

The Nurse as the Patient's Advocate

Richard Ingram

Submitted in part fulfilment towards

MSc Research Methods

September 1998

School of Social & Historical Studies

Department of Humanities - University of Portsmouth

ABSTRACT

Patient Advocacy has been a topic of considerable debate in the nursing profession, and it is often suggested that advocacy is a fundamental nursing activity at the core of nursing practice. Others argue that the nurse is inappropriately placed to be the patient's advocate because of role conflicts presented by loyalties to other health care team members and employers. This study investigates the status of patient advocacy in current nursing practice in the UK. A postal survey method was used to address two research questions: to what extent is patient advocacy a part of nursing practice; and what characteristics distinguish those nurses who are active advocates from those who are not? A simple random sample of 190 subjects was selected from a population of qualified nurses at one UK District General Hospital, however a poor response rate ($n = 86$) was achieved. Data was collected using the Patient Advocacy Scale (PAS), a 28 item Likert scale based on a development of Hatfield's (1991) Nursing Advocacy / Beliefs & Practices scale, and a Personal Data Sheet (PDS) to collect data on demographic variables. In addition, 7 informants were interviewed using a semi-structured format to provide a between-methods triangulation (Denzin, 1989). Quantitative data is presented using descriptive summary statistics, and analysed using multiple regression to explore relationships between the independent variables derived from the PDS and the dependent variable, the PAS score. Qualitative data from the semi-structured interviews are also presented. A pilot study was conducted to develop and validate the data collection instruments and procedures prior to the main study. The multiple regression analysis suggested that educational level and attendance on ethics courses were predictive of active advocacy, though the low value of R^2 indicates that much of the variance is unexplained. The qualitative data suggests that there is a range of views of what constitutes patient advocacy. The interview data did suggest some convergence with the questionnaire data, as enthusiastic advocates gained higher PAS scores. Recommendations are made for further research, practice and education to enhance the nurses advocacy role.

Acknowledgements

My thanks are extended to the following people who have helped and supported me in many ways:

Dr Darren Van Laar, my supervisor for his patience and support

Kate Dooley, for her help and encouragement throughout my studies

My friends and colleagues in the Faculty

Alex Gifford and Will White

1. ABSTRACT	2
2. STATEMENT OF AIMS	6
3. INTRODUCTION	7
4. LITERATURE REVIEW	10
4.1 Defining Advocacy:	10
4.2 Models of advocacy:	11
4.2.1 The advocate as guardian of patients rights:	11
4.2.2 The advocate as conservator of the patient's best interests:	12
4.2.3 The advocate as protector of patients autonomy:	13
4.2.4 The advocate as a champion of social justice:	15
4.3 Attributes and skills for advocacy	17
4.4 Nurses as advocates: problems and controversies	17
4.5 Research Literature:	19
4.6 Conclusion from the literature review:	25
4.7 Problem Statement	26
4.8 Research Questions	26
5. METHOD	27
5.1 Design	27
5.2 Population & Sampling	27
5.2.1 Eligibility and Exclusion Criteria	27
5.2.2 Sample Type	29
5.2.3 Sampling procedure	29
5.2.4 Sample size	30
5.2.4.1 Power Analysis	31
5.2.5 Response Rate and the Non-response Problem:	34
5.3 Instrumentation	36
5.3.1 Questionnaires:	36

5.3.2 Interviews:	40
5.4 Procedure	41
5.5 Ethical Issues	42
6. ANALYSIS AND FINDINGS	45
6.1 Quantitative Data	45
6.1.1 Descriptive Statistics	45
6.1.2 Multiple regression analysis	50
6.1.2.1 Preliminary exploration of data	50
6.1.2.2 Collinearity	52
6.1.2.3 Assumptions of multiple regression analysis	53
6.1.2.4 Methods for selecting variables	56
6.1.2.5 The regression equation and it's significance	59
6.1.2.6 Validating the results	60
6.1.2.7 Post-hoc power analysis	62
6.1.3 Conclusions from Quantitative Data Analysis	64
6.2 Qualitative Data:	65
6.2.1 Describing Patient Advocacy	66
6.2.2 Examples of advocacy:	70
6.2.2.1 Opinions regarding the nurse as a patient advocate:	70
6.2.2.2 Problems and limitations	71
6.2.2.3 Factors that assist with advocacy	72
6.2.2.4 Skills and qualities for advocacy	72
6.2.3 Conclusions from qualitative analysis	73
7. DISCUSSION	74
7.1 Limitations	77
8. CONCLUSION	79
8.1 Recommendations	79
8.1.1 Research	79
8.1.2 Education	80
8.1.3 Practice:	80
9. REFERENCES	81

STATEMENT OF AIMS

This study has the following aims:

To determine the extent to which patient advocacy as a part of day to day nursing practice in a UK general hospital

To determine the characteristics that distinguish those nurses who are active as patient advocates from those who are not.

To develop an instrument (the Patient Advocacy Scale) to measure patient advocacy amongst nurses, based on a development Hatfield's (1991) Nursing Advocacy / Beliefs and Practices scale.

In addressing these issues it is hoped that a clearer picture of the status of patient advocacy in nursing practice can be established that will put the ethical and professional debate into context. Against the background of fundamental changes in the organisation of the NHS, Nursing Education and the delivery of nursing care, the findings are likely to have implications for nursing practice and nursing education, and will provide a better understanding of the nurse-patient relationship and the role of the nurse in health care today.

The study may also serve as a basis for further research to investigate topics such as the preparation and education of nurses for their advocacy role, and the organisation of formalised advocacy policies, services and standards, as some health-care providers have begun to develop.

INTRODUCTION

In health care the concept of advocacy has become increasingly important over recent years as consumers demand better quality, more responsiveness and easier access to such services. The rise of consumerism through every walk of life has had its influence on expectations of health care, and there is an increasing demand for user-empowerment and public accountability for services.

Advocacy has been defined and implemented in many different ways, the major concepts include citizen advocacy; self-advocacy; collective or class advocacy; legal advocacy; and the focus of this paper, the nurse as patient-advocate. The advocate may be the person themselves (self-advocacy); an appointed official employed by a service organisation; an independent person or "befriender"; an "expert" (e.g., legal advocate), or a professional who works closely with the person (such as the nurse as advocate). In any of these different forms and interpretations of advocacy, the nature of the act, the relationship involved, and the goals and outcomes are likely to differ significantly. This proposed is concerned with the nurse acting as the patient's advocate within his or her professional role, and other formulations are therefore excluded.

Superficially, an advocate may be considered to be one who will always be acting in the person's "best interest" whatever that might be, and concerned with doing "good", however closer examination of the ethical basis of advocacy suggests that this is a simplistic and perhaps inaccurate portrayal of the role.

In nursing, the concept of the nurse as the patient's advocate has been a familiar one for a considerable time, it is implied in various nursing codes (e.g., ANA, 1985; UKCC, 1984 & 1992). There has been a common assumption that advocacy is a major role for the nurse (Marks-Maran, 1993) and for some, advocacy is definitive of nursing (e.g., Gadow, 1980, 1990) or as Murphy (1983) states "*the highest order nursing act...*". Others, (e.g., Miller *et al*, 1983; Trandel-Korenychuk, 1983) however argue that nurses cannot act effectively as

advocates because of their duties and loyalties to their employers, and the medical profession.

Some nurses who have taken their advocacy role to its full extent have often found themselves in conflict with their employers, other professionals or even their peers when they pursue issues on the behalf of their patients. In some instances (for example Graham Pink, cited by Snell, 1991) this has ultimately lead to disciplinary action and dismissal, even though the nurses professional body had judged that they had not acted outside of their professional code of conduct. Support for advocacy and patient advocates may therefore be more theoretical than actual, and an appreciation of this situation may well inhibit other nurses from full realisation of the patient advocacy role. The dilemmas posed for nurses considering this role are therefore significant. It is arguable that for many nurses advocacy is acknowledged and implemented only within certain limits and boundaries, and it is suggested that nurses often curtail or modify their advocacy activities when conflict with powerful authority figures, within or without nursing, appears to be likely.

For the nurse researcher, many questions about patient advocacy seem to be pertinent. Some of these questions relate to the experience of advocacy itself, such as what is the nature of advocacy? What is it like to be an advocate, or to be the recipient or subject of a nurses' advocacy act? What is the ethical basis of patient advocacy?

