laszewski, 1981; Thollaug, 1980). According to Fay (1978), advocacy is implicit in the definition of

nursing practice. Donahue (1985) states that patient advocacy has always been at the core of nursing although it has received different labels. "Perhaps the question to be answered ...", writes Donahue, "is not whether the nurse should be a patient advocate but rather how nursing lost this role" (p. 341).

On the other hand, doubts about the ability of nurses to assume the role of patient advocacy have been raised by authors such as Jenny (1979) who wrote that, if nurses are to become patient advocates, they must escape from their traditional bondage of subservience to physicians and employers. According to Miller, Mason, and Lee (1983), nurses cannot act as patient advocates because they have not been given the power or authority to do so by society, the medical profession, or the institutions which hire them. Lewis (1977) and Winslow (1984) both indicate that there is an expectation on the part of physicians, employers, and the public that nurses will continue to assume their traditional submissive roles. Abrams (1978), who also notes nursing's lack of autonomy within the hospital structure, adds that there is an inherent coercive nature in the nurse-patient relationship which makes it difficult for the nurse to relate to the patient as a unique individual. Brown (1986) is of the opinion that patient advocacy is an undesirable role for nurses because it involves identification with the weak and oppressed. Tesolowski, Rosenberg, and Stein (1983) have suggested that nurses should be advocate associates who facilitate the advocacy process on behalf of their clients through an external advocacy organization. In a similar vein, Zusman (1982) suggests that the most responsible action on the part of the nurse advocate may be to delegate advocacy situations and complaints to an appropriate authority.

In view of the above discussion, it is apparent that there is some question as to whether patient advocacy is an appropriate role for all nurses and, if it is, whether it is a role that nurses share with other health care workers. If patient advocacy is an appropriate role for nurses, implementation strategies should be identified. If nurses share the advocacy role with other health care workers, distinctions between the nurse's

responsibilities as an advocate and those of other health care workers should be identified.

Attributes Nurses Require To Act As Patient Advocates

According to Christy (1973), nurses must possess three attributes in order to be able to advocate adequately on behalf of patients:

> 1) motivation in the form of a personal commitment to the patient, without subjugation to the agency or obligation to the physician; 2) skill and expertness to perform whatever tasks may be required with a minimum of discomfort to the patient; and, the most vital of all, 3) knowledge to know how, when, where, and why. (p. 8)

Donahue (1978) claims that knowledge is the most important qualification for the nurse advocate to possess because it provides the rationale for the independent judgements the nurse makes. Kohnke (1982a), who states that the nurse advocate requires a broad knowledge base about people, society, and social order also states that the nurse advocate requires open-mindedness, self-knowledge and communication skills. The personal characteristics of a successful patient advocate are said to be the ability to relate to others, objectivity, empathy, tact, flexibility, tenacity, a sense of humor, and the ability to cope with stress and pressure (Robinson, 1985).

Problems Encountered By Nurses Who Act As Patient Advocates

One problem encountered by nurses who act as patient advocates is uncertainty about the rights and responsibilities of nurses as patient advocates. Such uncertainty includes how far should a nurse go in advocating on behalf of a patient, and what kind of support might the nurse who is acting as a patient advocate receive from peers, other health care professionals, administrators, and professional organizations (Abrams, 1978; Copp,

1986; Kelly, 1985; Walsh, 1978; Winslow, 1974). Another problem is the adversarial nature of patient advocacy. Because acting as an advocate may require the questioning of procedures and practices, nurses who act as advocates are placed in a position of conflict with co-workers (Annas, 1974; Kosik, 1972; Robinson, 1985; Winslow, 1984). In addition, advocacy can create a conflict of loyalties within the very nurse who is acting as an advocate (Winslow, 1984). Because of the problems inherent in the role of patient advocacy, nurses who act as advocates may encounter anger and frustration (Murphy, 1981; Smith, 1981), resignation (Smith, 1980), reprimands for insubordination (Flaherty, 1981), dismissal (Creighton, 1984; Feliu, 1983a; Regan, 1984; Witt, 1983), and loss of licensure (Tuma, 1977). Thus, acting as a patient advocate can be a risky business.

In order to reduce the risks and to maximize the benefits of advocacy actions, nurses are advised to maintain open channels of communication with other health care workers, to utilize proper channels of communication, and to be accurate and persistent (Becker, 1986; Feliu, 1983b; Price & Murphy, 1983). Zusman (1982) advises the would-be advocate to determine whether the negative effects of taking action outweigh the positive ones; to consider alternative ways of meeting goals for the patient; to distinguish between honest disagreement and dishonesty, neglect, and incompetence before involving a patient in controversy; to ask a colleague's opinion; to look for ways to be unobtrusive; and to try asking questions. In conclusion, it seems that there is contradiction in the messages nurses are receiving. On one hand, they are being encouraged to assume the role of patient advocate; on the other hand, they are being confronted with evidence to suggest that doing so may be an unpleasant and unrewarding experience which requires defensive strategies.

Relevant Research

Although much has been written about nurses and patient advocacy, most of the literature is discoursive or exhortive in nature. Very few research studies have been reported. An in-depth scholarly analysis of post World War II American and Canadian literature on consumer rights and health care, and nursing in particular, was completed by Storch (1977). The purpose of the study was to provide a background for the examination of common rights in health care and, subsequently, the formalization of mechanisms to construct a new way of relating to consumers (p. 6). According to Storch, the implementation of consumer rights in health care is tantamount to advocacy. Her study concludes with 34 recommendations for the implementation of consumer rights in health care. The initial 10 are general recommendations to all health care providers, policy-makers, planners, and evaluators while the remaining 24 recommendations are directed at nursing educators, administrators, practitioners, researchers, and associations. Storch's work is valuable because of its historical perspective, and because of its usefulness as a guide in establishing patient advocacy in nursing practice. It does not, however, provide information on how patient advocacy is actualized by nurses.

A scale which purports to measure attitudes toward advocacy was developed by Pankratz and Pankratz (1974). The scale is a five point Likert scale with responses ranging from strongly agree to strongly disagree. It consists of three subscales: nursing autonomy and advocacy, patients' rights, and rejection of traditional role limitations. Nursing autonomy and advocacy measures the extent to which nurses feel comfortable in taking initiative and responsibility in the hospital, and nurses' attitudes toward the patient's right to control in the hospital. Patients' rights measures the nurse's hypothetical concession of certain rights to patients. Rejection of traditional role limitations measures the nurse's willingness to dialogue openly with the doctor and to become highly involved in the personal matters of patients (p. 213). High scores on the subscales, especially nursing

autonomy and advocacy, are said to be indicative of a positive attitude toward advocacy. This claim is made on the assumption that nurses must feel that they have some influence on the system if they are to be patient advocates.

In developing their attitude scale, Pankratz and Pankratz (1974) administered a 69 item questionnaire to 702 nurses with differing educational backgrounds who were employed in a variety of positions and settings in the United States. Although Pankratz and Pankratz reported that an attempt was made to gather a diverse sample of nurses, they did not describe the techniques whereby their subjects were selected. The 69 item questionnaire was developed from a pool of items from a previous questionnaire developed to measure patients' rights, plus items generated by nurses. By using principal components factor analysis, Pankratz and Pankratz were able to obtain four factors, but eventually, reduced the number of factors to three (nursing autonomy and advocacy, patients' rights, and rejection of traditional role limitations). The final number of items included in the three factors was not reported by Pankratz and Pankratz. However, when the instrument was referred to by subsequent authors, it consisted of 47 items (Green, 1978; Meissner, 1981).

Pankratz and Pankratz (1974) reported that the validity of their instrument was established when an independent researcher performed a cluster analysis using their original data, and the items associated with the first three clusters matched most of the items included in the three factors obtained by them. Because the two statistical procedures produced similar factors, Pankratz and Pankratz indicated there was statistical validity for the three factors (subscales). Reliability coefficients for the three subscales were reported to be .93, .81, and .81 respectively. According to results obtained by Pankratz and Pankratz, higher scores on the scale were correlated with additional education, administrative position, academic setting, and non-traditional social climate.

Green (1978), who administered the Pankratz and Pankratz (1974) Nursing Attitude Scale to a stratified random sample of 392 practicing registered nurses in a large

metropolitan area in British Columbia, also found that high scores on the scale were related to administrative position, advanced education, and employment in educational and community health settings. The purpose of Green's study was to determine whether the attitudes of registered nurses in British Columbia toward autonomy, advocacy, and consumer rights were convergent with those of the provincial professional association, and to determine the relationship between position, hours of work, years of experience, work setting, age and education, and the attitudes measured by the Pankratz and Pankratz Nursing Attitude Scale. The sample was stratified by education and 99.1% of the subjects were contacted by phone prior to delivery of the questionnaire. A return rate of 92.23% was reported. Validity and reliability coefficients were not reported. Green concluded that "the mean of the total sample on all three clusters [subscales] was sufficiently high to encourage nurse leaders to provide assertive leadership on the issues of consumer rights in health care, informed access to information and nursing autonomy" (p. ii).

Qualitative research methods were utilized by Kraus (1981) and Wilberding (1984) to investigate the advocacy role of the nurse. The questions addressed by Kraus' study were "What common concepts (if any) emerge from the nursing literature that deals with patient advocacy?" and " Are these consistent with the concepts expressed by professionals who have taken an active interest in the nurse's function as a patient advocate?" (pp. 3-4). Kraus collected data from 20 current articles addressing advocacy as a nursing function, interviews with six registered nurses of varying educational and practice backgrounds who identified themselves as having strong beliefs in the nurse's role as a patient advocate, and one speech delivered at an advocacy workshop. She concluded that the nursing concept of patient advocacy is comprised of three conceptual elements:

> a guiding perspective of the nurse-client relationship that respects the patient's right to autonomy, a caring professional nurse who embodies certain qualities that are necessary for advocacy to be effective, and the facilitation of patient autonomy through the implementation of specific

advocacy actions. (p. 53)

According to Kraus the above conceptual elements must exist before advocacy can occur. Kraus also postulates that "The concept of advocacy may be the embodiment of professionalism for many nurses because the use of an advocacy framework for the delivery of nursing care encompasses the professional elements of accountability and responsiveness to the client's needs" (p. 45). On the basis of her findings, Kraus concluded that effective advocates must have the ability to listen, empathize, support, be non-judgemental, promote, and counsel. In addition, advocates must have the attributes of a caring attitude, involvement, commitment, honesty, patience, dedication, assertiveness, knowledge, and self awareness. Kraus also found that advocacy involves informing the patient, supporting the patient, and acting on behalf of the patient; and that there are legal, personal, and institutional limitations to the degree of support that can be offered to the nurse who acts as an advocate. Although two research questions were posed by Kraus' study as indicated above, Kraus' conclusions seem to relate to the first question only. The value of Kraus' work is that it embodies perceptions regarding patient advocacy from practical as well as theoretical sources.

Wilberding (1984) interviewed a convenience sample of 15 staff nurses regarding the role of the nurse as a patient advocate and concluded that becoming a patient advocate is a process which requires the following antecedent conditions: belief in the role, nursing education, and the experience of acting as a patient advocate. As indicated previously, Kraus (1981) also asserted that certain factors must exist before patient advocacy can occur. Similarities between Kraus' conceptual elements and Wilberding's antecedent conditions are evident. On the basis of his findings, Wilberding also concluded that the behaviors of the nurse advocate fall into two familiar categories: assessment and intervention. According to Wilberding, the criteria which indicate the need for advocacy on the part of the patient include feelings of inferiority, a knowledge deficit, lack of understanding, lack of familiarity, fear, non-recognition of patients' rights, inadequate

care, unnecessary treatments, and anger. The nurse assesses for these criteria by conversing with the patient, observing the patient's behavior, and spending time with the patient. The intervention behaviors which Wilberding found include:

> speaking for the patient, encouraging the patient or his significant others to speak for themselves, giving information to the patient, protecting the patient, supporting the patient's autonomy, and using presence to give emotional support to the patient. (p. 101)

One of Wilberding's recommendations was that there should be greater integration of content on patient advocacy into nursing school curricula.

The qualitative studies conducted by Kraus (1981) and Wilberding (1984) are useful because they provide a description of patient advocacy derived from the perceptions and experiences of practicing nurses. In each study, however, the subjects were not randomly selected from a large geographical area. Although Pankratz and Pankratz (1974) have developed an instrument which measures nurses' attitudes toward patient advocacy, their instrument does not collect information about the implementation of patient advocacy by nurses. Since very few studies on the nurse's role as a patient advocate have been conducted, it is timely for such a research study to be undertaken.

Summary

On the basis of the literature review presented in this chapter, it is apparent that although nurses are being exhorted to act as patient advocates, the nurse's role as a patient advocate has not been clearly delineated. It is also apparent that there is a paucity of research on the topic. In the following three chapters, a study which was undertaken by the writer to determine the perceptions of registered nurses regarding the nurse's role as a patient advocate is described in detail. The method which was utilized is described in Chapter III. In Chapter IV the analysis of the data and the results are presented. A discussion of the results appears in Chapter V.

CHAPTER III

METHODS

A descriptive, exploratory study utilizing a survey questionnaire to elicit the perceptions of registered nurses regarding the nurse's role as a patient advocate was undertaken. This chapter includes a description of the sample surveyed, the data collection techniques, and the development of the questionnaire which was used. In addition, ethical considerations and the delimitations of the study are discussed.

Sample

The subjects in the study were 200 randomly selected, registered nurses from Alberta who were employed in full-time positions as staff nurses. They were accessed through the membership files of the AARN. Staff nurses were chosen as subjects because their duties involve direct patient care. In choosing a sample size of 200, the anticipated response rate was taken into consideration. While response rates as low as 10% have been reported in the literature, so too have rates above 90% (Moser & Kalton, 1971). Although a response rate of 80% - 90% is desirable, Kerlinger (1987) writes that "At best, the researcher must content himself with returns as low as 50 to 60 percent" (p. 397). However, Kerlinger also states that response rates of less than 40% - 50% are common. In a similar vein, Fowler (1984) reports that rates of 20% - 30% are not uncommon. In view of the somewhat contradictory information in the literature regarding response rates, a response rate of 40% - 50%, resulting in a return of 80 - 100 completed questionnaires, was hoped for.

Procedure

A questionnaire entitled, Questionnaire On Patient Advocacy As A Nursing Role, was developed to elicit biographical data as well as nurses' opinions regarding their role as patient advocates, the preparation of nurses to act as patient advocates and the implementation of patient advocacy by nurses (Appendix A). The biographical data sought included type of employing agency, location of employing agency, gender, educational preparation, and number of years in nursing practice after graduation from a basic nursing program. The questionnaire was mailed to the 200 subjects on February 25, 1988. It was accompanied by a covering letter (Appendix B) as well as an addressed, stamped envelope for returning the completed questionnaire. After an interval of two weeks, a follow-up letter, which included a note of appreciation to those who had already responded, and a reminder to those who had not yet completed and returned the questionnaire, was sent to all the subjects. In the event that the original questionnaire had been lost or misplaced, an additional copy of the questionnaire was enclosed with the follow-up letter. As the completed questionnaires were received, they were assigned unique identification numbers. The identification number and the date that each questionnaire arrived was recorded. The last completed questionnaire was received on May 4, 1988.