Other questions relate to how advocacy is implemented: what are the characteristics of the advocacy act? What attributes does an effective patient advocate possess or require? To what extent do nurses act as advocates? How important do nurses perceive their advocacy role to be? How do nurses deal with conflict situations? How do nurses cope with failed attempts at advocacy?

Another group of questions relates to advocacy in special situations; such as how does one advocate for the non-communicative patient (such as one who is unconscious)? How does

the nurse advocate for an infant? How does the nurse advocate for the patient who is deemed to be incompetent?

This study relates to the second group of questions, and investigates the characteristics or attributes of active advocates. It builds upon previous work investigating the nature of the advocacy experience (Ingram, 1993).

LITERATURE REVIEW

Defining Advocacy:

The term advocacy has most commonly been used in a legalistic sense, describing the act of pleading or arguing a case for another in court. The Oxford English Dictionary, for example, defines the term advocate thus:

"One whose profession is to plead the cause of any one in a court of justice.....one who pleads, intercedes or speaks for, or on behalf of, another... pleads for another;"

(OED, 1989, p 194)

Whilst the nurse as an advocate is clearly not acting in court or in this legal context, other elements of this basic definition may well apply. A brief review of published definitions highlights the contrasting views of this phenomena.

Gates (1994) offers a definition of advocacy for the nursing context, he states, advocacy is:

The process of befriending and representing a patient in all matters where the nurse's help is needed, in order to protect the rights or promote the interests of that person in a true partnership where nurses see these partners as friends and therefore afford them the same care and love as they would to any of their own friends or relatives.

(Gates, 1994, pp 2-3).

This definition emphasises the nature of the nurse-patient relationship, and the similarity to that of friendship or that of a relative. It is arguable that a patient's friend may not always act in keeping with the patient's self-determined best interests, and paternalistic decisions may be possible.

Kohnke (1982) defines advocacy more concisely, thus:

"The role of the advocate is to inform the client and then to support him in whatever decisions he makes...."

(Kohnke, 1982, p 2)

Whilst Gadow (1979) described existential advocacy as a philosophical foundation for nursing, she states that:

"The concept of existential advocacyis based upon the principle that freedom of self-determination is the most fundamental and valuable human right."

(Gadow, 1979, p 82).

Mitty (1988), however, sees advocacy as a *"socio-political activity"*, perhaps indicating a broader interpretation of the role beyond the individual nurse-patient relationship.

Each of these views of advocacy can be related to one or more models that emerge from the literature.

Models of advocacy:

Several models of advocacy are proposed in the literature, some of which have some degree of overlap, however there seem to be four distinctive models, each of which is briefly introduced below.

The advocate as guardian of patients rights:

This model of advocacy has some parallel with the legalistic definition given above. It is based on the premise that the nurse is able to inform the patient of their rights, and can then enable them to exercise those rights, or intervene to ensure that their rights are respected (Gillette, 1988). Gates (1994) definition of advocacy could be seen as fitting within this model.

Criticisms of this model are that the nurse-patient relationship is not conceived in these terms by either party, and the nurse is not the best skilled or equipped to fulfil this role (Fowler, 1989; Melia, 1987). The legalistic or patient's rights model may be too narrow a conception to deal with everyday problems experienced by patients and their nurses, for example, treatment and care decisions are rarely as clear-cut as being supported by claiming a right. Also this perspective tends to pre-suppose a confrontational stance that may prevent nurses from taking an advocacy role.

The advocate as conservator of the patient's best interests:

The idea that the advocate should be involved in helping the patient receive care or make decisions that are in his or her best interests would at first consideration seem unarguable. The great difficulty with this approach is deciding *what* the patient's best interests are, and by *whose* definition?

Paternalism, described by Gadow (1983) may often be the rationale or motive behind "best interest" decisions. Paternalism is defined by Gadow as:

"the use of coercion to provide a good that is not desired by the one whom it is intended to benefit"

(Gadow, 1983, p 43)

An example of this might be the patient who is persuaded to continue with aggressive treatment of terminal illness because they have a theoretical chance of survival. In such an example "good" provided (i.e. potential cure) is defined according to the nurse's or physician's values based on cure (Gadow, 1989), however "good" for the patient may relate much more to the care experience in such a situation. In this instance, advocacy as paternalism cannot be defended as offering benefit in relation to the patient's values, and it also negates the principle of self-determination. The nurse's actions may be guided by "beneficence" (to do good) or "utilitarianism" (actions that are judged by their social utility, or that offer the greatest good to the greatest number of people (Harman, 1977)). The outcomes derived may not coincide with the patient's self-determined best interests.

The advocate as protector of patients autonomy:

Kohnke (1982) is a proponent of this model of advocacy, and identifies two principle tasks for the nurse, informing and supporting. Informing involves providing sufficient information for making informed decisions about health care, and the supporting task which is concerned with reinforcing and upholding the patients decision.

This model, however offers little assistance for the nurse caring for patients who are unable to communicate or make informed decisions, and the justification of action (or non-action) based on the client's right to self-determination may often bring the nurse into conflict with other ethical and legal considerations. Also, Quinn & Smith (1987) argue that respect for autonomy does not presume that the individual will make the best or even safe decisions for themselves, and there is much evidence in daily life that individuals do not do so, although it possible to make arguments such as that a decision to commit a "dangerous" act, say for example misuse of drugs, may be in the persons "best interests" given their own value system. Gadow (1979, 1983, 1989) is a significant contributor to the advocacy literature with her concept of "*Existential Advocacy*". She proposes this concept as the philosophical

foundation underpinning nursing, and that the nurse is uniquely placed in the health care professions to realise this ideal.

Gadow distinguishes existential advocacy from paternalism and consumerism as discussed previously. She describes existential advocacy thus:

"It is based upon the principle that freedom of self-determination is the most fundamental and valuable human right, and therefore is a greater good than any which health care can provide..."

and the ideal of existential advocacy is:

"...that individuals be assisted by nursing to authentically exercise their freedom of self-determination"

(Gadow, 1983, p 45)

The focus of any act of advocacy is therefore to assist the individual to become clear about their own wishes and values through a process of self-examination. Like Kohnke, Gadow emphasises the need for nurses to actively avoid the danger of imposing or coercing on the basis of nursing values which may then re-emerge as apparently (and falsely) those of the patient.

Gadow suggests that contrary to usual professional mores, nurses need to integrate their personal, emotional and aesthetic selves with the technical and managerial aspects of the nurses role. Only by responding to patients as whole people, can nurses assist patients in realising their own "wholeness", which is necessary for true self-determination to take place. Gadow recognises that this presents nurses working with other professionals with a conflict, as the personal sharing and involvement in the patient's experience is beyond the usual boundaries of professionalism, which favour detachment and superficial relationships.

Bishop and Scudder (1990) are critical of Gadow's existential advocacy because they say she neglects the competencies associated with traditional nursing that can extricate the patient from their predicament in which they require advocacy. They also point out that the nurse is in an "in-between" position between patients and other health care professionals, making them well placed to be advocates for both patients and physicians. It may be argued, however that this "*in between*" status represents no more than a conflict of interest.

In a more recent paper Gadow addresses the problems of advocacy for the "silent patient", that is the patient who is unable to communicate their wishes for whatever reason. Gadow (1989) argues that the silent patient who's subjective world is inaccessible to the nurse is the crucial test for an advocacy position. She states that if there is no way for the advocacy position to inform care for all patients, then it just becomes a convenient way of dealing with the more articulate.

Gadow identifies three approaches to attempt to reach the goal of advocacy for the silent patient. Firstly by gaining information on patient's wishes in advance whilst still able to communicate, the "living will" perhaps being the ultimate example of this. Secondly through involving others who had known the patient long and well enough to be familiar with their values, and asking them to anticipate the patient's wishes. Finally, where neither of the first two are possible, the only remaining approach is to use the nurse's own subjectivity.

The advocate as a champion of social justice:

This view of advocacy as Fowler suggests, takes the nurse's role as an advocate from the patient's bedside to beyond the institutional walls (1989, p 98). There may be an element of advocacy for individual patients, but the focus is on social and political change to deal with inequities and inequalities in provision of care at both macro' and micro-allocation levels.

Fowler states that this model encompasses elements of the autonomy and rights models, but broadens the nurses concern to the correction of both clinical and social injustices that impinge on patients' rights, respect or dignity.