Questionnaire Development

The development of the questionnaire was a multi-stage process which commenced with the articulation of specific questions related to the the research questions posed in the study. Each of the specific questions was accompanied by rationales based on the relevant nursing literature as well as the means by which a response to the question could be obtained. The purpose of compiling the above information was to establish the content validity of the questionnaire.

Subsequent steps in the development of the questionnaire included the generation of questionnaire items based on the specific questions, the organization of those items into a draft of the questionnaire, the distribution of the draft to nurses and others for feedback, the revision of the draft on the basis of feedback received, and the distribution of the revised draft for further feedback. Each draft of the questionnaire was accompanied by a document in which the specific research questions to which each item in the questionnaire was related were identified. Feedback concerning all aspects of the questionnaire including appearance, organization, clarity of expression, representativeness of the topic being studied, punctuation, grammatical consistency, and spelling was requested. In an attempt to maximize reliability of the questionnaire, efforts were focussed on developing questionnaire instructions and items that were written as clearly and as unambiguously as possible (Fowler, 1984).

The process of revising and redistributing draft questionnaires described above was repeated until feedback was primarily positive. At that time, a final questionnaire was written and pilot tested with 20 staff nurses under conditions identical to those of the planned study. The purpose of the pilot test was to determine the average length of time required to complete the questionnaire and to identify problems in either its construction or administration. The response rate on the pilot test was 70%; the average length of time required to complete the questionnaire was approximately 20 minutes. Overall, there were few problems with the questionnaire; thus few additional revisions were required.

Ethical Considerations

This study was approved by the Ethics Committee of the Faculty of Nursing at the University of Alberta. Consent to cooperate in the study was inferred from the return of a completed questionnaire. In order to maintain anonymity of the respondents and confidentiality of their responses, the subjects were not requested to identify themselves by

name, nor were the questionnaires coded in any way. Since the AARN handled the selection of subjects for the study and the mailing of the questionnaires, the writer is not aware of who received an invitation to participate in the study.

Delimitations

The study which was undertaken had several delimitations. To begin with, it was necessary to limit the sample size to 200 subjects since it was impossible to investigate the perceptions of all the staff nurses with full-time employment in Alberta. Another delimitation was the unavailability of a standardized tool for gathering information from staff nurses about the topic of patient advocacy. A large majority of the questionnaire items which were developed were of a forced-choice format. Thus, it is possible that the choices which were presented did not reflect the views of the respondents. It is also possible that the responses chosen by the respondents did not reflect their true opinions. Another delimitation is that in-depth information was not obtained. Because the questionnaire was mailed to the subjects, there was no control over the circumstances under which they were completed. In addition, follow-up procedures were restricted due to the manner in which the subjects were accessed and a concern for the anonymity of the subjects. Finally, the term patient advocate was not defined by the writer and was, therefore, open to interpretation by the subjects.

CHAPTER IV

ANALYSIS AND RESULTS

The percentage of subjects who responded to the questionnaire, and their characteristics, as well as the statistical procedures which were utilized to analyze the data and to establish reliability of the questionnaire are described in this chapter. So too, are the results which were obtained. The presentation of the results has been arranged according to the four research questions posed in the study. The results for the first three research questions are preceded by a discussion of the relevant questionnaire items. The results for the final research question are preceded by a discussion of the categorization of the respondents.

Response Rate

Of the 200 questionnaires which were mailed, 121 (60.5%) were returned. Of the returned questionnaires, three were not completed because the subjects had moved, one was deemed ineligible because it was completed by a nurse who did not have the characteristics necessary to participate in the study, and one was returned too late for inclusion in data analysis. Therefore, the following discussion is based on the analysis of data obtained from 116 questionnaires.

Description Of Respondents

Two of the respondents did not report their gender; of the 114 who did, one was a male. Ninety-four of the respondents reported that they were employed by agencies located in cities. Fifteen indicated that their employing agency was located in a town, and seven indicated other locations such as hamlets, native communities, or rural districts.

Eighty-eight of the respondents reported that they were employed by an active treatment hospital, while 28 reported employment by a variety of additional health care agencies. Table 1 shows the types of employing agencies reported as well as the number and percentage of the respondents employed by them. Agencies included in the other category were cancer institutions, walk-in clinics, and the Department of National Defense. The types of units represented by the respondents employed by active treatment hospitals are shown in Table 2.

Table 1

Respondents' Employers

Employing Agency	N	Percent
Active Treatment Hospitals	**88**	**75.8**
Additional Health Care Agencies	**28**	**24.2**
Public Health Agency	9	7.8
Physician's Office/Family Practice Unit	4	3.4
Extended Care/Auxilliary Hospital	3	2.6
Home Care/Visiting Care	2	1.7
Nursing Home	2	1.7
Business/Industry	1	0.9
Educational Institution	1	0.9
Psychiatric Hospital	1	0.9
Other	5	4.3
Total	**116**	**100!0**

Approximately 41% of the staff nurses indicated that they had educational preparation beyond an RN diploma. The following qualifications were reported: 23 certificates in a nursing specialty, 13 basic baccalaureate degrees in nursing, 11 post basic degrees in nursing, three non-nursing baccalaureate degrees and two master's degrees. The non-nursing baccalaureate degrees were in the disciplines of literature, psychology and pharmacology. The master's degrees were in education and health education. Several of the respondents, in addition to those with master's degrees, held multiple degrees. For example, one subject had two baccalaureates, and another one with a post basic

baccalaureate degree in nursing also had a post RN certificate. As indicated in Table 3, an RN diploma or post RN certificate was the highest level of preparation held by close to 78% of the staff nurses while approximately 22% held a university degree.

Table 2

Types Of Units Represented By Respondents Employed By Active Treatment Hospitals

Type of Unit	N	Percent
Surgery	13	14.8
Medicine	11	12.5
Maternal and Child Health	10	11.3
Mixed	9	10.2
Intensive Care Unit	8	9.1
Out Patient Department/Emergency	6	6.8
Neonatal Intensive Care Unit	6	6.8
Pediatrics (Med & Surg)	5	5.7
Urology	5	5.7
Operating Room	5	5.7
Oncology	2	2.3
Orthopedics	2	2.3
Psychiatry	2	2.3
Missing	4	4.5
Total	**88**	**100.0**

Table 3

Highest Reported Educational Preparation Of Respondents

Educational Preparation	N	Percent
Non-university	**90**	**77.6**
RN Diploma	68	58.6
Post RN Certificate	22	19.0
University	**26**	**22.4**
Baccalaureate Degree		
Basic Nursing	11	9.5
Post Basic Nursing	11	9.5
Other	2	1.7
Master's Degree	2	1.7
Total	**116**	**100.0**

As displayed in Table 4, the total number of years of nursing experience among the respondents ranged from one to 40 years. The median number of years was 11.3. The modal interval, which contained 27.6% of the respondents, was one to five years.

Table 4

Years Of Nursing Experience Of Respondents

Years of Experience	N	Percent
1 - 5	32	27.6
6 - 10	22	19.0
11 - 15	24	20.7
16 - 20	14	12.1
21 - 25	10	8.6
26 - 30	4	3.4
31 - 35	8	6.9
36 - 40	2	1.7
Total	**116**	**100.0**

Statistical Procedures

Prior to analysis with version X of the Statistical Program For The Social Sciences, ($SPSS^X$), all data were verified. The statistical procedures conducted were frequency distributions, one-way analyses of variance (ANOVA), and Newman-Keuls tests. As will be explained in detail later in this chapter, the above procedures were carried out selectively on those items of the questionnaire which were relevant to each of the research questions posed in the study. Content analysis was used to analyse the comments made at the end of the questionnaire.

For purposes of analysis, Part I of the questionnaire, which consisted of 11 items requiring a response of *always, generally, occasionally, never,* or *no opinion* was treated as a four-point Likert scale. The response *no opinion* was treated as missing data and not assigned a value. The other four choices were assigned values from 1 to 4 as follows: *always* =1, *generally* =2, *occasionally* =3, and *never* =4. Therefore, lower scores are more

positive than higher ones. The 11 items comprising Part I of the questionnaire were analyzed individually as well as collectively. When the items were grouped collectively, they were regarded as a measurement scale of nurses' attitudes toward patient advocacy. Throughout the remainder of this thesis, the term full-scale will be used to refer to the 11 items collectively. The items comprising the full-scale were organized into three subscales. Subscale 1 consists of items 1 - 7 and relates to the implementation of patient advocacy (Research Question 3). Subscale 2 relates to the perceptions of nurses regarding patient advocacy as a role for nurses (Research Question 1) and consists of items 8 - 9. Items 10 - 11 form subscale 3, which relates to the preparation of nurses to act as patient advocates (Research Question 2).

Determination Of Reliability

Cronbach alpha coefficients, which measure internal consistency, were calculated for the full-scale and the three subscales in Part I of the questionnaire. The internal consistency approach is an accepted technique for calculating reliability (Ferguson, 1981). Reliability coefficients range from 0 to 1 and tend to vary with the number of items in the test. A coefficient of .6, or greater, is a reasonable expectation for a test of 25 items (Ebel, 1980). Because the scales consisted of a small number of items, the Spearman-Brown procedure for calculating the reliability of a lengthened test was used (Ferguson 1981).

Subscale 1 had a Cronbach alpha coefficient of 0.795. If the subscale is lengthened from seven items to 21 items, the estimated reliability of the lengthened subscale is 0.921. A Cronbach alpha coefficient of 0.639 was obtained for subscale 2 and the estimated reliability of lengthening the subscale from two items to 22 items is 0.951. Analysis of subscale 3 resulted in a Cronbach alpha coefficient of 0.544 and a reliability coefficient of 0.929 for a test lengthened from two items to 22 items. The Cronbach alpha coefficient for the full-scale was 0.845. The corresponding estimated Spearman-Brown reliability

coefficient for a full-scale questionnaire containing 22 items is 0.916. In view of the above results, it can be concluded that all the scales were reliable.

Reported Perceptions Regarding Patient Advocacy As A Role For Nurses (Research Question 1)

Relevant Questionnaire Items

The parts of the questionnaire which elicit perceptions regarding patient advocacy as a role for nurses are subscale 2 and Part II-A. In addition, the full-scale is an over-all measure of nurses' attitudes toward patient advocacy. As described previously, the full-scale consists of all 11 Likert-type items comprising Part I of the questionnaire while subscale 2 consists of items 8 and 9 only. Part II-A of the questionnaire includes two types of items: direct questions requiring a *yes*, *no*, or *I don't know* response, and companion questions requiring a selection of the three most important rationales from a provided list of possible rationales for certain responses made to certain direct questions.

Presentation Of Results

In the following discussion, the results from the scales which elicited perceptions regarding patient advocacy as a role for nurses are presented first; then, the results from the other types of questionnaire items are presented. As displayed in Tables 5 and 6, the mean of the full-scale was 23.553 and the mean of subscale 2 was 4.965. Each of the these means is below the potential midpoint for the respective scale, therefore it can be concluded that the respondents were favorably disposed toward patient advocacy as a nursing role.

Table 5

Mean, Standard Deviation, Potential Range, And Potential Midpoint For The Full-Scale In Part I Of Questionnaire On Patient Advocacy As A Nursing Role

Scale	Mean	S.D.	Potential Range[a]	Potential Midpoint[b]
Full-scale (Items 1-11)	23.553	4.923	11 - 44	27.5

[a] Potential Range - was obtained by multiplying the lowest (1 = Always) and the highest (4 = Never) assigned values by the number of items in the full-scale. For example, there were 11 items in the full-scale; therefore, the minimum of the range was 11 (1x11) and the maximum of the range was 44 (4x11).

[b] Potential Midpoint - was obtained by calculating the mean of the minimum and maximum of the potential range. For example, the potential midpoint of the full-scale is 27.5 (55/2). A mean below the potential midpoint is more positive than one above the potential midpoint.

The average scores for each of the individual items comprising the full-scale can be found by referring to the following three tables: Table 6 which includes items 8 and 9, Table 11 which includes items 10 and 11, and Table 19 which includes items 1-7. With a mean score of 1.750, the item with the the most positive average score is item 3, which is a declaration of personal commitment to the role of patient advocacy (Table 19). With one exception, the mean of all the individual items is below the potential midpoint of 2.500 and, therefore, positive. As per Table 6, the one exception is item 9 which has a mean of 2.679. This item is one of the two comprising subscale 2, which measures attitudes towards the role of the nurse as a patient advocate. The other item comprising subscale 2, item 8, has a somewhat positive mean of 2.425. While item 8 refers to the priority of patient advocacy among all the other roles that nurses assume, item 9 refers to a universal understanding of the phrase patient advocacy.

Table 6

Descriptive Statistics For Subscale 2 (Including Individual Items) In Part I Of Questionnaire On Patient Advocacy As A Nursing Role

Scale	Mean	S.D.	Potential Range[a]	Potential Midpoint[b]
Subscale 2 (Items 8-9)	4.965	1.382	2 - 8	5.0

Individual Items	Frequencies[c]						Mean	S.D.	Mode	Observed Range[d]
	A	G	O	N	N/O	Total				
8. Among all the roles that they assume, I believe that nurses give patient advocacy a high priority.	6	59	42	6	0	113	2.425	.679	2	1-4
9. I believe that when the term patient advocate is used to describe a nursing role, it is understood in the same way by all nurses	3	46	43	17	6	115	2.679	.768	2	1-4

[a] Potential Range - was obtained by multiplying the lowest (1 = Always) and the highest (4 = Never) assigned values by the number of items in the full-scale. For example, there were 2 items in the subscale 2; therefore, the minimum of the range was 2 (1x2) and the maximum of the range was 8 (4x2).

[b] Potential Midpoint -was obtained by calculating the mean of the minimum and maximum of the potential range. For example, the potential midpoint of subscale 2 is 5.0 (10/2). Means below the potential midpoint are more positive than those above the potential midpoint.

[c] A=Always (1) G=Generally (2) O=Occasionally (3) N=Never (4) N/O=No Opinion

[d] Low scores are more positive than high scores

All the staff nurses who participated in the study responded to the direct question, "*Do you think that nurses should act as patient advocates*?". As shown in Table 7, a large majority of them, 95.7%, responded *yes*. Table 8 demonstrates that the respondents chose a variety of reasons to rationalize their stance. While the reason, *good nursing care is impossible without it*, was chosen most frequently, it was chosen by a majority consisting of only 58.6% of the respondents. The next highest ranking reason, *patients' rights are not being met by the health care system*, was chosen by less than 45% of the respondents. The third and fourth highest ranking reasons, *they understand the advocacy needs of patients*, and *they have a moral responsibility to do so*, were chosen by 39.6% and 34.2% of the respondents respectively. Almost 29% of the respondents indicated that nurses should act as patient advocates because *no one else is fulfilling the role*. Approximately 15% of the respondents indicated that *patient advocacy is a traditional nursing role* was a reason for nurses to act as patient advocates. Only 1.8% of the respondents chose either of the choices relating to professional nursing issues. Since none of the respondents chose *none of the above* from the provided list of possible rationales for advocacy action on the part of nurses, it can be assumed that the list contained all the rationales considered relevant by the participating staff nurses.

Only 2, or 1.7%, of the respondents indicated that nurses should not act as patient advocates (Table 7). As each of them chose three different rationales to support their position, there appeared to be a lack of congruence in their opinions. The six rationales which they chose were: *they do not hold a position of power in the health care system, they do not have adequate preparation to assume the role, there are no standards for the implementation of advocacy, there is no reward for doing so, the role is ambiguous*, and *nurses already have too much to do*.