Fowler states:

"Nurses must transmit the values of the nursing profession to society, in order that society may change in accord with these values"

(Fowler, 1989, p 98)

It is likely that a nurse may on occasions have to take issues relating to individual patients up the institutional hierarchy or even outside the institution to gain a resolution. Graham Pink's case (cited by Snell, 1991) may be representative of this model of advocacy. Whilst this type of action may reflect an evident need for a group of patients, it cannot be deemed to uphold individual autonomy and self determination.

The UKCC Code of Professional Conduct (UKCC 1992) may appear to support this model of advocacy as it demands that nurses promote the interests of individual patients and clients, and serve the interests of society, though these two demands will not always coincide; it could also be criticised as a highly paternalistic approach.

From this brief overview of the four models of advocacy that emerge from the literature it seems that the picture of what advocacy *is* remains controversial and ill-defined. Many acts that could be deemed to be advocacy by proponents of one model would be seen as undermining patients' autonomy by proponents of others. Nurses who value patient's autonomy as paramount may find they have great difficulty persuading others with more "common sense" perspectives.

Attributes and skills for advocacy

It is argued that patient advocacy is a natural role for nurses, merely a facet of the caring relationship with the patient (Miller *et al* 1983), and as such is common to all and requiring no particular training or special skills. Casteldine (1981, cited by Mallik 1997a) argues that if nurses are to be advocates they need preparation and education for this role. Whilst technical (clinical) knowledge may be necessary in order to deal with the material of the advocacy act, it does not confer the skills needed to achieve successful advocacy. For nurses to be effective as advocates they will need to have an awareness of ethical decision-making, communication and assertiveness skills, and an ability to manage conflict when it (inevitably) arises. Whilst some efforts are made to address such issues in current nurse training, the preparation for what is arguably a major part of the nurses role, is minimal, and may be inadequate for the potential challenges that they are likely to face on even a day to day basis.

Nurses as advocates: problems and controversies

There are many who would question the validity of the nurse as an advocate, and the ability of nurses to be advocates for patients (for example, Jenny, 1979, Abrams, 1978, Walsh, 1985).

A principal criticism is that of the nurses lack of independence. Almost invariably the nurse will be in the paid employment of the health care provider, and some would argue (e.g. Pagana, 1987) this makes true advocacy impossible, and nurses may merely act to support the needs of the institution; the *Bureaucratic Advocacy*, described by Millette (1993). Mallik (1997a) cites Ramos (1992) who suggests that even when nurses did act as advocates for patients, their actions were based on their own (i.e. the nurses own) values, and decisions

would be made unilaterally by the nurse if there was insufficient time or the patient was indecisive. A similar view (Becker, 1986 cited by Mallik, 1997a) is that nurses act as passive advocates, that is they will take actions to the level permitted by the institution, and to take advocacy further nurses have had to use covert rather than confrontational strategies.

The nurse may act as an advocate for the physician, (rather than the patient) perhaps by informing the patient certain course of treatment is presented by the nurse as the best for the patient, where a patient advocate may have offered more balanced information about the options.

Gates (1994) cites several role conflicts that may influence the nurse's ability to advocate, for example, the nurse is employment dependent; will frequently find themselves re-deployed, thus thwarting continuing advocacy; the nurse is expected to act within professional constraints when a patient may require that their advocate is "publicly disobedient". Another problem is that of loyalty; to the patient alone, versus loyalty to colleagues and other professionals.

There are also instances where the nurse's advocacy for a patient may have a detrimental effect on others, for example, arguing for the use of specialist equipment for one patient may mean, because of limited supply, that another therefore has to go without. To achieve equity, then surely all patients must have advocates.

Some argue that there are legal pitfalls to advocacy. Tingle (1989) suggests that nurses who, in an advocacy role, give patients information about treatment may fall foul of the law if the information is inaccurate or incomplete, such as in the case of the American nurse Tuma (cited by Trandel-Korenychuk & Trandel-Korenychuk, 1983). Mallik (1997a) suggests that there is evidence in both the US and the UK that the courts are reluctant to view nurses as autonomous professional decision makers, and as such the moral pressure on nurses to act as advocates may be great, whilst the authority to do so is weak. Mallik (1997a) concludes, as have other writers, that patient advocacy is a risky business for nurses.

Research Literature:

Despite the large amount of literature located dealing with nurses as patient advocates, only a small proportion is research literature, and as Mallik (1997a) suggests, the models of advocacy debated (for example the models proposed by Kohnke, 1982, & Gadow, 1980 and 1989) these have not yet been developed or tested in empirical studies, and a consequence of this is an uncertainty and lack of clarity about the very nature of advocacy. A few studies have been conducted, however, and these are discussed briefly below.

Penticuff (1989) conducted a study of nurses' advocacy on behalf of patients in three NICU (Newborn Intensive Care Units) in the USA. Interviews from 20 nurses collected over a period of six years were analysed, and themes relating to the nurses' views of themselves as advocates were identified.

She found that nurses experienced most conflict where potential outcomes for the infants were ambiguous. They experienced most distress where they perceived that the infants suffered without a clear justification, whereas they were able to accept aggressive treatment for the infants where prognosis was good. All nurses felt advocacy obliged them to alleviate suffering, but few were able to initiate discussion within the health care team about the value of continuation of life-prolonging treatment.

Certain characteristics were identified that influenced advocacy. Penticuff suggests that a moderate level of incongruence between the nurse's beliefs and the actions required by the health care team may be a trigger for advocacy, but where there is a high degree of incongruence may disrupt advocacy. Another important characteristic was the position of nursing in the institution; where nursing was highly valued and where nurses were able to call meetings of the health care team, advocacy was more likely to occur. Conversely, where nursing had a lower status, and / or a higher proportion of nurses were non-permanent or

part-time, advocacy was less likely, as cohesiveness and communication within the health care team was often impaired.

The Penticuff study offers only a limited insight into the issue of advocacy, the interviews took place over a long period (6 years) and one would anticipate considerable turnover in staff and other changes in the NICU's concerned. Whilst some depth is achieved with this methodology, external validity and generalisability is weak because of the serious problems associated with sampling in this manner, the effects of history; and the many sources of bias such as "experimenter expectancies" that a prolonged involvement are likely to engender.

Fetsch (1991) interviewed 29 paediatric nurses in one large hospital to investigate the experience of advocacy from their perspective. Fetsch used Giorgi's methodology (Giorgi 1985) for phenomenological analysis. Fetsch argues that Gadwo's existential advocacy has potential as a philosophical basis in paediatrics given that children often have limited ability for self-determination.

The study revealed four essential components of patient advocacy: patient/family vulnerability; a sense of professional obligation; nurse and patient and/or family rapport; and confidence level. Two forms of advocacy were identified, effective, where the advocate achieves the desired goal; and thwarted, where advocacy was frustrated or defeated.

A similar, but smaller scale study (4 informants) by Ingram (1993) investigated the experience of advocacy amongst UK oncology nurses. This study suggested that advocacy concerned three main interactions or roles; mediating between physicians and patients so that they could gain information they wanted; mediating between patient's and their relatives, particularly where relatives sought to deny a poor prognosis and / or wished the patient to pursue active treatment when the patient did not; and thirdly, in seeking adequate pain control for patients, often bringing the nurse into conflict with the physician.

Both the Fetsch and the Ingram studies are highly context specific and may have poor generalisability, however this is not usually the aim of this type of study. In addition Ingram's 1993 study may not have achieved "*saturation*" of data (Morse, 1995), with such a small sample size, thus new and alternative perspectives may have been missed.

The phenomenological approach offers insights into the lived experience of a phenomenon. Whilst such findings are not intended to be generalisable, the reader may identify common experiences, or differences, and nursing practice can be more insightful as a result. Such research can also support the development of other research initiatives, and can underpin instrument development for other studies such as the one presented here.

A similar small scale study was conducted by Nicklin (1994) who used a grounded theory approach investigating the meanings of acts of advocacy with six surgical nurses. The core category emerging from this study was of the advocate as a "go-between", who in the context of the nurse-patient relationship can choose either to pass on information (presumably in acts of advocacy) or take responsibility for action or non-action. This study bears similarities to the idea of the mediator described in Ingram's (1993) study discussed above, however the Nicklin study is also likely to have failed to achieve saturation with the sample used.

The study by Case (1991) also involved paediatric nurses but was broader in context. Case interviewed nine nurses to describe the experience of moral conflict in paediatric nursing, again Giorgi's methodology was used. Case identified six essential features of moral conflict: choice, advocacy, autonomy, pain and suffering, values, and relationships. Choice was found to be the unifying central feature of the other five.