Table 7

Responses to Direct Questions From Part II-A Of Questionnaire On Patient Advocacy As A Nursing Role

Question	Yes		No		Don't Know		TOTAL
	N	%	N	%	N	%	N
Do you think nurses should act as patient advocates?	111	95.7	2	1.7	3	2.6	116
Do you think that other health care workers such as physicians, respiratory technicians, social workers, and dieticians should act as patient advocates?	110	95.7	2	1.7	3	2.6	115
Do you think there is a difference in how nurses and health care workers act as patient advocates?	96	87.3	6	5.5	8	7.2	110
Do you think there is a need for a health care worker whose only responsibility is patient advocacy?	29	27.9	58	55.8	17	16.3	104

Table 8

Rationales Chosen By Respondents Who Indicated That Nurses Should Act As Patient Advocates

Rationales	Freq.	% of Respondents (N=111)
Good nursing care is impossible without it.	65	58.6
Patients' rights are not being met by the health care system.	48	43.2
They understand the advocacy needs of patients.	44	39.6
They have a moral responsibility to do so.	38	34.2
No one else is fulfilling the role.	32	28.8
Patient advocacy is the basis of nursing.	30	27.0
Patient advocacy is a traditional nursing role.	17	15.3
Patient satisfaction with health care is decreasing.	16	14.4
Patients expect them to do so.	14	12.6
That is one way of establishing the autonomy of the profession.	11	9.9
They are legally required to do so.	4	3.6
Professional nursing organizations have stated they should.	2	1.8
The survival of the profession is at stake.	2	1.8
None of the above	0	0.0

According to Table 7, 95.7% of the nurses who responded to the query, "*Do you think that other health care workers such as physicians, respiratory technicians, social workers, and dieticians should act as patient advocates*?", answered *yes*. Of those, 87.3% indicated that there was a difference in how nurses and other health care workers act as patient advocates. As shown on Table 9, the reason selected most frequently to explain the difference, *nurses are in a better position to be aware of patients' needs*, was chosen by 89.6% of the respondents. The reason which ranked second, *nurses are in a better position to make patients' needs known*, was chosen by a smaller majority, 63.5%, of the respondents. Close to 59% of the respondents chose *nurses are interested in the total well being of patients* which ranked third, and 56.3% selected the fourth ranking reason, *patients depend on nurses more than other health care workers*. Only 11.4% of the respondents chose *nurses are prepared to be advocates*. No respondent chose *none of the above* as a response, therefore it can be assumed that no important rationale was omitted from the list of possible rationales that was provided to explain the difference in how nurses and other health care workers act as patient advocates.

Table 9

Rationales Chosen By Respondents Who Indicated That The Nurse's Role As A Patient Advocate Differs From That Of Other Health Care Workers

Rationales	Freq.	% of Respondents (N=96)
Nurses are in a better position to be aware of patients' needs.	86	89.6
Nurses are in a better position to make patients' needs known.	61	63.5
Nurses are interested in the total well being of patients.	57	59.3
Patients depend on nurses more than other health care workers.	54	56.3
Nurses are prepared to be patient advocates.	11	11.4
It is less influential.	9	9.4
Nurses care more for patients as individuals.	8	8.3
It is more important.	2	2.1
Nurses are unable to do as much as other health care professionals to ensure that patients' needs are met.	2	2.1
None of the above	0	0.0

As displayed in Table 7, a small majority (55.8%) of the staff nurses indicated that there was not a need for a health care worker whose only responsibility is patient advocacy. While approximately 30% of the respondents indicated that there was a need for such a health care worker, another 16.3% did not know. Twelve respondents declined responding to the question altogether. According to Table 10, the respondents who answered affirmatively chose four reasons with approximate equal frequency to explain their opinion. The highest ranking reason, *have the time to meet patients' advocacy needs,* was chosen by 51.7% of the respondents. Approximately 48% of the respondents chose the second ranking reason, *have the necessary knowledge and skills*. Two rationales, *ensure that patients' advocacy needs are met*, and *have the authority to to be an advocate*, ranked third; they were both chosen by 44.8% of the respondents. One of the respondents chose *none of the above* indicating that the list of possible rationales that was provided did not include all justifications for the need of a health care worker whose only responsibility is patient advocacy.

Table 10

Rationales Chosen By Respondents Who Indicated That A Health Care Worker Whose Only Responsibility Is Patient Advocacy Is Needed

Rationales	Freq.	% of Respondents (N=29)
Have the time to meet patients' advocacy needs	15	51.7
Have the necessary knowledge and skills	14	48.3
Ensure that patients' advocacy needs are met	13	44.8
Have the authority to be an advocate	13	44.8
Be able to teach other health care workers about patient advocacy	7	24.1
Be able to give advice to other health care workers who act as patient advocates	6	20.7
Have the interest to meet patients' advocacy needs	4	13.8
Serve as a role model for other health care workers	4	13.8
Wield greater influence	3	10.3
Ease the work load of other health care workers	3	10.3
Be more accepted by other health care workers	2	6.9
None of the above	1	3.4

Reported Perceptions Regarding The Preparation Of Nurses To Act As Patient Advocates (Research Question 2)

Relevant Questionnaire Items

The parts of the questionnaire which elicit perceptions regarding the preparation of nurses to act as patient advocates are subscale 3 and Part II-B. As previously described, subscale 3 consists of two Likert-type items from Part I of the questionnaire, items 10 and 11. Two types of items are included in Part II-B of the questionnaire: direct questions requiring a *yes*, *no*, or *I don't know* response as well as questions which usually required a response of three selections from a list of provided options.

Presentation Of Results

In the following discussion, the results from subscale 3 are presented first; then, the results from the other types of questionnaire items are presented. As shown in Table 11, the mean of subscale 3 was 4.104, which indicates that the respondents were positive in their perceptions about the preparation of nurses to fulfill the role of patient advocate. In addition, the average scores for each of the individual items comprising the subscale were also positive. With a mean of 1.956, item 10 was the second most positive item of all the items in the full-scale (Tables 6, 11 and 19). Since the average score of item 11 was 2.24, the respondents were somewhat less positive about the preparation of other nurses to be patient advocates than they were of their own preparation.

All of the respondents, as per Table 12, responded to the question, "*Do you think nurses should be aware of patient advocacy as a role for nurses?*", and a large majority of them (98.2%) answered affirmatively. Table 13 shows that a large majority of the respondents who answered yes (85%), also chose *basic nursing education* as a factor which should contribute to that awareness, ranking it highest. The second ranking factor, *inservice programs conducted by employer*, was chosen by a smaller majority consisting of

Table 11

Descriptive Statistics For Subscale 3 (Including Individual Items) In Part I Of Questionnaire On Patient Advocacy As A Nursing Role

Scale	Mean	S.D.	Potential Range[a]	Potential Midpoint[b]
Subscale 3 (Items 10-11)	4.104	1.158	2 - 8	5.0

Individual Items	Frequencies[c]									
	A	G	O	N	N/O	Total	Mean	S.D.	Mode	Observed Range[d]
10. I feel prepared to act as a patient advocate.	28	66	17	3	2	116	1.956	.709	2	1-4
11. I think that other nurses are prepared to act as patient advocates.	6	73	31	1	5	116	2.243	.559	2	1-4

[a] Potential Range - was obtained by multiplying the lowest (1 = Always) and the highest (4 = Never) assigned values by the number of items in subscale 3. For example, there were 2 items in the subscale 3; therefore, the minimum of the range was 2 (1x2) and the maximum of the range was 8 (4x2).

[b] Potential Midpoint -was obtained by calculating the mean of the minimum and maximum of the potential range. For example, the potential midpoint of subscale 3 is 5.0 (10/2). Means below the potential midpoint are more positive than those above the potential midpoint.

[c] A=Always (1) G=Generally (2) O=Occasionally (3) N=Never (4) N/O=No Opinion

[d] Low scores are more positive than high scores

53.1% of the respondents. The next four ranking factors were selected less frequently, but by approximately the same percentage of nurses: *experience* (28.3%), *workshops or conferences not conducted by employer* (27.4%), *nursing literature* (26.5%), and *professional nursing organizations* (24.8%). Since none of the respondents chose *none of the above* from the provided list of possible factors which should contribute to making nurses aware of patient advocacy as a role for nurses, it can be assumed that the list was inclusive.

Table 12

Responses Of Respondents to Direct Questions About The Preparation Of Nurses To Act As Patient Advocates

Question	Yes		No		Don't Know		Total
	N	%	N	%	N	%	N
Do you think nurses should be aware of patient advocacy as a role for nurses?	114	98.2	1	0.9	1	0.9	116
Do you think that nurses should learn how to be patient advocates?	109	94.8	0	0.0	6	5.2	115
Since your most recent graduation from a formal educational institution (basic, post-basic, or graduate education), have you read anything on the topic of the nurse's role as a patient advocate?	67	58.3	40	34.8	8	6.9	115
Since your most recent graduation from a formal educational institution (basic, post-basic, or graduate education), have you attended any information sessions on the topic of patient advocacy?	12	11.1	95	88.0	1	0.9	108

Table 13

Factors That Should Contribute To Making Nurses Aware Of Patient Advocacy According To Respondents Who Indicated That Nurses Should Be Aware of Patient Advocacy As A Role For Nurses

Factors	Freq.	% of Respondents (N=113)
Basic nursing education	96	85.0
Inservice programs conducted by employer	60	53.1
Experience	32	28.3
Workshops or conferences not conducted by employer	31	27.4
Nursing literature	30	26.5
Professional nursing organizations	28	24.8
Other nurses	17	15.0
Other members of health care team	12	10.6
Post basic nursing education	9	8.0
Graduate nursing education	7	6.2
Nursing supervisors	4	3.5
Public media	3	2.7
None of the above	0	0.0

In comparison to Table 13, Table 14 shows that *experience* was identified by the largest majority (68.3%) of the respondents who participated in the study as the factor which actually contributed to their awareness of patient advocacy as a role for nurses while *basic nursing education* was identified as an awareness contributing factor by the second largest majority of the respondents (55.4%). *Other nurses* and *advocacy needs of patients*, which ranked third and fourth, as awareness contributing factors were identified by 40.6% and 37.6% of the respondents respectively. Approximately 12% of the respondents indicated that *this questionnaire* had contributed to their awareness of patient advocacy as a role for nurses, ranking that factor sixth in a field of 16. *None of the above* was not chosen as an option from the provided list of possible factors which actually contributed to the respondents' awareness of patient advocacy as a role for nurses, leading to the assumption that the list was inclusive. However, fifteen of the respondents did not respond to the questionnaire item.

Table 14

Factors That Actually Contributed To The Awareness Of Respondents About Patient Advocacy As A Role For Nurses

Factor	Freq.	% of Respondents (N=101)
Experience	69	68.3
Basic nursing education	56	55.4
Other nurses	41	40.6
Advocacy Needs of Patients	38	37.6
Nursing literature	28	27.7
This questionnaire	12	11.9
Other members of health care team	10	9.9
Post basic nursing education	9	8.9
Inservice programs conducted by employer	7	6.9
Graduate nursing education	7	6.9
Nursing supervisors	5	5.0
Workshops or conferences not conducted by employer	4	4.0
Public media	3	3.0
I was not aware	2	2.0
Professional nursing organizations	1	1.0
None of the above	0	0.0

According to Table 12, approximately 95% of the respondents indicated that nurses should learn how to be patient advocates. Table 15 shows that the largest majority of those respondents (62.4%) indicated that nurses should learn how to act as patient advocates *through experience*. A similar percentage of the respondents chose the next two ranking types of learning activities: *attending lectures* (61.5%) and *receiving positive acknowledgement for acting as an advocate* (60.6%). According to Table 16, the factor which the largest majority of the respondents who participated in the study identified as the one which actually helped them learn to act as a patient advocate was *acting as an advocate* (54.1%), and the factor identified by the second largest majority of the respondents was *receiving positive acknowledgement for acting as an advocate* (44.9%). *Talking with other nurses*, which ranked third, was identified as a learning factor by 43.9% of the respondents. Two factors, *lectures attended while a student* and *watching other nurses*, ranked fourth. They were both identified as learning factors by 29.6% of the respondents. While *none of the above* was not chosen as a response to the questionnaire item on how

nurses should learn to act as patient advocates (Table 15), it was chosen by two respondents as a response to the questionnaire item on factors that actually assisted the respondent to learn to act as patient advocates (Table 16). Therefore, some pertinent learning activities may have been missing from the latter list of learning activities which was provided. Eighteen respondents did not complete the questionnaire item on factors that actually assisted the respondent to learn to act as a patient advocate.

Table 15

How Nurses Should Learn To Act As Patient Advocates According To Respondents Who Indicated That Nurses Should Learn To Be Patient Advocates

Learning Mode	Freq.	% of Respondents (N=109)
Through experience	68	62.4
Attending lectures	67	61.5
Receiving positive acknowledgement for acting as an advocate	66	60.6
Talking with other nurses	53	48.6
Reading Articles and Books	37	33.9
Role playing	16	14.7
Watching other nurses	15	13.8
Following directions	1	0.9
None of the above	0	0.0

Table 16

Factors That Have Actually Assisted Respondents To Learn To Act As Patient Advocates

Factor	Freq.	% of Respondents (N=98)
Acting as an advocate	53	54.1
Receiving positive acknowledgement for acting as an advocate	44	44.9
Talking with other nurses	43	43.9
Lectures attended while a student	29	29.6
Watching other nurses	29	29.6
Articles and books	25	25.5
Workshops and/or conferences	15	15.3
Talking with non-nurse health care workers	9	9.2
I have not yet learned how to act as a patient advocate	7	7.1
Role playing	3	3.1
Following directions	2	2.0
None of the above	2	2.0

Approximately 53% of the respondents who indicated that nurses should learn to be patient advocates indicated that nurses should learn about *communication skills* in order to be adequately prepared to act as patient advocates. As shown in Table 17, *communication skills* was chosen most frequently. The topics which ranked second and third were *human rights* (48.6%), and *their own value systems* (44.4%). The next ranking topics, *individual differences*, *differing value systems*, and *channels of communication*, were chosen by approximately an equal percentage of respondents: 37.0%, 34.3% and 33.3% respectively. One respondent selected *none of the above* from the provided list of possible learning topics indicating that pertinent topics may have been omitted from the list.

Table 17

Learning Topics Selected By Respondents Who Indicated That Nurses Should Learn To Be Patient Advocates

Factor	Freq.	% of Respondents (N=108)
Communication skills	57	52.8
Human rights	53	49.1
Their own value systems	48	44.4
Individual differences	40	37.0
Differing value systems	37	34.3
Channels of communication	36	33.3
The legal system	26	24.1
Moral principles	16	14.8
Government policies	5	4.6
None of the above	1	0.9

From Table 12, it is apparent that since their most recent graduation from a formal educational institution, 58.3% of the respondents had read something on the topic of patient advocacy, and 11.1% had attended an information session on the topic. It is also apparent that one of the respondents did not respond to the questionnaire item regarding reading activity, and eight did not respond to the questionnaire item regarding attendance at information sessions. The average length of time reported since reading had taken place was 9.7 months. The maximum length of time was four years and the shortest length of

time was one month. As shown in Table 18, the type of article read by the largest majority of the respondents (95.5%) was *articles from nursing journals*. The types of information sessions attended most frequently were *inservice presentations offered by employer* and *workshop, conference, or seminar not offered by employer*, which were attended by 50% and 58.3% of the respondents respectively.