Cole (1991) attempted to describe the experience of advocacy from the client's perspective, and interviews were conducted with ten adults in their own homes who had previously received care from registered nurses. Again Giorgi's methodology was used to analyse the data. Four essential characteristics of advocacy were identified: The "***Competent Knower***"

was perceived to be knowledgeable about the clients conditions and needs, experienced in nursing practice, and capable.

The "*Competent Doer*" acted on behalf of clients, either by their own initiative or at the request of clients', solved problems, acted as an intermediary and followed through on the clients' needs and desires.

In relationships with client, family, and professional colleagues, the "*Humanizer*" was perceived as a personable, caring team member who intervened on the clients' behalf, supported their decisions, and treated them as valued individuals. They encouraged clients, made extra effort for the client, and made themselves available to clients by being there.

The "*Communicator*" transmitted and exchanged information with client, family, physician, and other health care professionals, served as liaison between them, provided explanations and education, and kept clients informed by disclosing pertinent information voluntarily and by request.

The study also found that not all nurses demonstrated these characteristics, and not all of the client's experiences were positive.

In a recent study, Mallik (1997b) used focus group interviews to explore to investigate the interpretation of advocacy by practising nurses. From the advocacy stories recounted by the respondents, a triadic conflict model of advocacy was proposed (involving the patient, the nurse and a third party in potential conflict). This is differentiated from the previously proposed dyadic models that focused on information giving and counselling between the nurse and the patient, but omitted to account for any other parties involved, yet advocacy frequently appears to involve making a case or pleading a cause. This study also echoes the ideas of a mediator or a "*go-between*" identified in Ingram's (1993) and Nicklin's (1994) studies, though Mallik has gone significantly further in iterating an explanatory model.

This study has merit as the use of focus groups means that respondents have a direct role in model development and refinement, however this methodology also poses some limitations, for example as Mallik suggests, the process of story-telling in such a group can lead to a reinterpretation of experiences which are then rationalised and justified in order to make sense of their own behaviour. Mallik noted that there was very little critical comment or appraisal of group members accounts or their behaviours that were purported to be acts of advocacy.

Millette (1989, 1993) used a postal questionnaire to survey a random sample of 500 registered nurses in one US State. Millette hypothesised that nurses would favour a client advocate model over physician or bureaucratic advocacy models (described earlier), that those showing a client advocacy preference would be more likely to be older, with more education, working in the community and with a management position or greater autonomy.

Using the instrument the "*Advocacy Assessment*" the subjects were asked to rate their agreement or disagreement with statements about three models of advocacy on a Likert scale. They were then asked to select and rank their most and least favoured responses to a moral dilemma. Demographic data were also collected in the questionnaire.

Although most of the respondents (response rate was 44%) stated a preference for the client advocate model, 81% selected it as the worst response to the moral dilemma that had been presented. Also those nurses in management positions were more likely to favour bureaucratic advocacy rather than client advocacy. The study appeared to be well conducted and efforts were made to validate the instrument used. It may be of relevance to the findings that the dilemma concerned a mistake by a doctor that was being concealed. Although it would be a relevant scenario for advocacy, it is hardly neutral and would elicit conflicts of loyalties that may exist. This is not necessarily a flaw, however, but further scenarios could have been useful. It is also of note that, as is often the case with postal questionnaires, there was a low response rate. One always has to question what characteristics the responders have that may differentiate them from the non-responders.

The implications of the study are that on a theoretical level nurses favour client advocacy, but might be unable or unwilling to carry it out in practice when faced with a dilemma, and are likely to fall back on supporting the institution or the physician rather than the patient.

Fahy (1992) surveyed 33 critical care nurses in several critical care units in Australia, who were all members of the State Critical Care Nurses Group. The researcher's aim was to discover if critical care nurses believed it was part of their role to act as advocates for incompetent patients in their care.

The researcher sent each subject a case study with eleven fixed alternative questions regarding appropriate care and treatment. Four of these dealt with situations where advocacy might be appropriate, the rest were disregarded. Responses were in three categories for each situation. No advocacy needed, recognition of advocacy needed, and assertiveness in acting as an advocate.

The findings suggested that although almost all saw the need for an advocacy role, almost half would not act in that role. The author identified various limitations, such as the small sample size, and the potential bias introduced by sampling from a professional interest group. The instrument also appeared to be very limited in scope and situations were based on a view of advocacy as acting in the best interests of the patient, which in this study may well translate as being the values of critical care nurses, the problems of such a definition of advocacy having been outlined above. There are consequently serious doubts about the construct validity of the instrumentation.

The research literature available is limited, although there have been some promising lines of investigation. The studies cited do seem to highlight some discrepancy between advocacy as nurses would like it to be, and advocacy as actually practised. Further studies could focus on the extent to which nurses actually do fulfil an advocacy role, how they do this, and what sorts of outcomes there are for patients. There is also the need for such research in a UK

nursing setting. In addition there is a need to develop suitable instruments for use to undertake larger scale quantitative studies. Other areas for research could be to investigate how nurses can be best prepared for their advocacy role, and how initial and post-basic education could respond to these needs.

Conclusion from the literature review:

From the literature review it appears that the ethical and professional debate about patient advocacy has been well developed. Whilst it is a role that is highly valued by many, others have indicated conflicts and limitations for the nurse as advocate. Knowledge about how nurses define, experience advocacy and be advocates, and indeed how patients experience advocacy is extremely limited. The few studies conducted to date have begun to give some form and meaning to this phenomenon from an experiential rather than a philosophical viewpoint, and this must only serve to improve understanding.

Given the lack of research literature it could be argued that advocacy is predominantly a professional and ethical talking point rather than a nursing reality. It could, however reflect the fact that such a phenomenon is not easily or even appropriately addressed by traditional and more common quantitative methods, and the lack of naturalistic and qualitative research mirrors the relative recency of these approaches in nursing research.

This study attempts to integrate and build upon the previous studies cited to investigate the status of patient advocacy amongst nurses in one UK hospital. From this it is hoped that the extent that advocacy is a part of everyday nursing practice can be determined, and the characteristics or predictors of "active" advocates can be identified.

Problem Statement

Whilst advocacy is often debated and discussed it is unclear the extent to which nurses actually consider advocacy to be a part of day to day nursing practice, and incorporate it in their practice. It is also unclear what individual characteristics are likely to be associated with "active" advocates.

Research Questions

The study is intended to address two research questions: *to what extent is patient advocacy a part of nursing practice*; and *what characteristics are predictive of higher levels of advocacy practice amongst nurses*.

METHOD

Design

The study adopts a descriptive correlational design (Burns & Grove 1993). A sample of registered nurses were surveyed and data were collected to investigate how demographic variables (the predictor or independent variables in this study) are related to a measure of patient advocacy (the criterion or dependent variable). Between-methods triangulation (Denzin, 1989) was achieved by gathering qualitative interview data from 7 informants.

Population & Sampling

The target population for the study was qualified nurses in UK hospitals. The study population comprised all qualified nurses at one UK District General Hospital.

The study (accessible) population was all qualified nurses employed on clinical grades C to I at the hospital, which at the time of the study comprised 729 such nurses known to the human resources department. The population is distributed so that there are far more subjects on C, D & E grades than those on higher grades. Grades C, D & E are likely to account for approximately 70% of the population, and H & I approximately 2%.

Eligibility and Exclusion Criteria

Excluded from the population were bank nurses (nurses who are registered on a bank, but who work on a casual basis on variable hours and in a variety of wards depending on demand and their own chosen work pattern) and agency nurses on any grade. Whilst both of these

groups of nurses are likely to act as patient advocates, their work patterns would make it impractical to include them in the study, however they do make up an important sub-group of the UK nursing workforce, and would merit inclusion in a larger study.

Midwives are also employed on the same clinical grades as nurses, however they are excluded from this study as they are considered to be a separate profession, though many midwives have originally come from a nursing background. Some nurses may hold midwifery qualifications although they are employed in nursing posts, they were not excluded unless employed solely as midwives. Also excluded were pre-registration student nurses, and post-registration student nurses on placement at the hospital if they were not also normally employed there.

Those employed on grades A to C are usually unqualified nursing auxiliaries, however, some newly qualified nurses are employed on C grades, depending upon the employment practices of the hospital. Those on grades A to C who are not registered nurses are excluded from the study. Whilst they may act as patient's advocates, they do not have the professional accountability that Registered nurses have, and advocacy would be considered to be beyond their sphere of responsibility.