Table 18

Learning Experiences Respondents Have Had On The Topic Of Patient Advocacy Since Most Recent Graduation From A Formal Educational Institution

Reading	Freq.	% of Respondents (N=67)
Articles from nursing journals	64	95.5
Newspaper articles	8	11.9
Books	7	10.4
Popular magazine articles	7	10.4
Attendance At Information Sessions	**Freq.**	**% of Respondents (N=12)**
Workshop, conference, or seminar not offered by employer	7	58.3
Inservice presentation offered by employer	6	50.0
Course offered by an educational institution	1	8.3

Reported Perceptions Regarding The Implementation Of Patient Advocacy By Nurses (Research Question 3)

Relevant Questionnaire Items

Subscale 1, Part II-C, and items 6 - 10 in Part III of the questionnaire elicit perceptions regarding the implementation of patient advocacy by nurses. As previously described, subscale 1 consists of the first seven Likert-type items in Part I of the questionnaire. Each of the items in Part II-C is a question requiring a response of three selections from a list of provided options. The items from Part III of the questionnaire are

direct questions requiring a response of *yes, no* or *I don't know* about employers' policies relating to patient advocacy, and the respondent's familiarity with said policies.

Presentation Of Results

In the following discussion, the results from subscale 1 are presented prior to the results from the other types of questionnaire items. As shown in Table 19, the mean of subscale 1 was 14.474. Since this score is below the potential midpoint of 17.5, the perceptions of the respondents regarding the implementation of patient advocacy by nurses was positive. As per Table 19, the average scores of the individual items comprising subscale 1 were also positive. Of the seven items, items 3 and 5, which asked about the commitment and comfort of the respondent in relation to the role of patient advocacy, were the most positive with average scores of 1.750 and 1.965 respectively. At 2.148 and 2.310 respectively, the average scores of items 4 and 6, which were parallel items about the commitment and comfort of other nurses in relation to the role of patient advocacy, were somewhat less positive.

Approximately 85% of the respondents reported that they had, at some time, acted as a patient advocate; 7.8% reported that they had not. Another 6.0% did not know if they had ever acted as a patient advocate, and 1.7% declined responding to the question. Table 20 shows that of the choices provided to describe actions which nurses take when they are acting as patient advocates, *informing patients about the treatments and medications which they are taking,* was chosen by the largest majority of respondents (78.4%). The action which was selected with the second highest frequency, *speaking to others on behalf of the patient,* was chosen by 63.8% of the respondents, and the one which ranked third, *ensuring that patients' rights are met,* was chosen by 55.2% of the respondents. The action which ranked fourth, *providing emotional support for patients,* was chosen by 34.5% of the respondents. *Informing patients about facts related to their care that their physician(s) have not told them,* and *providing good nursing care* were each chosen by 30.2% of the

Table 19

Descriptive Statistics For Subscale 1 (Including Individual Items) In Part I Of Questionnaire On Patient Advocacy As A Nursing Role

Scale	Mean	S.D.	Potential Range[a]	Potential Midpoint[b]
Subscale 1 (Items 1-7)	14.474	3.128	7 - 28	17.5

Individual Items	Frequencies[c] A	G	O	N	N/O	Total	Mean	S.D.	Mode	Observed Range
1. In my opinion, nurses are acting as patient advocates.	18	73	25	0	0	116	2.060	.608	2	1-3
2. In my opinion, nurses are implementing the role of patient advocacy as it should be implemented.	2	57	50	2	2	113	2.468	.568	2	1-4
3. I am committed to acting as a patient advocate.	47	53	14	2	0	116	1.750	.733	2	1-4
4. I think that other nurses are committed to acting as patient advocates.	10	78	27	1	0	116	2.148	.550	2	1-3
5. I am comfortable acting as a patient advocate.	26	68	18	2	1	115	1.965	.677	2	1-4
6. I think that other nurses are comfortable acting as patient advocates.	2	75	35	1	3	116	2.310	.519	2	1-4
7. In my opinion, nurses who advocate on behalf of their patients are supported by their peers.	14	80	19	0	3	116	2.044	.541	2	1-3

[a] Potential Range - was obtained by multiplying the lowest (1 = Always) and the highest (4 = Never) assigned values by the number of items in subscale 1. For example, there were 7 items in subscale 1; therefore, the minimum of the range was 7 (1x7) and the maximum of the range was 28 (4x7).

[b] Potential Midpoint -was obtained by calculating the mean of the minimum and maximum of the pot ential range. For example, the potential midpoint of subscale 1 is 17.5 (35/2). Means below the potential midpoint are more positive than those above the potential midpoint.

[c] A=Always (1) G=Generally (2) O=Occasionally (3) N=Never (4) N/O=No Opinion

respondents. None of the 116 respondents answered *I don't know*. In addition, none of the respondents chose *none of the above* from the provided list of possible actions undertaken by nurses when they are acting as patient advocates, therefore the list can be considered to be inclusive.

Table 20

Activities Undertaken By Nurse Advocates According To Respondents

Activity	Freq.	% of Respondents (N=116)
Informing patients about the treatments and medications which they are receiving	91	78.4
Speaking to others on behalf of the patient	74	63.8
Ensuring that patients' rights are met	64	55.2
Providing emotional support for patients	40	34.5
Informing patients about facts related to their care that their physician(s) have not told them	35	30.2
Providing good nursing care	35	30.2
Assisting patients to find meaning in their experiences	3	2.6
Going beyond their duties	2	1.7
I don't know	0	0.0
None of the above	0	0.0

As displayed in Table 21, *physicians* was the response selected by 74.1% of the respondents when asked where, in addition to the individual patient, nurses should focus their attention when they are acting as patient advocates. Ranking a close second, the response, *the families of their patients*, was chosen by 71.6% of the participating nurses. *Within health care organizations to bring about change*, which ranked third, was selected by 37.9% of the respondents. Ranking last, the option, *politically to lobby for social change*, was chosen by 15.5% of the respondents. Although all the respondents answered this item, 5.2% did so by chosing *I don't know*. *None of the above* was not chosen by any of the respondents, therefore it can be assumed that the list of provided options regarding the focus of activities undertaken by nurse advocates was inclusive.

Table 21

Focus Of Nurse Advocate's Attention According To Respondents

Focus (In addition to individual patients)	Freq.	% of Respondents (N=116)
Physicians	86	74.1
The families of their patients	83	71.6
Nurse co-workers	56	48.3
Within health care organizations to bring about change	44	37.9
Non-nurse health care workers	32	27.6
Politically to lobby for social change	18	15.5
I don't know	6	5.2
None of the above	0	

According to Table 22, *supportive work climate* and *personal values* ranked highest among factors that enable nurses to act as patient advocates. They were the only factors chosen by a majority of the respondents: 62.3% and 55.3% respectively. *Educational preparation* and *experience* ranked third (48.2%) and fourth (42.1%) respectively. Three respondents answered *I don't know*, and two declined responding to the questionnaire item. Since one respondent chose *none of the above* from the provided list of possible enabling factors, it is possible that the list was incomplete.

Table 22

Factors Which Enable Nurses To Act As Patient Advocates According To Respondents

Enabling Factor	Freq.	% of Respondents (N=114)
Supportive work climate	71	62.3
Personal values	63	55.3
Educational preparation	55	48.2
Prior experience with advocacy	48	42.1
Personal beliefs	38	33.3
Performance standards	28	24.6
Professional organizations	11	9.6
Legislation	10	8.8
I don't know	3	2.6
None of the above	1	0.9

When asked to identify factors which interfere with the ability of nurses to act as patient advocates, the respondents ranked *fear of conflict with physicians* highest (Table 23). However, that response was chosen by a small majority of 53% of the respondents. *Lack of required knowledge,* which was chosen by 44.3% of the respondents, ranked second. The response which ranked third, *ambiguity about the role*, was chosen by 43.5% of the respondents. *Attitudes of administrators on nursing unit* ranked fourth and *risks involved* ranked fifth. The latter two factors were chosen by 33.0% and 28.7% of the respondents respectively. One (0.9%) of the 115 staff nurses who responded to the question answered *I don't know*. Another one indicated that none of the factors which were included on the provided list interfered with the nurse's ability to act as a patient advocate. Therefore, it can be concluded that the perceptions of that respondent were not reflected by the list of interfering factors that was provided.

Table 23

Factors Which Interfere With Nurses' Ability To Act As Patient Advocates According To Respondents

Interfering Factor	Freq.	% of Respondents (N=115)
Fear of conflict with physicians	61	53.0
Lack of required knowledge	51	44.3
Ambiguity about the role	50	43.5
Attitudes of administrators on nursing unit	38	33.0
Risks involved	33	28.7
Lack of necessary skills	25	21.7
Lack of motivation	22	19.1
Lack of support from other nurses	21	18.3
Attitudes of other administrators	13	11.3
Lack of supportive legislation	13	11.3
Lack of performance standards	6	5.2
Lack of expectation from patients	3	2.6
I don't know	1	0.9
None of the above	1	0.9

As displayed in Table 24, the response which the respondents chose most frequently when asked about likely outcomes for patients if nurses act as patient advocates was *make informed choices*. It was chosen by 73.3% of the respondents. The responses which ranked second and third, *become involved in their own care*, and *be aware of their rights*, were each chosen by over 55% of the respondents. None of the 116 respondents chose *none of the above* in response to the query, indicating that the provided list of likely outcomes for the patient was complete. One respondent answered *I don't know*.

Table 24

Likely Outcomes For The Patient If Nurses Act As Patient Advocates According To Respondents

Outcomes	Freq.	% of Respondents (N=116)
Make informed choices	85	73.3
Become involved in their own care	69	59.5
Be aware of their rights	66	56.9
Be more satisfied with the care they receive	47	40.5
Maintain their dignity	37	31.9
Receive more individualized care	12	10.3
Recover more quickly	10	8.6
Receive the same care they would if the nurse was not acting as a patient advocate	7	6.0
Be unaware of the nurses' efforts	4	3.4
Find meaning in their situation	2	1.7
Be indifferent to the nurses' efforts	1	0.9
I don't know	1	0.9
None of the above	0	0.0

According to Table 25, two responses were chosen by a majority of the respondents when they were asked to identify the outcomes for the nurse of advocating on behalf of a patient. They were *personal pride* and *a clear conscience*, which were chosen by 62.1% and 55.2% of the respondents respectively. *Peer support*, which ranked third, was chosen by 37.1% of the respondents, and *strained relations with other health care workers*, which was selected by 27.6% of the respondents, ranked fourth. Although all 116 respondents answered the questionnaire item, approximately 13% of them indicated

that they did not know what the likely outcomes would be for the nurse who advocates on behalf of a patient. In addition, 3.4% of the respondents chose *none of the above* from the provided list of possible likely outcomes for the nurse, indicating that the list may not have been comprehensive.

Table 25

Likely Outcomes For The Nurse Advocate According To Respondents

Outcomes	Freq.	% of Respondents (N=116)
nal pride	72	62.1
ear conscience	64	55.2
Peer support	43	37.1
Strained relations with other health care workers	32	27.6
Approval from administrators on nursing unit	19	16.4
I don't know	15	12.9
Reprimands from administrators on nursing unit	12	10.3
Lack of peer support	8	6.9
Dismissal	5	4.3
Strained relations with other nurses	5	4.3
Reprimands from other administrators	3	2.6
Promotion	2	1.7
Loss of Licensure	0	0.0
Approval from other administrators	0	0.0
None of the above	4	3.4

Sixty-nine percent of the respondents were of the opinion that nurses may choose not to act as patient advocates because they *do not feel capable of fighting the system*. According to Table 26, this reason was chosen by considerably more respondents than the two ranking below it, *do not wish to create unpleasant working conditions* and *do not wish to take on more than they have to*, which were selected by 46.6% and 37.9% of the respondents respectively. The fourth ranking reason, *do not think it is their responsibility*, was cited by 34.5% of the staff nurses. Approximately one-quarter of the respondents chose the fifth ranking response, *think the risks outweigh the benefits*. All 116 respondents answered the questionnaire item which asked about factors that may influence nurses not to act as patient advocates. Approximately 8% of them chose *I don't know*.

Another 3.4 % chose *none of the above* from the provided the list of possible factors, suggesting that the list may have been incomplete.

Table 26

Factors Influencing Nurses Not To Act As Patient Advocates According To Respondents

Factor	Freq.	% of Respondents (N=116)
Do not feel capable of fighting the system	80	69.0
Do not wish to create unpleasant working conditions	54	46.6
Do not wish to take on more than they have to	44	37.9
Do not think it is their responsibility	40	34.5
Think the risks outweigh the benefits	30	25.9
Do not feel any personal gain in doing so	19	16.4
Want to keep their position	12	10.3
I don't know	9	7.8
Need the money they are earning	5	4.3
Want to continue working within the profession	5	4.3
None of above	4	3.4

As shown in Table 27, all 116 respondents answered the request to identify risks that nurses should be prepared take in order to act as patient advocates. The highest ranking risk, *strained relations with other health care workers,* was chosen by a small majority 51.3% of the respondents. *Lack of peer support* was chosen by 47% of the respondents, ranking that risk second. Less than 45% of the respondents indicated that *strained relations with other nurses* was an acceptable risk ranking it third. Approximately 24% of the respondents answered *nothing* in response to the query. Since *none of the above* was chosen by approximately 21% of the respondents, it can be assumed that the provided list of possible risks that nurses should be prepared to take in order to act as patient advocates was not complete.

Table 27

Acceptable Risks For Nurse Advocates According To Respondents

Risk	Freq.	% of Respondents (N=116)
Strained relations with other health care workers	59	51.3
Lack of peer support	54	47.0
Strained relations with other nurses	50	43.5
Nothing	28	24.3
Official reprimand	19	16.5
Dismissal	4	3.5
Loss of licensure	0	0.0
None of the above	24	20.9

Table 28 shows that close to 13% of the 116 respondents indicated that their employer had written policies regarding patient advocacy. According to Table 29, one-third of the respondents with employers having such policies were very familiar with the policies, while 60% were somewhat familiar with them. Table 28 also shows that approximately 11% of the respondents indicated that their employer had written policies regarding the nurse's role as patient advocate. According to Table 29, 41.7% of the respondents with employers having such policies were very familiar with the policies while 50% were somewhat familiar with them.

Table 28

Responses Of Respondents To Direct Questions About Whether Employers Have Policies Relating To Patient Advocacy

Question	Yes		No		Don't Know		TOTAL
	N	%	N	%	N	%	N
Does your employer have any **written** policies regarding patient advocacy?	15	12.9	58	50.0	42	36.2	116
Does your employer have any **written** policies regarding the nurse's role as patient advocate?	13	11.3	56	48.7	46	40.0	115

Table 29

Familiarity With Policies On The Topic Of Patient Advocacy Among Respondents Employed In Agencies Having Such Policies

Question	Very N	Very %	Some N	Some %	None N	None %	TOTAL N
How **familiar** are you with your employer's written policies regarding patient advocacy?	5	33.3	9	60.0	1	6.7	15
How **familiar** are you with your employer's written policies regarding the nurse's role as patient advocate?	5	41.7	6	50.0	1	8.3	12

Differences In Reported Perceptions (Research Question 4)

Categorization of Respondents

In order to determine whether differences existed in the perceptions of the respondents regarding the nurse's role as patient advocate, the preparation of nurses to fulfill the role of patient advocate, and the implementation of patient advocacy by nurses, the results were organized into categories according to the following biographic characteristics of the respondents: type of employer, location of employing agency, educational background, years of nursing experience, and exposure to information on patient advocacy since most recent graduation from a formal educational institution. Henceforth, the latter category will be referred to as exposure to information.