Clinical grades generally equate with particular job titles, so grades C & D might be held by Enrolled Nurses and Staff Nurses; E & F, Senior Staff Nurses / Junior sisters; and G, H & I grades might equate with Senior Sister / Senior Nurse / Clinical Nurse Specialist / Nurse Manger. Clinical grading was introduced in 1987 in order to recognise particular duties and responsibilities in nursing work and allow for a more flexible and elaborate career structure than the traditional grades of Staff Nurse / Sister / Senior Nurse would allow. Although there is often variation (the current tendency seems to be to expect greater responsibilities from

those on lower grades as the skill mix is depleted), the grades within each category involve broadly similar work, though there is likely to be individual variation depending on the skill mix in any ward or department. Often nurses on lower grades have to assume the duties of higher grades where staffing levels / skill mix is poor.

"Second level" or Enrolled Nurses, who tend to be restricted to grades C and D will be considered as registered nurses and will be included in the study on the basis of their grades, as above.

Sample Type

In order to make generalisations about the whole population it is necessary to study a probability sample, that is one in which each member or case in the population has a known probability of being selected (Burns & Grove, 1993). The simplest way of achieving this is a simple random sample, whereby subjects are randomly selected from the whole population, usually by using random numbers to select informants from a numbered list. This approach was used in this study, as described below.

Sampling procedure

To meet the hospital's obligations under data protection legislation, it was decided that the human resources department would select informants and address envelopes and distribute them in accordance with a procedure provided by the researcher. This ensured that the researcher only learned the identity of informants after they had been sampled, and only then

if they responded and had chosen to provide their names on the questionnaire (which was optional). Whilst this was acceptable did meet ethical and data protection requirements it did prevent specific follow-up of non-responders, which may have been a more effective way of increasing response rate, or could have allowed for interviews of non-responders, as a way of interpreting non-response bias.

With instructions from the researcher the human resources department at the hospital prepared a list from their database of all nurses that met the defined population and exclusion criteria outlined above. From this sampling frame, comprising 729 potential informants, 190 were selected using a list of random numbers provided by the researcher. The random numbers were selected using a Microsoft Excel random number generation tool.

Sample size

Estimation of an appropriate sample size is a contentious issue and few clear guidelines are available. Many adopt a “rule of thumb” approach to sample size determination, though there is an increasing demand for the use of statistical approaches to sample size determination. These approaches relate mainly to the use of confidence intervals (Knapp, 1996) or power analysis, which is the approach that seems to be favoured currently (Polit & Sherman, 1990; Cohen, 1992).

Power analysis allows the researcher to determine the sample size necessary to detect significant differences or effects of a predetermined magnitude and significance level, thus the researcher can clearly quantify the likelihood that a study will yield worthwhile results. Samples may then be selected that avoid the waste of inconclusive studies due to inadequate

size, or overlarge samples that include unnecessarily large numbers of informants. Power analysis is the approach used in this study to determine sample size.

Power Analysis

There is a considerable body of literature discussing the use of power analysis procedures (see for example Cohen, 1988, & 1992, and Kraemer & Thiemann, 1987) however it is apparent that it has not been embraced by researchers and many “*under-powered*” studies continue to be conducted in many disciplines (Polit & Sherman, 1990). The use of adequate sample sizes to achieve statistical power is becoming both a methodological and an ethical imperative, and there is an increasing range of resources to assist the researcher. A full discussion of power analysis procedures and the range of available software can be found in Ingram, 1998. A brief discussion of the power analysis is presented below.

Power analysis concerns the relationship of four factors: the power of a test (a power of 0.8 is usually considered the minimum acceptable - this gives a 20% chance of making a type II error), the significance level set (alpha, usually 0.05, or 0.01); the number of informants; and the effect size (that is differences that are considered significant, commonly 0.5 standard deviations, or more). Changes in any of these factors will influence one or more of the other three; so for example, larger sample sizes will increase power, or allow the use of the more stringent alpha level, or will detect smaller effect sizes, or a combination of these. To use power analysis to determine sample size, one determines the desirable power, detectable effect size and the alpha level, and computes the necessary sample size to achieve this. Different formulae are required for the particular statistical test in use, and many statistical software packages and stand-alone programmes exist to assist with this (see Ingram, 1998).

Post-hoc power analysis can also be conducted to aid interpretation of studies where the null-hypothesis has not been rejected. The power calculation will provide a measure of the risk that a type II error has been committed (i.e.; failing to reject the null-hypothesis when it is, in fact false). For example, if post-hoc analysis suggests that the study has a power of 0.50, the implication is that there is a 50% chance that a type II error was committed, which would be unacceptably high. The use of post-hoc analysis is no substitution for using power analysis at the design stage, as the knowledge that a study was under-powered merely confirms that resources have been wasted.

In multiple regression analysis power analysis is relatively simple as the effect size relates to R^2 coefficient that the researcher deems to be of significance. Cohen (1992) suggests values for small medium and large effect sizes for various tests, and for multiple regression suggests values of 0.02; 0.15 and 0.35 respectively. With a medium effect size of 0.15 (which will detect an R^2 of ≥ 0.1304), 8 independent variables, with alpha set at 0.05; and a power of 0.8 Cohen's power table (1992, p158) indicates a sample size of 107 is required, and for 7 independent variables, 102 is indicated.

Alternatively, and more simply, computer software may be used for power analysis. One stand alone programme that deals with power analysis in multiple regression is "R2" (Steiger and Fouladi, 1992).

```
Output from R2 -- Version 1.1

High Accuracy Algorithm is in use.
-----
Sample Size Calculation

K:          9
Rho Square: .13040
Alpha:      .05000
Needed Power: .80000
Use an N of at least 111
```

Figure 1: Sample size calculation; output from R2 software

Figure 1 shows the output of this programme for similar values to those in Cohen's table. (In the R2 programme, K independent variables includes the criterion variable (PAS) so for 8 IV's ($K = 9$). It will be seen that using either method the indicated N is very similar and either method of calculation is considered acceptable.

In this study, with 8 IV's and accepting the effect sizes suggested by the R2 output above, a sample of 111 would provide adequate power. Given that a survey such as this is likely to suffer from a non-response problem, any sample selected will have to be increased to allow for this. Estimates vary regarding likely response rates in studies such as this, ranging from 45 to 75% (Czaja & Blair, 1995), or as Babbie (1992, p 267) suggests, response rates of 50%, 60% and 70% may be regarded as "*adequate*", "*good*" and "*very good*" respectively. Given that the instruments used are relatively brief and easy to complete, that a reminder will be given, and the population might be expected to be more positive than some to research, it is anticipated that a response rate of 60% may be realistic. To achieve an adequately powered study in keeping with the parameters outlined above an initial sample of 190 would provide 114 returned questionnaires given a response rate of 60%, and is therefore the sample size selected for this study.

Response Rate and the Non-response Problem:

The use of power analysis, as described above, may provide an adequate sample size, but will not address the inevitable problem of response bias caused by the non-response problem, however large that may be.

Babbie (1992) suggests that response bias is likely to be inversely proportional to response rates, therefore high response rates are likely to result in a lower response bias. Whilst response bias cannot be eliminated, approaches to dealing with this problem may be to minimise it by maximising response rates, and attempting to discover the characteristics of the non-responders, so that the study findings can be reviewed with some idea of the nature and direction of the bias that may have been introduced (Oppenheim, 1992). Although steps had been taken in the design and administration of the questionnaires (discussed in the following sections), the final response rate was poor.

90 returned questionnaires from a sample of 190 were received, giving a response rate of 47.4%. Of these, 2 were completed by ODA's (Operating Department Assistants, who are not nurses and were therefore excluded). This was an indication of problems with the sampling frame used. Another had no responses on the PAS instrument (see appendix 1), and a fourth was returned without the Personal Data Sheet (PDS, see appendix 2), so only 86 were used for analysis, giving a response rate of 45.3%.

Many reasons may account for the poor response rate, which was lower than the 60% anticipated. The instrument itself may have contributed to this, although as described below, efforts were made to pilot it and make it as acceptable to informants as possible. A considerable portion of the non-response problem may be due to inaccuracies with the

sampling frame. 9 of the envelopes were returned “not at this address” by the hospital internal post or by staff working on the ward in question. Some of these related to staff who had already left or had been moved to other wards. It is likely that many more were incorrectly addressed and never reached their intended recipients. In addition it is likely that some non-nurses, such as the ODA’s mentioned above, were mistakenly sent the questionnaires, and may not have bothered to return them.

Because of the need to deny access to the sampling frame by the human resources department, there was no means of assessing how accurate or up to date the database was, and the assurances of the staff there had to be taken at face value. The actual non-response due to these problems as opposed to the “normal” non-response problem is difficult to quantify, but it may account for the low rate achieved with what would normally be expected to be an interested and research-minded population.

Each returned questionnaire was numbered and dated on receipt and this allows for some potential to investigate possible non-response bias. Babbie (1992) suggests that non-responders will have more characteristics in common with late responders rather than early responders, so the indexing of returns as described above allows for tentative projections to be made of the likely characteristics of non responders.

Table 1 shows the mean values for variables for the first 20 and final 20 returns.

Table 1: Mean values for first 20 and final 20 responses

Variable	1st 20 \bar{X}	last 20 \bar{X}
ETHICS	.5	.33
EDLEVEL	1.05	1.00
GRADE	3.85	2.90
INSPECIA	6.3	6.77
NURSEYRS	12.83	14.01
AGE	36.05	38.33
PAS	112.55	105.05

It appears that the greatest differences between the early and late responders were in respect of GRADE and PAS (Patient Advocacy Scale) score - the dependent variable in the study. In addition to the comparisons in table 1, correlation coefficients were calculated for the same variables, and a variable representing the return order (higher values represented later returns). Two variables were negatively correlated with the return variable (GRADE: $\rho = -.3232$, $p = .002$; PAS: $\rho = -.3812$, $p = 0.000$). Whilst there is no statistical justification for extrapolating from the returns to the non-returns in this way, it may be that non responders were likely to have lower PAS scores, and lower grades, thus the sample might be biased in favour of higher grade nurses and PAS scores, and this may assist with careful interpretation of the findings.

Instrumentation

Questionnaires:

Two instruments were used for quantitative data collection in this study: a Patient Advocacy Scale (PAS) based on Hatfield's The Nursing Advocacy / Beliefs & Practices (NABP) scale,

which provides an "*advocacy score*"; and a Personal Data Sheet (PDS) to gain information on demographic variables. These demographic variables represent the independent or "*predictor*" variables in the multiple regression analysis, with the PAS score as the dependent or "*criterion*" or dependent.

The Nursing Advocacy / Beliefs & Practices (NABP) scale was devised by Hatfield (1991) for her study. This is a 28 item, Likert scale questionnaire, with 5 response modes ranging from strongly disagree, to strongly agree, with an undecided category at the midpoint. This instrument yields data that can be scored from 1 to 5 for each category. The instrument contains items that cover the nurse's beliefs and practice of advocacy, and the organisational and educational support required or available to the nurse. The original version is reproduced in appendix 3.

Whilst it is generally desirable to utilise an existing instrument that has been validated in previous studies, it was apparent that the NABP scale, the only one of it's kind available, was not suitable for use in this study in it's existing form. Although some of the terminology in the items was unsuitable, and would not have been appropriate to a UK sample, the problematic scale items could have been modified relatively easily to retain their intended coverage whilst being in appropriate language. A more important problem is that some items appear to measure variables other than advocacy beliefs and practices of the individual nurse, and thus compromise the construct validity of the instrument. For example, item 7 asks about the agency's (employers) support for continuing education, and item 19 asks about agency policies.

Hatfield (1991) adopted various strategies to establish construct validity and reliability of the instrument. A panel of three experts reviewed the instrument and modified items

accordingly. The instrument was then piloted and Spearman-Brown split halves (Burns & Grove, 1993) were performed which indicated a good degree of homogeneity amongst items, though this is somewhat surprising given the problems identified with some items, as discussed above.

In order to modify the instrument the first step was to identify and discard the items that were considered to measure variables other than advocacy. Of the remaining items these were modified to reflect appropriate UK terminology. Additional items were then developed to provide a total item pool of 50 items for pilot testing. The new items were developed to reflect the four models of advocacy identified in the literature review. If it is accepted that there are different perceptions of patient advocacy as illustrated by these models, then inclusion of these in the new scale should contribute to the validity of the instrument.

The 50 item pool for the PAS were piloted with a purposive sample of 20 informants known to the researcher, selected because of their expertise as nurses and / or researchers. 19 responded, though only 17 completed questionnaires were received in time to be incorporated in the analysis. The Pilot PAS appears in appendix 4.

Informants were asked to complete the 50 item instrument by responding genuinely to the items included. They were then asked to identify any problematic items, such as those that were poorly worded or were thought to be poorly related to the construct under investigation. They were also asked for comments and suggestions for modifications. Comments were also requested for the PDS (Personal Data Sheet).

An item analysis (Oppenheim, 1992) was conducted to determine items to be included in the final version of the PAS. From the pilot study data, each item score was correlated with the

scores for the pool of items, this identified item-item correlations and item-total correlations. The assumption is that if the instrument as a whole serves as a measure of the construct under investigation, then those individual items that have stronger correlations have greater construct validity, and those with weaker correlations have poorer validity. The items can then be arranged in a hierarchy (excluding those already identified as problematic by the pilot study informants), and the best 28 are selected for the revised instrument. Further reliability data was derived from the main study (see below).

The PAS as used in the main study is presented in Appendix 1. Scores range from 1 for strongly disagree, to 5 for strongly agree, thus providing a possible PAS score for each subject of between 28 and 140. 7 of the items were “reversed” that is expressed in a way that “strongly disagree” response was equivalent to a high advocacy rating, the scoring for these items was also reversed accordingly. Reversing items in an instrument such as this can combat “response-set bias” where the subject merely ticks an item with little consideration (Oppenheim, 1992). The reversed items were numbers 12,13,14,17, 20, 23,24.

Using the 86 returned questionnaires from the main study the homogeneity of the final PAS was assessed using Chronbach’s alpha (Burns & Grove, 1993). A coefficient approximating 0.8 to 0.9 would indicate that the instrument has homogeneity. A coefficient very close to 1.0 would suggest that fewer items were required as they were measuring the same aspect of the variable or construct, whereas a weak coefficient would suggest that some items are measuring different variables or constructs. Figure 2 shows the SPSS output with the alpha for the final PAS.

```
RELIABILITY ANALYSIS - SCALE (ALPHA)
Reliability Coefficients 28 items
Alpha = .8608      Standardized item alpha = .8768
```

Figure 2: SPSS Output - Chronbach's Alpha for PAS

The alpha coefficient (0.8608) demonstrates that the instrument has acceptable homogeneity. The Item-Total analysis is presented in appendix 5. The “*alpha if item deleted*” can assist with identifying problematic items, and it is of note that those items that offer greatest increase in alpha if deleted that correspond closely with the reversed items on the scale (6 out of the 7 reversed items). This could imply that respondents were perhaps confused by the wording or there was response-set bias despite these reversed items. Either conclusion suggests that the instrument requires further development and testing.

Interviews:

Semi-structured interviews were to be conducted with up to 10 volunteers selected from those who agree to further participation as indicated on their returned questionnaires. A non-probability purposive sample was selected from those questionnaires received, with the aim of including the range of PAS scores obtained, including extreme scores. 29 of the 86 informants returning questionnaires volunteered for interview, however given the difficulties with locating the volunteers (several were away, either sick or on annual leave or study leave) it was only possible to make 7 appointments for interview at mutually acceptable

times, however the aims of collecting the interview data were still achieved with this slightly reduced sample.

The purpose of the interviews was to gather additional data using an alternative technique to establish if there was some convergence, so that, for example, high PAS scores should equate with evidence of active advocacy or positive attitudes towards advocacy. In addition, collecting qualitative data in this way would allow greater understanding of the phenomena than the quantitative data provides on its own. The use of qualitative and quantitative data collection methods in this study could be considered to be "*between-methods triangulation*" as described by Denzin, (1989) and Kimichi *et al* (1991) and is seen as an opportunity for cross-validation in studies such as this (Robson, 1993).

A semi-structured format allows for elaboration of questions to gain a fuller understanding of the informants' perspective, whilst maintaining consistency across interviews. The interview schedule was reviewed by four expert nurses and after modification was piloted with one informant prior to use in the main study. The interview schedule is presented in appendix 6.

Interviews took place in a private room on the hospital site, but away from the wards. Interviews were recorded with audiotape (all informants gave their specific consent to this). Interviews lasted between 20 and 45 minutes, and included introductions, consent procedures, and the opportunity for the informants to ask questions and discuss related matters.