As displayed in Table 1, the category, type of employer, is comprised of one group of 88 respondents employed by active treatment hospitals, and another group of 28 employed by additional health care agencies. The category, location of employing agency, includes one group with a total of 94 respondents who were working in an urban center and another group with 22 respondents who were working in another kind of setting. As shown in Table 3, the category, educational background, contains one group of 90

respondents with RN diplomas and another group composed of 26 respondents with university degrees. The category, years of nursing experience, is comprised of five intervals as per Table 30. The category, exposure to information, contains four groups. The characteristics and the number of respondents of each group are displayed in Table 31.

Table 30

Categorization Of Respondents According To Years Of Nursing Experience

Interval	N	Percent
1 - 5 years	32	27.6
6 - 10 years	22	19.0
11 - 15 years	24	20.7
16 - 25 years	24	20.7
26 - 40 years	14	12.0
Total	**116**	**100.0**

Table 31

Categorization Of Respondents According To Exposure To Information On Patient Advocacy Since Most Recent Graduation From A Formal Educational Institution

Group Characteristic			
Read Material	Information Session	N	Percent
yes	**yes**	9	8.4
yes	**no/don't know**	51	47.7
no/don't know	**yes**	3	2.8
no/don't know	**no/don't know**	44	41.1
	TOTAL	**107**	**100.0**

Presentation of Results

Analysis of variance (ANOVA) was performed on all the scales and items in Part I of the questionnaire to determine if there were significant differences at the .05-level in the mean scores obtained by the groups within each of the categorizations. In those cases

where significant differences were found, the Newman-Keuls test was used to determine which group(s) differed (Howell, 1982). As indicated previously, certain scales and items in Part I of the questionnaire relate to each of the research questions. The chi-square test of independence was considered for the direct question items in Parts II and III of the questionnaire, but, when cross tabulations were run, many cells turned up empty resulting in a majority of cells containing expected frequencies of less than five. Since this condition violates a basic assumption underlying the utilization of chi-square, it was apparent that the chi-square procedure was an inappropriate statistical technique to use in this section of the analysis. Chi-square was also an inappropriate procedure for the questionnaire items requiring a response of three selections because the selections were not independent (Howell, 1982).

As seen in Table 32, the category, years of nursing experience, had a significant probability value for the full-scale ($p \leq .0317$), subscale 1 ($p \leq .0394$), and subscale 2 ($p \leq .0351$).

Table 32

Obtained Probability Levels From ANOVAs For Scales From Part 1 Of Questionnaire On Patient Advocacy As A Nursing Role Per Categorization Of Respondents

Scale	Employer	Location	Education	Experience	Exposure
Full-scale	.3514	.9678	.3645	**.0317**	.1866
Subscale 1	.2602	.9060	.1123	**.0394**	.2424
Subscale 2	.6287	.3717	.8551	**.0351**	.4726
Subscale 3	.7200	.3375	.8055	.0617	.3630

Table 33 shows that for two categories, type of employer and location of employing agency, none of the individual items had obtained probabilities which were significant at the .05-level. The categories, educational background and exposure to information each had one significant item. For educational background, the significant item was item 2 (*In my opinion, nurses are implementing the role of patient advocacy as it*

Table 33
Obtained Probability Levels From ANOVAs For Items From Part I Of Questionnaire On Patient Advocacy As A Nursing Role Per Categorization Of Respondents

	Individual Items	Employer	Location	Education	Experience	Exposure
1.	In my opinion, nurses are acting as patient advocates.	.0946	.7948	.3494	.1163	**.0420**
2.	In my opinion, nurses are implementing the role of patient advocacy as it should be implemented.	.3931	.3551	**.0490**	.5916	.5370
3.	I am committed to acting as a patient advocate.	.3767	.4215	.1726	.1622	.2969
4.	I think that other nurses are committed to acting as patient advocates.	.2164	.6961	.2509	.5664	.2886
5.	I am comfortable acting as a patient advocate.	.3347	.1838	.0938	**.0216**	.2312
6.	I think that other nurses are comfortable acting as patient advocates.	.1236	.2464	.6522	**.0475**	.6828
7.	In my opinion, nurses who advocate on behalf of their patients are supported by their peers.	.6199	.6138	.6367	.4454	.5062
8.	Among all the roles that they assume, I believe that nurses give patient advocacy a high priority.	.7546	.8199	.8372	.1220	.2609
9.	I believe that when the term patient advocate is used to describe a nursing role, it is understood in the same way by all nurses.	.4406	.7692	.2406	**.0089**	.4731
10.	I feel prepared to act as a patient advocate.	.7080	.3230	.7880	**.0136**	.2227
11.	I think that other nurses are prepared to act as patient advocates.	.1593	.4150	.8973	.1507	.8257

should be implemented.) with a probability of .0490. For exposure to information, the significant item is item 1 (*In my opinion, nurses are acting as patient advocates.*) with a probability of .0420. The category, years of nursing experience, resulted in four items with significant F-values: items 5 (*I am comfortable acting as a patient advocate.*), 6 (*I think that other nurses are comfortable acting as patient advocates.*), 9 (*I believe that when the term patient advocate is used to describe a nursing role, it is understood in the same way by all nurses.*), and 10 (*I think that other nurses are prepared to act as patient advocates.*). The respective probabilities of the above items were .0216, .0475, .0089, and .0136.

Tables 34-42 contain the complete data for those scales and items in which the ANOVAs were significant at the .05 level. The mean of each of the groups within the category is shown. So too, are the results of the Newman-Keuls test in those cases where the test distinguished differences between the groups. As shown in Tables 34, 35, and 36, the interval 6-10 years in the category, years of nursing experience, contrasted significantly with the interval 1-5 years for the full-scale, plus subscales 1 and 2. Tables 37 and 40 show that the Newman-Keuls test did not detect differences between the extreme groups for item 1 in the category, exposure to information, and for item 6 in the category, years of nursing experience. Table 38 shows that nurses with university preparation were more positive than those prepared at the diploma level in their perceptions regarding the way nurses are implementing the role of patient advocacy. According to Table 39, the interval 6-10 years, in the category years of nursing experience, contrasted significantly with the interval 1-5 years for item 5. Table 41 shows that for item 9, the intervals 6-10 years and 16-25 years contrasted significantly with the interval 1-5 years, while Table 42 shows that for item 10, the interval 6-10 years contrasted significantly with all the other intervals in the category years of nursing experience.

Table 34

ANOVA: Full-scale

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

Nurses' Attitudes Toward Patient Advocacy

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	32	25.31	4.652
2. (6 - 10 years)	21	21.33	3.088
3. (11 - 15 years)	23	22.87	4.536
4. (16 - 25 years)	24	22.96	5.575
5. (26 - 40 years)	14	25.00	5.936
Total	114	23.553	4.923

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	251.076	62.769	2.751	.032
Within Groups	109	2487.109	22.818		
Total	113	2738.184			

Significant Newman-Keuls Contrasts

6 - 10 years vs. 1 - 5 years

Table 35

ANOVA: Subscale 1

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

Implementation Of Patient Advocacy

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	32	15.688	3.393
2. (6 - 10 years)	22	13.273	2.051
3. (11 - 15 years)	24	13.833	1.899
4. (16 - 25 years)	24	14.208	3.203
5. (26 - 40 years)	14	15.143	3.439
Total	116	14.474	3.128

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	96.679	24.170	2.609	.039
Within Groups	111	1028.245	9.264		
Total	115	1124.924			

Significant Newman-Keuls Contrasts

6 - 10 years vs. 1 - 5 years

Table 36

ANOVA: Subscale 2

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

Perceptions Of The Nurse's Role As Patient Advocate

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	32	5.531	1.391
2. (6 - 10 years)	21	4.476	.981
3. (11 - 15 years)	23	4.826	1.230
4. (16 - 25 years)	24	4.625	1.555
5. (26 - 40 years)	14	5.214	1.477
Total	114	4.965	1.382

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	19.366	4.842	2.686	.035
Within Groups	109	196.493	1.803		
Total	113	215.859			

Significant Newman-Keuls Contrasts

6 - 10 years vs. 1 - 5 years

Table 37

ANOVA: Rating Of Item 1

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

In My Opinion Nurses Are Acting As Patient Advocates

By Exposure To Information Category

Category (Exposure to Information)	Freq.	Mean	S.D.
1. Reading (Yes) AND Info (Yes)	9	1.667	.707
2. Reading (Yes) AND Info (No / Don't know)	51	2.216	.541
3. Reading (No / Don't know) AND Info (Yes)	3	2.000	1.000
4. Reading (No / Don't know) AND Info (No / Don't know)	44	1.977	.590
Total	102	2.065	.539

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	3	2.937	.979	2.832	.042
Within Groups	103	35.605	.346		
Total	106	38.542			

Table 38

ANOVA: Rating Of Item 2

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

In My Opinion Nurses Are Implementing The Role Of Patient Advocacy As It Should Be Implemented

By Educational Background Category

Category (Education)	Freq.	Mean	S.D.
1. RN Diploma	88	2.522	.546
2. University Degree	23	2.261	.619
Total	111	2.469	.569

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	1	1.250	1.250	3.963	.049
Within Groups	109	34.389	.316		
Total	110	35.639			

Table 39

ANOVA: Rating Of Item 5

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

I Am Comfortable Acting As A Patient Advocate

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	32	2.156	.767
2. (6 - 10 years)	22	1.682	.477
3. (11 - 15 years)	23	1.957	.638
4. (16 - 25 years)	23	1.783	.518
5. (26 - 40 years)	14	2.286	.825
Total	114	1.965	.677

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	5.142	1.285	2.999	.022
Within Groups	109	46.718	.429		
Total	113	51.869			

Significant Newman-Keuls Contrast

6 - 10 years vs. 1 - 5 years

Table 40

ANOVA: Rating Of Item 6 (Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

I Think That Other Nurses Are Comfortable Acting As Patient Advocates

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	31	2.516	.508
2. (6 - 10 years)	21	2.143	.359
3. (11 - 15 years)	23	2.217	.422
4. (16 - 25 years)	24	2.208	.588
5. (26 - 40 years)	14	2.428	.646
Total	113	2.310	.519

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	2.546	.637	2.489	.048
Within Groups	108	27.6133	.256		
Total	112	30.1593			

Table 41

ANOVA: Rating Of Item 9

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

I Believe That When The Term Patient Advocate Is Used To Describe A Nursing Role It Is Understood In The Same Way By All Nurses

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	31	3.032	.706
2. (6 - 10 years)	20	2.300	.657
3. (11 - 15 years)	21	2.714	.561
4. (16 - 25 years)	23	2.478	.898
5. (26 - 40 years)	14	2.714	.826
Total	109	2.679	.768

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	7.712	1.928	3.577	.009
Within Groups	104	56.050	.539		
Total	108	63.762			

Significant Newman-Keuls Contrasts

6 - 10 years	vs.	1 - 5 years
16 - 25 years		

Table 42

ANOVA: Rating Of Item 10

(Part I Of Questionnaire On Patient Advocacy As A Nursing Role)

I Feel Prepared To Act As A Patient Advocate

By Years Of Nursing Experience Category

Category (Years of Experience)	Freq.	Mean	S.D.
1. (1 - 5 years)	31	2.032	.658
2. (6 - 10 years)	22	1.500	.512
3. (11 - 15 years)	23	2.087	.515
4. (16 - 25 years)	24	2.000	.722
5. (26 - 40 years)	14	2.214	1.051
Total	114	1.956	.709

Source	DF	Sum Squares	Mean Square	F	P-value
Between Groups	4	6.130	1.632	3.298	.014
Within Groups	109	50.651	.456		
Total	113	56.781			

Significant Newman-Keuls Contrasts

6 - 10 years	vs.	1 - 5 years
		11 - 15 years
		16 - 25 years
		26 - 40 years

Results Of Open-Ended Comments

Forty-nine of the respondents wrote comments on the last page of the questionnaire where space had been allotted for that purpose. On the basis of their prevailing content, the comments were organized into the following five categories: advocacy per se, major interfering factors, risk taking, public health experience, and other. With 26 comments, the category, advocacy per se, ranked highest in number. Included in the category were comments on the importance and necessity of patient advocacy in the health care system, and on the necessity of in-depth information on the topic via written policies, as well as articles in nursing magazines and newsletters. So too, were comments attesting to the fact

that nurses act as patient advocates on a daily basis. In the category, major interfering factor, six comments were included and all cited physicians as the major interfering factor. According to the respondents, physicians interfere with the nurse's ability to act as a patient advocate by either failing to take the nurse's information into consideration, or by generating fear of reprisals. Three of the four comments included in the category, risk taking, stated that there should not be any risks involved in acting as a patient advocate. A willingness to take risks in order to be a patient advocate, along with the observation that there is no obvious support system for nurses who do act as advocates, was noted in the fourth comment included ~~in the~~ risk taking category. It was noted in the three comments included the category, public health experience, that the implementation of patient advocacy is easier for a nurse employed by a public health agency than one employed by a hospital. According to the respondents, this is because public health nurses have greater access to community resources and because they are less constrained by protocol and policies. Included in the category, other, were 11 comments of a personal, encouraging, or rambling nature.

Summary

The typical respondent in this study was a female staff nurse prepared at the Diploma level, who possessed approximately 11 years of experience and who was working with adult patients in an active treatment hospital located in an urban centre.

The apparent overall perceptions of the respondents regarding patient advocacy as a role for nurses were positive. A vast majority of the respondents were of the opinion that nurses should act as patient advocates. Although there was a diversity of opinions as to why nurses should act as patient advocates, a majority of the respondents indicated it was because good nursing care is impossible without it. A vast majority of the respondents also acknowledged that other health care workers have an advocacy role to fulfill, however, a

small majority were of the opinion that there is not a need for an individual in the health care system whose only responsibility is patient advocacy. A very large percentage of the respondents were of the opinion that the nurse's role as a patient advocate differs from that of other health care workers because nurses are in a better position to be aware of patients' needs.

A vast majority of the respondents were of the opinion that nurses should be aware of patient advocacy as a role for nurses, and that they should also learn how to be patient advocates. Although experience was identified by the largest majority of respondents as the factor which actually contributed to their awareness of patient advocacy as a role for nurses, a very large majority indicated that basic nursing education should be an awareness contributing factor. A bare majority of the respondents were of the opinion that employers have a responsibility for creating awareness among nurses of their patient advocacy role through inservice programs. The largest majority of the respondents were of the opinion that nurses should learn how to act as patient advocates through experience. Coincidently, the largest majority of the respondents reported that they had learned to act as a patient advocate by acting as one. A bare majority of the respondents were of the opinion that knowledge of communication skills was important for the nurse to be adequately prepared to act as patient advocate. Overall, the apparent perceptions of the respondents regarding the preparation of nurses to act as patient advocates was positive. However, the respondents were more positive about their own preparation to assume the role than that of other nurses.