Procedure

The two questionnaires (PAS and PDS) were sent with an introductory letter (appendix 7), and the information sheet (appendix 8). An envelope was included for return of the questionnaires directly to the researcher. The hospital internal post was used so there were no postal costs, and informants could easily return questionnaires from their workplace. As questionnaires were received they were dated and numbered in ascending order.

Two weeks after the initial distribution a prompt was sent to all informants, including a statement thanking those that have already responded, and duplicate questionnaires and return envelopes, as suggested by Babbie (1992). Given the sampling procedure used, it was not possible to identify non-responders, so it was appropriate to send out prompts to the entire sample.

At the end of four weeks following initial distribution selection of informants for interview commenced as discussed above. Interviews were completed within a six week period.

Ethical Issues

The study proposal was submitted to the appropriate Local Research Ethics Committees and was approved (see appendix 9) with only minor modifications required to the informants documentation.

All informants sampled in the two questionnaire mailings received an introductory letter (appendix 7) and an information sheet (appendix 8). The information in keeping with the type of information required by the Department of Health guidelines (DOH, 1992). The

information reflects the attention that has been given to the major ethical principles of self-determination; privacy; anonymity and confidentiality; and protection from harm (Burns & Grove, 1993).

Informants were advised that that they consent to participate by returning the questionnaire. As the questionnaires were anonymous unless the informants chose to provide their names either to volunteer for an interview or because they wanted further information. In such circumstances it is therefore inappropriate and unnecessary to ask for signed consent forms.

Those that were selected for interview (from those who had voluntarily supplied their name and work address) were asked to sign a consent form (appendix 10) prior to the interview. The format of the consent form is adapted from the DOH (1992) / Royal College of Physicians (1990) form for clinical trials.

In this type of study there are unlikely to be any significant risks, and the informants' main concerns are likely to be related to issues of confidentiality. Raw data was only be seen by the researcher and much of this was anonymous. Tapes, transcripts and questionnaires were stored in secure conditions, and no data was linked to any individuals. Any information that could lead to individuals being identified will be altered or omitted from this or any other reports produced. The involvement of a member of the human resources / personnel staff to distribute questionnaires was considered to be acceptable, because they are bound by rules of confidentiality because of the nature of their work, and whilst they were aware of the names of those sampled they did not know who responded (return envelopes were addressed to the researcher) and they did not see any raw data.

There was a possibility that recalling traumatic events related to advocacy scenarios could prove to be upsetting for informants. The interviewer undertook to offer time and support following interviews should any informant request or appear to require this. Part of the consent procedures included reminding informants that they could withdraw from the study at any time without penalty.

Analysis and Findings

Quantitative Data

The data acquired using the two instruments (PAS and PDS) were analysed using a multiple regression procedure. Descriptive statistics for relevant variables, findings from the multiple regression analysis, and results from various diagnostic procedures are presented below.

Descriptive Statistics

Table 2, below shows the variable labels and definitions used in this analysis.

Table 2: Variable labels and definitions

Variable Label	Definition
AGE	Age in years of informants
NURSEYR	Time spent in nursing in years.
EDLEVEL	Highest education level attained by informants
ETHICS	Whether informants have attended an ethics course
GENDER	Gender of informants
GRADE	Nursing grade (from C to I)
PAS	Patient Advocacy Scale score
INSPEC	Time spent in current speciality, in years

Table 3 shows descriptive statistics for EDLEVEL (Education Level) and PAS (Patient Advocacy Scale). As the table shows, the majority of informants were qualified to certificate level which is in keeping with knowledge of this population. It will be noted that mean PAS

increases with EDLEVEL, though the three highest levels are represented by very few informants ($n=4$).

Table 3: EDLEVEL and PAS

Level	n	%	\bar{X} PAS	SD
< certificate	31	36	104.9032	10.2253
Certificate	35	40.7	107.1429	8.2965
Diploma	16	18.6	113.1875	10.8886
Degree	1	1.2	115.0000	
Post-grad cert / dip	2	2.3	118.0000	
Masters	1	1.2	115.0000	

Table 4 shows job title and PAS. The largest proportion of informants were employed as staff nurses ($n=51$), followed by enrolled nurses ($n=10$).

Table 4: Job title and PAS

Job title	n	%	\bar{X} PAS	SD
enrolled nurse	10	11.6	109.6000	11.0373
staff nurse	51	59.3	105.3725	8.8203
senior staff nurse	4	4.7	115.7500	15.4785
sister	5	5.8	106.6000	11.0589
ward manager	6	7.0	109.5000	4.8062
practice development	2	2.3	121.0000	5.6569
senior nurse	1	1.2	123.0000	
clinical specialist	6	7.0	114.5000	10.4067
bed manager	1	1.2	104.0000	

Table 5 shows ward or department by PAS. It can be seen that most informants worked in medical and elderly care wards, which represents a fairly typical picture for a hospital such as the used for this study.

Table 5: Ward or Department and PAS

Ward./ Department	<i>n</i>	%	\bar{X} PAS	SD
A&E	4	4.7	96.5000	3.3166
private	3	3.5	98.6667	9.0185
out patients	2	2.3	99.5000	7.7782
haematology	1	1.2	102.0000	
occupational health	1	1.2	102.0000	
bed management	1	1.2	104.0000	
theatres	7	8.1	105.5714	6.6548
recovery	3	3.5	106.3333	9.2376
surgical	9	10.5	107.5556	9.2481
medical	17	19.8	107.9412	7.2065
elderly	13	15.1	108.0769	10.2018
ophthalmology	5	5.8	109.2000	11.8195
oncology	1	1.2	112.0000	
ENT	1	1.2	113.0000	
orthopaedics/ trauma	9	10.5	113.4444	14.8754
coronary care	8	9.3	114.1250	10.4258
pain management	1	1.2	119.0000	

The data presented here suggest that most hospital wards or departments were represented in the sample, with no significant omissions, perhaps with the exception of ITU (Intensive Therapy Unit).

Table 6 shows PAS and post-basic courses informants had undertaken. Most informants had undertaken ENB (English National Board) short courses. These short courses are designed to prepare nurses for enhanced practice or developing new roles, for example teaching and assessing or pain management. They are usually of a few days to a few weeks duration and have been until recently, at certificate level. Almost all such courses have been offered at diploma or degree level, in modular programmes, since 1995. ENB Clinical Courses tend to be of longer duration (often 6 months to 1 year) and they provide nurses with recognised qualifications for specialist or advanced practice, such as Coronary Care Nursing, Accident and Emergency Nursing, etc. These courses are all at Diploma or Degree level, and may be required for employment in certain specialist roles.

The apparent difference between table 3 data (EDLEVEL) for diploma (n=16) and that shown below (n=4) is explained in that initial nursing training is now at diploma level, though post-basic nursing diploma and degree courses are available.

Table 6: Post-basic courses and PAS

Course type	n	%	\bar{X} PAS	sd
none	27	31.4	104.1852	9.8841
ENB Short course	39	45.3	113.0714	8.6332
ENB Clinical	14	16.3	108.1282	9.9477
Diploma	4	4.7	107.5000	5.2599
Degree	1	1.2	113	
Post Grad	1	1.2	123	

Table 7 shows employment grade by PAS. No informants were on grade C, which is theoretically the lowest grade that a qualified nurse can be employed on, and has often been used as the starting grade for Enrolled nurses, though some unqualified nurses (auxiliaries) do achieve this grade. It has effectively been the norm to employ registered nurses on a minimum of grade D, and given current demand for nurses it is unlikely that trusts could recruit or retain nurses on grade C.

Table 7: Employment Grade and PAS

Grade	n	%	\bar{X} PAS	sd
C	0	0	0	0
D	23	26.7	108.2609	11.2622
E	33	38.4	104.6667	8.0143
F	14	16.3	110.3571	12.1314
G	14	16.3	110.7143	7.5593
H	2	2.3	120.0000	4.2426

Multiple regression analysis

Multiple regression analysis was used to analyse the data collected. Multiple regression allows the researcher to identify combinations of independent variables that are strongest predictors of the dependent variable (the PAS score in this study) so that values for the dependent variable can be predicted from values of the independent variables (Hair *et al*, 1995). Alternatively multiple regression can be used to develop a model that explains variation in the dependent variable.

Multiple regression requires metric data, however non-metric data can be included (as in this study) by converting them to dummy variables (Hair *et al*, 1995). SPSS for Windows, version 6.3 was used for all statistical procedures except power analysis, where R2 was used as discussed in the previous chapter.