Similarly, the respondents were more positive about their own commitment and comfort in relation to implementing the role of patient advocacy than they were about that of other nurses. A very large majority of the respondents reported that they had acted as patient advocates. The activities which were identified by a majority of the respondents as those undertaken by nurses when they are acting as patient advocates were informing patients about the treatments and medications which they are receiving, speaking to others

on behalf of the patient, and ensuring that patients' rights are met. In addition to the individual patient, physicians and patients' families were each identified by a majority of the respondents as foci of the nurse advocate's attention. A majority of the respondents indicated that a factor influencing nurses not to act as patient advocates was a feeling of not being capable of fighting the system. The factor which the largest majority of respondents identified as an enabling factor was a supportive work climate, and the only factor which was identified by a majority of the respondents as a factor which interferes with the nurse's ability to act as patient advocate was fear of conflict with physicians. Three likely outcomes for the patient of advocacy action on the part of the nurse were identified by a majority of the respondents: make informed choices, become involved in their own care, and be aware of their rights. Two likely outcomes for the nurse who acts as a patient advocate were identified by a majority of the respondents: personal pride and a clear conscience. A very small number of the respondents reported that their employers have policies related to patient advocacy. Furthermore, those respondents working in agencies with such policies tended not to be very familiar with them.

On the basis of the results of the statistical analysis which was performed on the data, the largest number of significant results were associated with the variable, years of nursing experience. According to the statistical analyses which were conducted on the scales from Part I of the questionnaire, respondents with 6-10 years of nursing experience expressed more positive perceptions than those with 1-5 years toward patient advocacy as a role for nurses and toward the implementation of patient advocacy by nurses.

According to the results of the statistical analyses which were performed on the individual items comprising the full-scale, respondents with 6-10 years of nursing experience were more positive in their opinions than respondents with 1-5 years with respect to feeling comfortable while acting as a patient advocate. Respondents with 6-10 years and with 16-25 years of nursing experience were more positive than those with 1-5 years with respect to believing that the term patient advocate is understood in the same way

by all nurses when it is used to describe a nursing role. Respondents with 6-10 years of nursing experience were more positive than all the other groups in their perception regarding their preparation to act as patient advocates. Although years of nursing experience was a significant variable, with respect to perceptions regarding the comfort of other nurses when acting as patient advocates, it was not possible to distinguish between the five groups.

Analysis of the individual items comprising the full-scale produced two other significant results. There were significant differences between the four groups in the category, exposure to information, with regard to their opinions as to whether nurses are acting as patient advocates. However, the Newman-Keuls test did not distinguish between the groups in the category. In addition, respondents possessing university degrees were significantly more positive than those with RN diplomas in their attitudes regarding whether nurses are implementing the role of patient advocate as it should be implemented.

CHAPTER V

DISCUSSION OF RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

In order to be consistent with the format established in Chapter IV, this chapter is also organized according to the research questions posed in the study. Therefore, the findings and conclusions for each of the research questions are discussed separately. The discussion related to each research question concludes with suggestions for further research. The chapter opens with several brief statements about the characteristics of the respondents. It culminates with a discussion of the limitations of the study and several concluding statements relating the findings of the study to its stated purpose.

Characteristics of Respondents

According to Statistics Canada, there were 15,394 staff nurses among the nurses registered in Alberta in 1987, and 7,509 of them were employed in full-time positions. Of those with full-time positions, 86.3% were employed in hospitals while the remaining 13.7% were employed by agencies such as nursing homes, community health, or physicians offices. In this study, the percentage of respondents who were employed by hospitals (Table 1) appears to be somewhat lower than the population at large. Since Statistics Canada (1987) also reports that 12% of the total population of staff nurses among the nurses registered in Alberta in 1987 had university preparation at the baccalaureate level or higher, it may be that the percentage of respondents who had such preparation (Table 3) was somewhat higher than that of the population at large. It was not possible to compare the other biographical data of the respondents with that of the population of staff nurses employed in full-time positions in Alberta.

Reported Perceptions Regarding Patient Advocacy As A Role For Nurses (Research Question 1)

Discussion

Clearly, the staff nurses who participated in this study were in favor of patient advocacy as a nursing role. According to the results obtained on the full-scale and subscale 2 of the questionnaire, the respondents' expressed attitudes towards the role were positive (Tables 5 and 6), and close to 100% of them indicated that nurses should act as patient advocates (Table 7). Thus, the sentiments of the respondents were congruent with those of nursing authors such as Bandman (1987), Christy (1973), Curtin (1978, 1979, 1983), Donahue (1985), Fay (1978), Fonesca (1980), Gadow (1979, 1980, 1983), Kohnke (1982a), Kosik (1972), Laszewski (1981), Sklar (1979), Thollaug (1980), and Van Kempen (1979), who have championed patient advocacy in nursing. The sentiments of the respondents were also aligned with those of the AARN (1983) and the CNA (1985) which have both indicated that patient advocacy is an important nursing function.

In spite of the fact that the respondents were very supportive of patient advocacy as a nursing role, it must be remembered that several interpretations of the role exist (Curtin,1983; Donahue, 1985; Nelson, 1988, Winslow, 1984). Therefore, it is possible that all the respondents did not have the same concept of patient advocacy in mind when they were completing the questionnaire. An awareness on the part of the respondents of the difficulties associated with interpretation of the role of patient advocacy is evident from the results obtained for the Likert-type item which referred to a universal understanding of the term patient advocate (Table 6). With a mean of 2.679, it had the least positive score of all the individual Likert items (Tables 6, 11, and 19).

An examination of the rationales chosen by those respondents who indicated that nurses should act as patient advocates revealed divergent thinking, as well as a lack of widely held opinions (Table 8). For example, the highest ranking reason was chosen by

less than 59% of the respondents; all the other rationales were chosen by less than 44%. Interesting patterns in the way the rationales were chosen are also evident. While the rationale, *good nursing care is impossible without it*, was chosen by 58.6% of the respondents, the rationale, *patient advocacy is the basis of nursing*, was chosen by only 27% of the respondents. This result suggests that the respondents may consider patient advocacy to be a component of nursing care, rather that an underlying philosophy or conceptual framework as postulated by Curtin (1979), Donahue (1985), Gadow (1980), and Thollaug (1980). Further evidence that the respondents may consider patient advocacy to be a component of nursing care comes from the fact that the Likert-type item asking about the priority of patient advocacy in relation to other nursing roles was not answered highly positively (Table 6). According to Donahue (1985), it would be a grave injustice to consider patient advocacy simply as a nursing intervention (p. 348). Another interesting finding, in view of the fact that the need for a patient advocate is often said to be due to the increased vulnerability and powerlessness of patients in today's health care system (Annas & Healey, 1974; Chapman & Chapman, 1975; Christy, 1973; Copp, 1986; Curtin, 1978, 1979; Jenny, 1979; Kosik, 1972; Thollaug, 1980; Van Kempen, 1979), was that the rationale, *patients' rights are not being met by the health care system*, while ranking second, was chosen by only 43.2% of the respondents (Table 8).

Because professional issues were cited least frequently by the respondents as rationales for nurses to act as patient advocates, it can be asked whether staff nurses are aware that patient advocacy is an important nursing function according to professional nursing organizations. Additional questions, such as whether staff nurses attach any importance to the positions taken by their professional organizations, or to the organizations themselves, can also be raised. Questions are also generated by the finding that only 15.3% of the respondents chose *patient advocacy is a traditional nursing role* as a rationale for their opinion that nurses should act as patient advocates. Was that rationale chosen infrequently because other reasons were more important or because the respondents

viewed patient advocacy as a new role for nurses? If the respondents believe that patient advocacy is a new role for nurses, their views differ from those of nursing authors such as Donahue (1985) and Nelson (1988), who claim that nurses have always acted as patient advocates.

An identical proportion of respondents who indicated that nurses should act as patient advocates also indicated that non-nurse health care workers should act as patient advocates (Table 7). The proportion was very high, with 95.7% of the respondents answering affirmatively. It would appear, therefore, that the participants in this study did not consider patient advocacy to be a role exclusive to nursing. However, a large proportion of those respondents who indicated that non-nurse health care workers should act as patient advocates (87.3%) also indicated that nurses act differently than other health care workers as patient advocates. The rationales chosen by the respondents to support this position suggest that the majority of them were of the opinion that nurses have a unique type of relationship with patients which enables them to advocate for patients in a unique way (Table 9). Although this idea has also been expressed in the literature by several authors (Altschul, 1988; [illegible]87; Laszewski, 1981; Thollaug, 1980; Van Kempen, 1979), it appears that the nurse's role as a patient advocate has never been differentiated from that of other health care workers.

In view of the fact that professional nursing organizations have taken the position that patient advocacy is an important nursing function, and in view of the fact that nurses themselves consider patient advocacy to be an appropriate nursing role, perhaps the time is ripe for nursing leaders to come to some common understanding of the nurse's role as a patient advocate and to find creative and imaginative methods of informing all nurses, as well as other health care professionals, patients, and the general public of that role. If this is done, ambiguity surrounding the role of the nurse as a patient advocate may be lessened. In addition, duplication of advocacy roles among health care givers may be reduced, and

possibly eliminated. It is also possible that the nurse's role as a patient advocate may receive legitimization, particularly from the general public.

The respondents were not generally receptive to the notion of a health care worker whose only responsibility is patient advocacy (Table 7). There was, however, some hesitancy about the idea. Twelve of the 116 respondents did not answer when asked about the need for such an individual. Only 83.7% of those who did respond answered either *yes* or *no*, and only 55.8% answered negatively. The above results may be due to an impression among the respondents that the advocacy needs of patients can be met by health care workers who are already in the system. They may also be due to a reluctance to admit that the health care system or that nurses, in particular, are not meeting the advocacy needs of patients. There may also have been a lack of knowledge on the the part of the respondents about the purpose and functions of a health care worker whose only responsibility is patient advocacy.

Evidence suggesting that the respondents were not well informed about the role of such a worker may be found in the rationales of the 27.9% of the respondents who answered affirmatively when asked about the need for a health care worker whose only responsibility is patient advocacy (Table 10). Of those respondents, only 48.3% chose the rationale *have the necessary knowledge and skills*. Authors such as Annas (1974), Annas and Healey (1974), Storch (1978), and Tesolowski, et al., (1983), have emphasized that a health care worker whose only responsibility is patient advocacy would require special preparation. Only one rationale, *have the time to meet patients' advocacy needs,* was chosen by a majority of the respondents. It was, however, chosen by a small majority of 51.7%, suggesting that there may have been a lack of congruency in the perceptions of the respondents regarding the matter. It is interesting that the rationale, *have the interest to meet patients' advocacy needs*, was chosen by only 13.8% of the respondents to explain the need of a health care worker whose only responsibility is patient advocacy.

Because some hospitals have moved toward the appointment of a patient representative or a patient ombudsman (Robinson, 1987; Storch, 1977) and it seems likely that other institutions will follow suit, the implications of the above results regarding the need for a worker in the health care system whose only responsibility is patient advocacy are important. For example, they give rise to speculation as to how well such an individual would be accepted by established health care workers, such as staff nurses. According to Copp (1986), nurses often become defensive and experience ownership of the patient, his possessions, and his space. It would seem, therefore, that hospital administrators who are planning to create the position of patient representative or patient ombudsman within their institutions would be well advised to precede such an action with an intensive orientation campaign designed to explain the purpose and advantages of such an individual. This suggestion is very timely in Alberta where Bill 29 (1988), a Mental Health Act which legislates the appointment of a mental health advocate, is presently awaiting proclamation.

Recommendations For Further Research

The preceding discussion of the respondents' reported perceptions regarding patient advocacy as a role for nurses has given rise to the following questions which could serve as the basis of further research on the topic:

- What is patient advocacy: a philosophical underpinning, or a set of readily identifiable actions?
- How does the nurse's role as a patient advocate differ from that of other health care professionals?
- How can other health care professionals, patients and the general public best be apprised of the nurse's role as a patient advocate?
- How do patients, the public, and other health care workers perceive the nurse's role as a patient advocate?

Reported Perceptions Regarding The Preparation Of Nurses To Act As Patient Advocates (Research Question 2)

Discussion

Overall, the respondents strongly agreed that nurses should be prepared for the role of patient advocacy. However, their opinions regarding the degree of preparation which nurses should have differed slightly (Table 12). Approximately 98% of the respondents indicated that nurses should be aware of patient advocacy as a nursing role, while approximately 95% indicated that nurses should learn how to act as patient advocates. Those respondents who indicated that nurses should learn how to act as patient advocates, also indicated that nurses should learn about communication skills in order to be prepared to act as patient advocates (Table 17). This result is consistent with the findings of Wilberding (1984), whose respondents also indicated that communication skills are essential to patient advocacy.

Although none of the respondents indicated that nurses should not learn how to act as patient advocates, close to 5% indicated that they didn't know whether nurses should learn how to act as patient advocates. This slight uncertainty could be due to a belief that patient advocacy is a specialized role rather than a role for all nurses, or a belief that nurses do not need to make an effort to learn how to act as patient advocates because such learning occurs insidiously. If the respondents believe that nurses do not need formal preparation to act as patient advocates, their beliefs are contrary to those of Donahue (1985), Fay (1978), Jones (1982), and Namerow (1982) who have stated otherwise.

The respondents who indicated that nurses should be aware of patient advocacy as a role for nurses were unequivocal in identifying *basic nursing education* as the highest ranking factor among those which should contribute to that awareness (Table 13). While it was identified as an awareness contributing factor by 85% of the respondents, the second ranking factor, *inservice programs conducted by employer*, was identified by only 53.1%

of the respondents. It is noteworthy that both, *basic nursing education* and *inservice programs conducted by employer,* are provided for the nurse. At the same time, *nursing literature*, which is an activity that would require initiative on the part of the individual nurse, was identified as an awareness contributing factor by less than 27% of the respondents. This result is understandable if it is true that one would likely not seek information about a topic about which one is unaware. In contrast to the large percentage of respondents who identified *basic nursing education* as a factor which should contribute to making nurses aware of their role of patient advocacy, less than 9% of the respondents indicated that either *post-basic nursing education* or *graduate nursing education* should be awareness creating factors. It seems, therefore, that the respondents were of the opinion that patient advocacy is not too complex for beginning level nurses, and that nurses should become aware of the role while they are still students.

Although 85% of the respondents who were of the opinion that nurses should be patient advocates indicated that *basic nursing education* should contribute to making nurses aware of patient advocacy as a nursing role (Table 13), only 55.4% of the respondents who participated in the study reported that they had became aware of patient advocacy by that means (Table 14). Similarly, although 53.1% of the respondents who were of the opinion that nurses should be patient advocates indicated that *inservice programs conducted by employer* should be an awareness contributing factor, only 6.9% of the respondents who participated in the study reported that they had became aware of patient advocacy by that means. The factor which created awareness among the largest majority of the respondents (68.3%) was reported to be *experience.* Although *experience* ranked third as a factor which should contribute to making nurses aware of their role of patient advocacy, it was identified as an awareness creating factor by only 28.3% of the respondents. In view of the preceding discussion, it is evident that there was a discrepancy as to how the respondents indicated that nurses should become aware of patient advocacy as a nursing role, and how they actually become aware of the role.

There was more congruence in the perceptions of the respondents regarding how nurses should learn to act as patient advocates and how they actually learned to do so. In the former case, the largest majority (62.4%) of the respondents who indicated that nurses should learn to be patient advocates, indicated that *experience* should be an important learning factor (Table 15). In the latter case, the largest majority (54.1%) of the respondents who participated in the study reported that had actually learned how to act as a patient advocate by *acting as an advocate* (Table 16). In each of the above cases, *receiving positive acknowledgement* ranked among the top three factors. However, in the case of actually learning to act as a patient advocate, it was not identified as an important factor by a majority of the respondents. In the case of how nurses should learn to act as patient advocates, *attending lectures* was considered to be an important factor by the second largest majority of the respondents (61.5%). *Lectures attended while a student* ranked fourth in the case of actually learning to act as a patient advocate, but it was identified as an important factor by only 29.6% of the respondents.

In summary, although the respondents reported that they had actually become aware of patient advocacy as a role for nurses, and had actually learned how to act as patient advocates through work related experiences primarily, the results of the study suggest that they were of the opinion that nurses should be prepared for their advocacy role through a combination of educational preparation, experience, and positive acknowledgement. The results also suggest that the respondents did not give much credence to the notion that *professional nursing organizations* have a part to play in making nurses aware of their role of patient advocacy; less than 25% of the respondents indicated that *professional nursing organizations* should be an awareness contributing factor (Table 13). In addition, only 1% of the respondents indicated that they had become aware of patient advocacy as a role for nurses through such organizations (Table 14).

Since their most recent graduation from a formal educational institution, the respondents tended to read about patient advocacy rather than attend information sessions

on the topic, and those that read about patient advocacy tended to read articles from nursing journals rather than other types of printed matter (Table 18). It is possible that journal articles are appealing because of their accessibility and brevity, and that information sessions are infrequently presented. No data on their availability were collected in this study. Since a majority of the respondents who indicated that nurses should be aware of patient advocacy as a nursing role also indicated that *inservice programs conducted by employer* should be an awareness contributing factor (Table 13), it is possible that nurses would be receptive to inservice presentations on the topic.

The above results, regarding the preparation of nurses to act as patient advocates, have implications for basic nursing educators, inservice co-ordinators, and professional nursing organizations. Basic nursing educators should examine their programs to determine if, and how, advocacy as a role for nurses is presented to nursing students. If the topic of advocacy is not included in the curriculum, then efforts to do so should be initiated. Nursing curricula should also include content related to communication skills. In addition to learning factual information, students should have an opportunity to practice those skills under the supervision of a skilled instructor. The relationship between communication skills and patient advocacy should be made explicit.

Ideas on how to incorporate patient advocacy in the nursing curriculum have been presented in the nursing literature. Fay (1978) introduced the topic into the curriculum of her nursing program by assigning junior students enrolled in a six week medical-surgical course in a baccalaureate program an advocacy assignment which includes reading as well as experiential tasks. Similarly, the Master's level program in gerontological nursing offered by Seton Hall University College of Nursing includes an advocacy project which involves immersion in the advocacy role (Namerow,1982). Jones (1982) has suggested that the concept of patient advocacy could serve as the basis for the entire curricula in schools of nursing. According to Jones, such an approach would begin with the selection of a nursing theory, such as that of Henderson (1969), which is consistent with the

principles of advocacy. Methods for the incorporation of patient advocacy within nursing education programs can be gleaned from Storch (1977) who has made several recommendations to nursing educators for sensitizing nursing students to consumer rights, including the incorporation of consumer rights issues, trends, and problems, as well as legal education in the curriculum; the involvement of consumers in classroom and clinical instruction; the provision of role models; and the development of relevant teaching materials. Storch also recommends that the preparation of clinical nurse specialists in patient advocacy be considered.

Kohnke (1982) has noted that acting as a patient advocate requires an act of free will. Nursing students should therefore, be exposed to learning climates which may encourage them to choose to be patient advocates. Learning climates that would encourage patient advocacy to flourish would be based on democracy, rather than law and order. In such climates, students would be supported and recognized for their efforts at patient advocacy. The validity of positive encouragement as an effective learning tool is derived from learning theory, as well as from the results of this study. Consideration, however, should be given to the student's level of maturity. According to Kohlberg (1984), moral reasoning, which would probably have an impact on decisions relative to acting as a patient advocate, develops through sequential stages which are are influenced by the cognitions and the experiences of the individual. Although the discussion in the preceding two paragraphs has focused on basic nursing educators, the above suggestions of evaluating current offerings for patient advocacy content, arranging presentations on, or related to the topic, and creating a supportive climate apply equally well to inservice co-ordinators and professional nursing organizations.

Recommendations For Further Research

The preceding discussion of the respondents' reported perceptions regarding the preparation of nurses to act as patient advocates has given rise to the following questions which could serve as the basis of further research on the topic:

- Is patient advocacy a function for basic or specialized nursing practice?
- To what extent is patient advocacy being included in the curriculum of basic and graduate nursing education programs?
- What techniques are being employed to teach student nurses about the nurse's role as patient advocate?
- What is the best way of teaching nurses and student nurses to advocate on behalf of patients?
- What factors constitute a climate which is supportive of patient advocacy?

Reported Perceptions Regarding The Implementation Of Patient Advocacy By Nurses (Research Question 3)

Discussion

Overall, the staff nurses who participated in this study expressed positive perceptions about the implementation of patient advocacy by nurses (Table 19). They indicated that they were committed to the role and that they felt comfortable assuming it. However, they were less positive about the commitment and comfort of other nurses in relation to implementing the role of patient advocacy. The respondents also expressed positive perceptions about the manner in which patient advocacy is being implemented and the support which nurses who advocate on behalf of their patients receive from their peers.

Approximately 85% of the respondents reported that they had acted as patient advocates. As noted previously, however, patient advocacy can be interpreted in many ways. Therefore this self report is open to interpretation. So, too, are the self reports of

those respondents who said that they had not, or that they didn't know, if they had acted as patient advocates. It is possible that nurses do not recognize when they have acted as patient advocates and vice versa. If the relationship between patient advocacy and nursing practice is to be clarified, a common understanding of the term is necessary (Alfano, 1987; Donahue, 1985).

The largest majority of the respondents (78.4%) indicated that nurses are acting as patient advocates when they are *informing patients about the treatments and medications which they are receiving* (Table 20). Other advocacy activities which were identified by a majority of the respondents were *speaking to others on behalf of the patient* (68.3%), and *ensuring that the patient's rights are met* (55.2%). Thus, the majority of the respondents chose concrete, tangible activities to describe patient advocacy rather than obscure ones such as assisting patients to find meaning in their experiences. Therefore, the perceptions of the respondents regarding patient advocacy appeared to differ from those of authors like Curtin (1978,1979) and Gadow (1979,1980,1983) who suggest that patient advocacy is the philosophical basis of nursing. The perceptions of the respondents were congruent with those expressed by the AARN in its 1983 publication, Guidelines For Registered Nurses As Client Advocates

Of note is the fact that less than 31% of the respondents indicated that *informing patients about facts related to their care that their physician(s) have not told them* was not an advocacy activity to be undertaken by nurse advocates (Table 20). Thus, it appears that most of the participating staff nurses would not emulate nurse Tuma (1977), who did just that. Whether the respondents were motivated by loyalty to physicians, fear of the consequences, lack of knowledge, or a philosophical belief is not clear from the data. However, a hint may be evident in the fact that a majority of the respondents indicated that the factor which was most likely to interfere with the nurse's ability to act as a patient advocate was *fear of conflict with physicians* (Table 23). The subjects in a study

undertaken by Green (1978) also failed to identify with the role of patient advocate if it specifically contained a rejection of the physician's authority.

The results of the study suggest that the respondents were of the opinion that nurses who act as patient advocates should work on an interpersonal, rather than an organizational level (Table 21). Since the percentage of respondents (74.1%) who indicated that patient advocates should work with *physicians*, in addition to patients, was almost identical to the percentage (71.6%) who indicated that patient advocates should work with patients and the *families of their patients*, it seems that the respondents' opinions regarding the interpersonal nature of patient advocacy were congruent. Only 37.9% of the respondents indicated that patient advocates should work *within health care organizations to bring about change*, and only 15.5% indicated that patient advocates should work *politically to lobby for social change*. This latter finding was consistent with the fact that only 4.6% of the respondents indicated that *government policies* was an important topic for nurses to learn about in order [redacted]ately prepared to act as patient advocates (Table 17). The perception that patient [redacted]s not involve political activity at the institutional or societal level is not [redacted]the views expressed by nursing authors, such as Kosik (1972), who [redacted]ient advocacy involves taking on the system. The above results regarding [redacted]cy activity may reflect a belief that professional nursing organizations [redacted]ividual nurses would be more effective in the political arena, or a feeling of powerlessness on the part of staff nurses within the health care hierarchy. In fact, 69% of the respondents indicated that the factor most likely to influence nurses not to act as patient advocates was *do not feel capable of fighting the system* (Table 26).

In spite of the fact that the majority of the respondents indicated that nurses should receive formal preparation to act as patient advocates (Tables 13 and 15), they ranked *supportive work climate* and *personal values* before *educational preparation* as factors which enable nurses to act as patient advocates (Table 22). Kraus (1981) and Wilberding (1984), who conducted qualitative studies on the topic of patient advocacy, also found that

personal values such as a general belief in advocacy and self determination were important facilitators of patient advocacy.

Only one factor, *fear of conflict with physicians,* was identified by a majority of the respondents as likely to interfere with the nurse's ability to act as a patient advocate (Table 23). Therefore, it can be concluded that there was a diversity of opinion among the respondents on the matter. Perhaps the diversity of opinion can be attributed to the various settings in which the respondents were employed. It seems that some settings may be more conducive to patient advocacy than others. For example, several of the respondents observed that a public health setting was an excellent one in which to act as a patient advocate. In addition, Green (1978) and Pankratz & Pankratz (1974), who administered the Pankratz & Pankratz Attitude Scale to nurses, found that subjects who worked in non-traditional settings had higher attitudes towards nursing autonomy and advocacy, patient rights, and rejection of traditional role limitations than nurses employed in other settings. Interestingly, the earliest reference to patient advocacy in the nursing literature that this writer could find was made by a public health nurse (Kosik, 1972), who described advocacy in a community setting.

The results of the the study suggest that the likely outcome for patients, if nurses act as patient advocates, would be interactive health care. In other words, patients would be active, informed participants with input into their own health care rather than passive recipients of treatment (Table 24). The results also suggest that the likely outcomes for nurses who act as patient advocates would be favorable rather than negative. The three top ranking likely outcomes for the nurse advocate were *personal pride, a clear conscience,* and *peer support* (Table 25). In conjunction with these results regarding the likely outcomes of advocating for the nurse advocate, approximately 24.3% of the respondents indicated that there should be no risks associated with acting as an advocate (Table 27). The only risk which was acceptable to a majority of the respondents (51.3%) was *strained relations with other health care workers* (Table 27). Concomitantly, *strained relations with other nurses*

was deemed to be acceptable by 43.5% of the respondents (Table 25). Thus, despite reports in the nursing literature to the contrary, the staff nurses who participated in this study appeared to reject the idea that nurses who act as patient advocates should be prepared to take risks. They may have done so on the basis of positive personal experiences as a patient advocate. It may be, however, that the respondents have only acted as advocates in situations where there was no risk involved.

Few of the respondents reported that they were employed by agencies with written policies regarding patient advocacy (Table 28). In addition, those respondents who were employed by agencies where such policies exist were poorly informed about them (Table 29). Although it is possible that policies related to patient advocacy exist under the guise of different terminology, the above results have implications for nursing administrators and inservice co-ordinators. It would be advisable for nursing administrators in institutions without policies on patient advocacy or the nurse's role as a patient advocate to initiate the drafting of such policies. In addition to serving as guidelines for practice, such policies would indicate a commitment on the part of administration to the concept of patient advocacy. Inservice co-ordinators could assume the responsibility of informing nurses about the intent and content of said policies when they are drafted, and at periodic intervals to ensure familiarity with them. In those agencies where statements relating to patient advocacy are subsumed in policies of an encompassing nature, inservice co-ordinators could again act as clarifiers and informers. Another implication of the results from this study for nursing administrators and inservice co-ordinators is that they should work toward creating a supportive climate in which nurses are rewarded for acting as patient advocates and the risks of acting as an advocate are reduced.

Since the results of this study indicate that nurses believe that they are acting as patient advocates, the need for clarifying and explicating practice standards relating to patient advocacy is evident. Such clarification and explication would provide the nurse advocate with the means to recognize advocacy actions and to evaluate their effectiveness.

They would also inform nurses of the advocacy standards to which they may be held accountable.

Recommendations For Further Research

The preceding discussion of the respondents' reported perceptions regarding the implementation of patient advocacy by nurses has given rise to the following questions which could serve as the basis for further research on the topic:

- What are the advocacy needs of patients?
- What is involved in acting as a patient advocate?
- How often do nurses act as a patient advocate?
- What factors determine whether nurses will act as a patient advocate?
- What strategies can nurses employ in order to ensure that their efforts at advocating on behalf of patients are successful?
- Do health care agencies have policy statements related to patient advocacy?
- How do selected factors, such as supportive work climate and articulated practice standards, affect patient advocacy?

Differences In Reported Perceptions (Research Question 4)

Discussion

Although the opinions of the respondents tended to be homogeneous, those with 6-10 years of nursing experience had more positive attitudes than those with 1-5 years toward advocacy as a role for nurses and toward the implementation of patient advocacy by nurses (Tables 34-36). This finding may be due to a unique combination of practical experience and educational preparation which the respondents with 6-10 years of experience alone possess. Since the term patient advocacy first seems to have appeared in the nursing literature in 1972 (Kosik), it is possible that information on patient advocacy

was not included in nursing curricula till the late 1970s. Thus, it may be that the respondents with more than 10 years of experience did not learn about the nurse's role as a patient advocate when they were students. It is also possible that the respondents with less than six years of experience have views that have not been tempered by exposure to the realities of nursing practice. As noted by Benner (1984), experience is more than the passing of time. It is "the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory." (p. 36). When speaking of experience, Benner refers to length of service in a particular setting rather than cumulative time as a practicing nurse. From the data obtained in this study, it was not possible to ascertain the length of time the respondents had been working in their current clinical settings.

Other studies have also found that experience is a critical element with regard to patient advocacy. In a study conducted by Green (1978), nurses' attitudes, as measured by the Pankratz & Pankratz (1974) Nursing Attitude Scale, differed on the basis of experience. Green's subjects fell into two groups with 15 years of experience as the breakpoint. Those with 15 years or less of experience had the highest attitudes for two of the subscales in the Pankratz & Pankratz (1974) Nursing Attitude Scale: nursing autonomy and advocacy and rejection of traditional role limitations.

In a qualitative study conducted by Wilberding (1984), experience was identified as a strong source of belief in advocacy. On the basis of information from his subjects, Wilberding concluded that

> becoming an advocate is a continuing process that may take years as experience makes the nurse aware of more options for the patient. Experiences as a patients' advocate in nursing practice increase the nurse's confidence in and comfort with their role. Positive feedback from patients as the nurse gains experience reinforces her in the role. (p. 76)

According to Wilberding, the phases of the process of becoming an advocate are coming to believe in advocacy as a nursing role, learning about patient advocacy as a nursing student and functioning as a patient advocate over a period of years after graduation from nursing school.

Nursing educators should not decide to abandon patient advocacy as curriculum content on the basis that experience appears to be an essential element for becoming a patient advocate. Nursing education probably has a part to play in socializing the student nurse to the role of patient advocate and in providing the beginning advocate with the necessary knowledge and skills. Green (1977) and Pankratz and Pankratz (1974), who administered the Pankratz and Pankratz Nursing Attitude Scale to nursing subjects, found that education was substantially correlated with positive attitudes towards patient advocacy. In this study, it was found that respondents who had university preparation were more positive than those with diplomas in their perceptions regarding whether nurses are implementing the role of patient advocacy as it should be implemented (Table 38). It was also found that respondents who had both read material and attended information sessions on the topic of patient advocacy were more positive in their opinions regarding whether nurses are acting as patient advocates than respondents who had done neither (Table 37). Differences related to educational preparation may be accounted for by the manner in which patient advocacy and its implementation are presented in different types of educational programs. It may be, however, that individuals who seek university education have a unique view of the world..

Because becoming a patient advocate seems to be a process, nursing educators must be prepared to provide the support which students will require in their initial attempts at advocating. They must also have realistic expectations of what the beginning advocate can accomplish. Nurses in supervisory positions in health care agencies should also have realistic expectations of their staff based on an awareness that becoming a patient advocate is a process which requires experience.

Recommendations For Further Research

The preceding discussion of differences in the respondents' reported perceptions regarding patient advocacy as a role for nurses and the implementation of patient advocacy by nurses, according to years of experience, has given rise to the following questions which could serve as the basis for further research on the topic:

- Why do nurses with 6-10 years of nursing experience have more positive views towards patient advocacy than nurses with 1-5 years of nursing experience?
- What are the effects of length of service in a particular clinical setting on attitudes toward patient advocacy?
- How can nursing educators incorporate into nursing curricula the benefits that experience provides for nurses as they are learning to be patient advocates?

Limitations

Because a self administered, mailed questionnaire was utilized to elicit the data in this study, it may be that those who chose to respond do not represent the views of all staff nurses employed in full-time positions in Alberta. Therefore, although a random sample of staff nurses with full-time employment received invitations to participate in the study, it may not be possible to generalize the results of the study to the population at large, because a possibility of response bias exists. Furthermore, although the staff nurses who participated in this study expressed positive attitudes about patient advocacy, it cannot be assumed that they are acting as patient advocates.

Summary

The purpose of this study was to enhance understanding of the nurse's role as a patient advocate by augmenting theoretical formulations of the role with information from nurses whose practice involves direct patient care. The expressed perceptions of the staff nurses who participated in the study were basically congruent with those expressed in the nursing literature which are supportive of patient advocacy as a nursing role. The respondents indicated that nurses require communication skills if they are to become effective patient advocates, that becoming a patient advocate requires a combination of educational preparation and experience, and that a supportive climate is necessary for patient advocacy to flourish. The above information can be of use to those who are responsible for educating and assisting nurses to implement patient advocacy. It is hoped that the information which was obtained by this study will also serve as a catalyst for further thought and research on the nurse's role as a patient advocate.

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Appendix A

Questionnaire On Patient Advocacy As A Nursing Role

QUESTIONNAIRE

ON

PATIENT ADVOCACY

AS A

NURSING ROLE

This questionnaire is divided into three parts. Part I and Part III consist of one section each, and Part II consists of three sections.

General Instructions

Please read each of the items in this questionnaire and respond to them as requested.

While you are responding to the items, please remember that there are no correct answers, and that you are being asked to express your opinions and ideas because they are important in assisting others to understand patient advocacy as a nursing role.

If you have any questions about this questionnaire, please feel free to call me (Camille Romaniuk) at 434 - 8371.

February 25, 1988

PART I

Instructions

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

1 - Always
2 - Generally
3 - Occasionally
4 - Never
5 - No Opinion

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

Please check to make sure that you have responded to each item in this part of the questionnaire.

PART II

Instructions

For several items, indicate your response of yes, no, or I don't know, by circling **the** corresponding letter. For other items, circle the letters corresponding to **three** statements as directed.

Part II - A. OPINIONS OF STAFF NURSES ABOUT PATIENT ADVOCACY AS A ROLE FOR NURSES

1. Do you think that nurses should **act** as patient advocates? (Circle **one.**)

   a. Yes **[Go to Item 2]** b. No **[Go to Item 3]** c. I Don't Know **[Go to Item 4]**

2. In my opinion, nurses should **act** as patient advocates **because:** (Circle **three,** no more, that are most important.)

   a. they hav moral responsibility to do so.
   b. they are legally required to do so.
   c. professional nursing organizations have stated they should.
   d. no one else is fulfilling the role.
   e. patient satisfaction with health care is declining.
   f. patients expect them to.
   g. that is one way of establishing the autonomy of the profession.
   h. the survival of the profession is at stake.
   i. patient advocacy is a traditional nursing ro
   j. patients' rights are not being met by the health care system.
   k good nursing care is impossible without it.
   l. patient advocacy is the basis of nursing.
   m. they understand the advocacy needs of patients.
   n. none of the above

   Go to Item 4

3. In my opinion, nurses should **not** act as patient advocates **because:** (Circle **three,** no more, that are most important.)

   a. they do not have adequate preparation to assume the role.
   b. they do not hold a position of power in the health care system.
   c. the public does not expect them to.
   d. doctors do not expect them to.
   e. patients do not expect them to.
   f. there is no reward for doing so.
   g. the risks are too great.
   h. the role is ambiguous.
   i. there are no standards for implementation of advocacy.
   j. the job should be left to specialists.
   k. nurses already have too much to do.
   l. advocacy is the responsibility of other health care workers.
   m. none of the above

   Go to Item 5

4. Do you think that **other health care workers** such as physicians, respiratory technicians, social workers, and dieticians should act as patient advocates? (Circle **one.**)

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

5. Do you think that there is a **difference** in how nurses and other health care workers act as patient advocates? (Circle **one**.)

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

6. I believe that when the nurses' role as a patient advocate is compared to that of other health care workers, the nurses' role is **different because**: (Circle **three**, no more, that are most important.)

a. it is more important.
b. nurses are in a better position to be aware of patients' needs.
c. nurses are in a better position to make patients' needs known.
d. nurses are prepared to be patient advocates.
e. nurses care more for patients as individuals.
f. nurses are interested in the total well being of patients.
g. nurses are unable to do as much as other health care professionals to ensure that patients' needs are met.
h. patients depend on nurses more than other health care workers.
i it is less influential.
j. none of the above

Go to Item 7

7. Do you think there is a **need** for a health care worker whose **only** responsibility is patient advocacy ? (Circle **one**.)

a. Yes **[Go to Item 8]**
b. No **[Go to Part II - Section B]**
c. I Don't Know **[Go to Part II - Sect. B]**

8. In my opinion, a health care worker whose only responsibility is patient advocacy is needed **because** such a worker would: (Circle **three**, no more, that are most important.)

a. ensure that patients' advocacy needs are met.
b. have the necessary knowledge and skills.
c. have the authority to be an advocate.
d. wield greater influence.
e. be more accepted by other health care workers.
f. ease the work load of other health care workers.
g. have the time to meet patients' advocacy needs.
h. have the interest to meet patients' advocacy needs.
i. serve as role models for other health care workers.
j. be able to offer advice to other health care workers who act as patient advocates.
k. be able to teach other health care workers about patient advocacy.
l. none of the above

Go to Part II - Section B

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

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

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

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

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

Go to Item 3

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

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

Go to Item 4

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

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

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

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

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

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

Go to Item 7

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

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

Go to Item 8

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

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

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

_____ Years and _____ Months

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

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

Go to Item 11

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

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

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

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

Go To Part II - Section C

PART II - C. OPINIONS OF STAFF NURSES ABOUT THE IMPLEMENTATION OF PATIENT ADVOCACY BY NURSES (Answer all 8 items)

1. Which of the following **actions**, if any, do you think nurses take when they are acting as patient advocates? (Circle **three**, no more, that are most important.)
   a. Informing patients about the treatments and medications which they are receiving
   b. Informing patients about facts related to their care that their physician(s) have not told them
   c. Providing emotional support for patients
   d. Providing good nursing care
   e. Ensuring that patients' rights are met
   f. Assisting patients to find meaning in their experiences
   g. Speaking to others on behalf of the patient
   h. Going beyond their duties
   i. I don't know
   j. None of the above

2. In addition to working with the individual patient, where do you think that nurses should focus their **attention** when they are acting as patient advocates? (Circle **three**, no more, that are most important.)
   a. The families of their patients
   b. Nurse co-workers
   c. Non-nurse health care workers
   d. Physicians
   e. Within health care organizations to bring about change
   f. Politically to lobby for social change
   g. I don't know
   h. None of the above

3. Which of the following, if any, do you think **enable** nurses to act as patient advocates? (Circle **three**, no more, that are most enabling.)
   a. Legislation
   b. Personal values
   c. Personal beliefs
   d. Performance standards
   e. Educational preparation
   f. Supportive work climate
   g. Prior experience with advocacy
   h. Professional organizations
   i I don't know
   j. None of the above

4. Which of the following, if any, do you think **interfere** with nurses' ability to act as patient advocates? (Circle **three**, no more, that are most interferring.)
   a. Attitudes of administrators on nursing unit
   b. Attitudes of other administrators
   c. Lack of support from other nurses
   d. Lack of supportive legislation
   e. Lack of expectation from patients
   f. Ambiguity about the role
   g Lack of performance standards
   h. Lack of required knowledge
   i. Lack of necessary skills
   j. Lack of motivation
   k. Risks involved
   l. Fear of conflict with physicians
   m. I don't know
   n None of the above

5. What do you think are the usual **outcomes** of advocating on behalf of a patient, for the nurse? (Circle **three**, no more, that are most likely.)

a. Dismissal
b. Loss of licensure
c. Promotion
d. Peer support
e. Personal pride
f. A clear conscience
g. Lack of peer support
h. Strained relations with other nurses
i. Strained relations with other health care workers
j Approval from administrators on nursing unit
k. Reprimands from administrators on nursing unit
l. Approval from other administrators
m. Reprimands from other administrators
n. I don't know
o. None of the above

6. In my opinion, nurses may choose **not** to act as patient advocates because they: (Circle **three**, no more, that are most likely.)

a. need the money they are earning.
b. want to keep their position.
c. want to continue working within the profession.
d. do not feel capable of fighting the system.
e. do not see any personal gain in doing so.
f. do not wish to create unpleasant working conditions.
g. do not wish to take on more than they have to.
h. do not think it is their responsibility.
i. think the risks outweigh the benefits.
j. I don't know
k. none of the above

7. Which of the following, if any, do you think that nurses should be prepared to **risk** in order to act as patient advocates? (Circle **three**, no more, that are most acceptable.)

a. Dismissal
b. Loss of licensure
c. Official reprimand
d. Lack of peer support
e. Strained relations with other nurses
f. Strained relations with other health care workers
g. Nothing
h. None of the above

8. If nurses act as patient advocates, I think that **patients** could be expected to: (Circle **three**, no more, that are most likely.)

a. be indifferent to the nurses efforts.
b. be unaware of the nurses efforts.
c. recover more quickly.
d. maintain their dignity.
e. be aware of their rights.
f. be more satisfied with the care they receive.
g. make informed choices.
h. receive more individualized care.
i find meaning in their situation.
j. become involved in their own care.
k. receive the same care that they would if the nurse was not acting as a patient advocate.
l. I don't know
m. none of the above

Go To Part III

PART III - BIOGRAPHIC INFORMATION

Instructions

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

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

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

2. Location of Employing Agency:
   a. City (population greater than 10,000)
   b. Town (population less than 10,000 but greater than 1,000)
   c. Other (please specify)_____

3. Gender:
   a. Female b. Male

4. Educational Background: (Circle as **many** as apply).
   a. RN Diploma
   b. Basic Baccalaureate Degree in Nursing
   c. Post Basic Baccalaureate Degree in Nursing
   d. Baccalaureate in another discipline (Specify)_____
   e. Post RN Certificate in a nursing specialty
   f. Master's Degree in Nursing
   g. Master's Degree in another discipline (Specify)_____
   h. Doctorate Degree in Nursing
   i. Doctorate Degree in another discipline (Specify)_____

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

a. 1 - 5 years	d. 16 - 20 years	g. 31 - 35 years
b. 6 - 10 years	e. 21 - 25 years	h. 36 - 40 years
c. 11 - 15 years	f. 26 - 30 years	i. over 40 years

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

a. Yes **[Go to Item 7]**
b. No **[Go to Item 8]**
c. I Don't know **[Go to Item 8]**

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

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

Go to Item 8

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

a. Yes **[Go to Item 9]**
b. No **[Go to Item 10]**
c. Don't know **[Go to Item 10]**

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

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

Go to Item 10

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

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

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

Turn to last page

Additional Comments (continued)

Thank you very much for taking the time to complete and return this questionnaire.

Please return by **March 18, 1988.**

If the stamped, addressed envelope which accompanied this questionnaire has become misplaced, please return the questionnaire to:

Camille Romaniuk
4727 - 143 Street
Edmonton, Alberta
T6H 4C7
Phone: 434-8371

Appendix B

Cover Letter

4727 - 143 Street
Edmonton, Alberta
T6H 4C7
Feb. 25, 1988

Dear Nurse:

Allow me to introduce myself. My name is Camille Romaniuk. I, too, am a nurse. I have worked in a variety of settings such as maternity, oncology, public health, and nursing education. Currently I am a student in the Master's Program in the Faculty of Nursing at the University of Alberta. In order to complete the thesis requirements of the program, I am conducting a study on the topic of patient advocacy. I am sending questionnaires to 200 practicing nurses across Alberta in order to learn about their opinions regarding patient advocacy as a role for nurses, the preparation of nurses to be patient advocates, and the implementation of patient advocacy by nurses.

You have been randomly selected from all the Registered nurses in Alberta who are presently employed in full-time positions as a staff nurses, to participate in my study. I sincerely hope that you will take the time to complete the questionnaire which accompanies this letter. According to preliminary tests which have been conducted, it will take approximately 20 minutes of your time to do so. There are no correct or incorrect responses to the items in the questionnaire. You are requested to express your own opinions and ideas which are based on your own personal experiences.

Your input is very important because little is known about how practicing nurses view patient advocacy. Therefore, the information which you provide will assist others to understand, more fully, a matter which is frequently discussed in relation to patient care.

Once you have completed the questionnaire, please return it by March 18, 1988, in the addressed, stamped envelope which is provided. You are not required to sign the questionnaire and you can be assured that complete anonymity will be maintained throughout the study. The questionnaires and return envelopes have not been coded or marked in any way, and I myself do not know which nurses will be receiving them.

Because you may be interested in knowing the results of this study, a copy of my thesis will be placed in the library operated by the Alberta Association Of Registered Nurses. I anticipate that it will be approximately 6-8 months before the thesis is completed. If you prefer to contact me personally in that amount of time, you are welcome to do so.

Thank you in advance for your anticipated cooperation. Your interest and participation are appreciated very much.

Yours truly,

Camille Romaniuk