Preliminary exploration of data

Prior to the multiple regression analysis, correlations amongst variables were examined to identify likely predictor variables and to detect any collinearity that existed, (Collinearity is where 2 independent or predictor variables correlate, thus confounding each other in the regression equation. Multicollinearity is where 3 or more variables correlate, resulting in the same problem). As can be seen from the correlation matrix (table 8) there were significant correlations involving the variables NURSEYR, EDLEVEL, ETHICS, GENDER, GRADE, INSPEC and PAS, the criterion variable, in different combinations.

Table 8: Correlation matrix (n=86)

Variable	NURSYR	EDLEVEL	ETHICS	GENDER	GRADE	INSPEC	PAS
NURSYR	1.00	-.3224**	.1025	.0526	.0467	.4527**	-.0069
EDLEVEL		1.00	.2945**	.0533	.3290**	-.1909	.3333**
ETHICS			1.00	.3079**	.2423*	-.0881	.2561*
GENDER				1.00	.1148	-.1303	.1585
GRADE					1.00	.1756	.1908
INSPEC						1.00	-.0450
PAS							1.00

* P<0.05

**P<0.01

Most of the correlations were fairly weak, the strongest being between NURSEYR and INSPEC ($r = 0.4527$, $p = 0.000$). There was a positive relationship between the informants time in their current speciality, and their years in nursing, and as many nurses work throughout their careers in the same speciality, this is unsurprising.

Of note is the negative correlation between NURSEYR and EDLEVEL ($r = -0.3224$, $p = 0.002$), suggesting that nurses with longer experience have been educated to lower levels. At first sight this may appear to be contrary to expectations, however it may reflect the recent trend for nurses to qualify with degrees, and the fact that all initial nursing training has been to at least diploma level since the early 1990's. The correlation between ETHICS and GENDER is probably best discounted because of the small numbers of males in the sample (7 males to 79 females).

Of the other variables the strongest correlations are those between EDLEVEL, and ETHICS ($r = 0.2945$, $p = .006$), and GRADE ($r = 0.3290$, $p = .002$). The weak correlation between

EDLEVEL and ETHICS is indicative of collinearity, discussed below. The relationship with GRADE may reflect that higher grade posts tend to be held by nurses who are educated beyond their initial nurse training, indeed this may often be a requirement for more senior posts, or where there is significant competition for promotion.

Collinearity

Only two variables, EDLEVEL ($r = 0.3333$, $p = .002$) and ETHICS ($r = 0.2561$, $p = 0.017$) had significant, though weak, correlations with PAS. These would therefore be likely predictors of PAS in the multiple regression analysis, though as described above there was also a problem of collinearity.

The collinearity between these two variables ($r=0.2945$, $p=0.006$) can be explained in that it is likely that those who are educated to higher levels (at least in studies relating to nursing or health care), are likely to have covered ethics in some depth as part of their studies. It would seem reasonable to expect that those who have studied ethics may be more aware of advocacy issues, thus contributing to a higher PAS.

Stevens (1992) suggests collinearity is a problem for 3 reasons: because it severely limits the size of R ; it masks the relative importance of the predictors because of correlations amongst them; and it increases the variances of the regression coefficients, thus reducing the stability of the regression equation. Stevens suggests that diagnosis of collinearity is achieved by examining the correlation matrix (as above), though warns that subtle forms may not be apparent; and / or by examining the variance inflation factors (VIF). Stevens (1992) cites

Myers' (1990) "rule of thumb", that if any VIF exceeds 10 there is cause for concern and variable deletion or some other method should be employed to overcome the problem.

Given that the correlations identified in the matrix above were weak, and the VIF values (see figure 3 below) are both low (1.095) it was deemed appropriate to include both EDLEVEL and ETHICS in the multiple regression analysis.

----- Variables in the Equation -----						
Variable	B	SE B	Beta	Tolerance	VIF	T
EDLEVEL	2.800884	1.057729	.282317	.913279	1.095	2.648
ETHICS	3.551250	2.188786	.172979	.913279	1.095	1.622
(Constant)	103.912069	1.482857				70.076

Figure 3: Output from SPSS showing VIF (variance inflation factors) values for EDLEVEL & ETHICS variables

Assumptions of multiple regression analysis

One of the principal assumptions with parametric statistical tests is that the dependent variable is treated as an interval level measure. In this study the dependent variable is the advocacy score derived from the PAS. There has been some debate in the literature concerning the treatment of Likert scale items as interval data, when they are technically at the ordinal level (see for example Knapp, 1990 & 1993), however this appears to be a widely adopted practice, and it does allow for the use of more powerful parametric statistical analysis (Burns & Grove, 1993; LoBiondo Wood & Haber, 1994), and as such the researcher may be deemed to have failed to "do justice" to the data if it is not treated as such.

Hair *et al* (1995) argue that it is essential to ensure that the assumptions of multiple regression are met so that the results obtained are truly representative of the sample and that the best possible results are obtained from the analysis, however it is argued that multiple regression analysis is robust to violations of the assumptions of normality (Stevens, 1992, Hair *et al* 1995; Howell, 1977).

The four assumptions that must be met for multiple regression analysis are independence, linearity, constant variance, and normality (Hair *et al*, 1995). Given the nature of sampling and data collection in this study (random sampling, informants were unknown to each other), it is likely that the independence assumption (that the informants responded independently of each other) has been upheld.

Stevens (1992) suggests that residual plots can be utilised to determine whether threats to the linearity and constant variance assumptions exist. In particular the Studentized residuals can be plotted against the predicted values. If the assumptions are met, then the residual should scatter randomly (or in a generally random manner, Hair *et al*, 1995) about a horizontal line defined by $r_i = 0$ (see figure 4, below). Patterns representing curvilinearity or heterogenous variance, for example, would indicate violations of the assumptions.

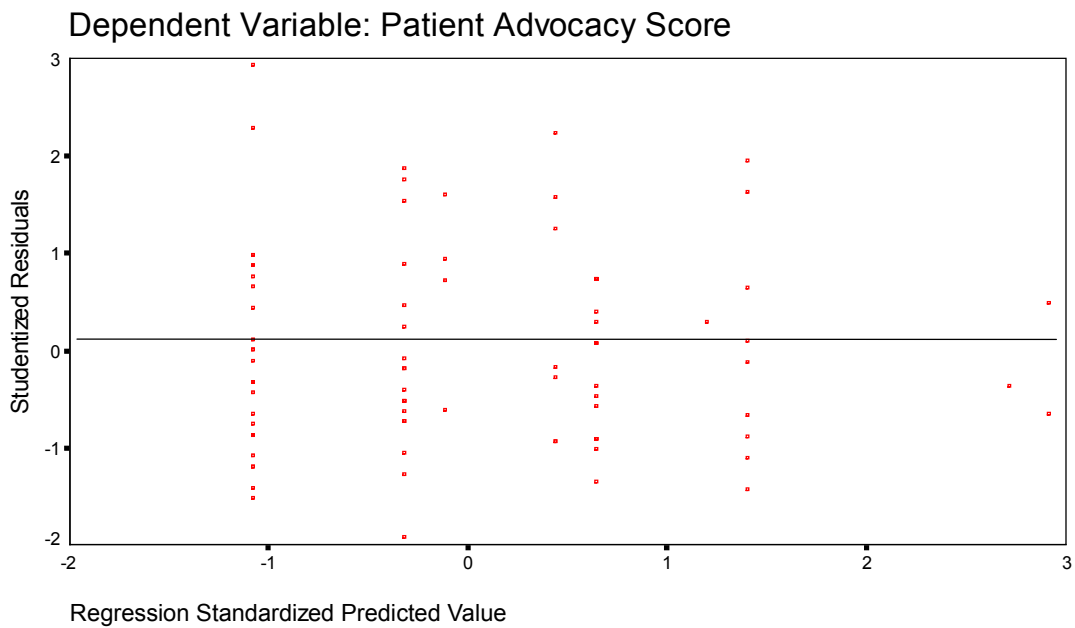


Figure 4: Residual plot of Studentized residuals by predicted values

As can be seen in figure 4, the plot shows no evidence of nonlinearity or curvilinearity, nonconstant or heterogenous variance.

Normality may be examined with a normal probability plot (see figure 5). In this instance there are no significant departures from the norm indicated by the solid diagonal line. It is likely that the small departure visible is not a significant threat to the assumptions of the multiple regression equation.

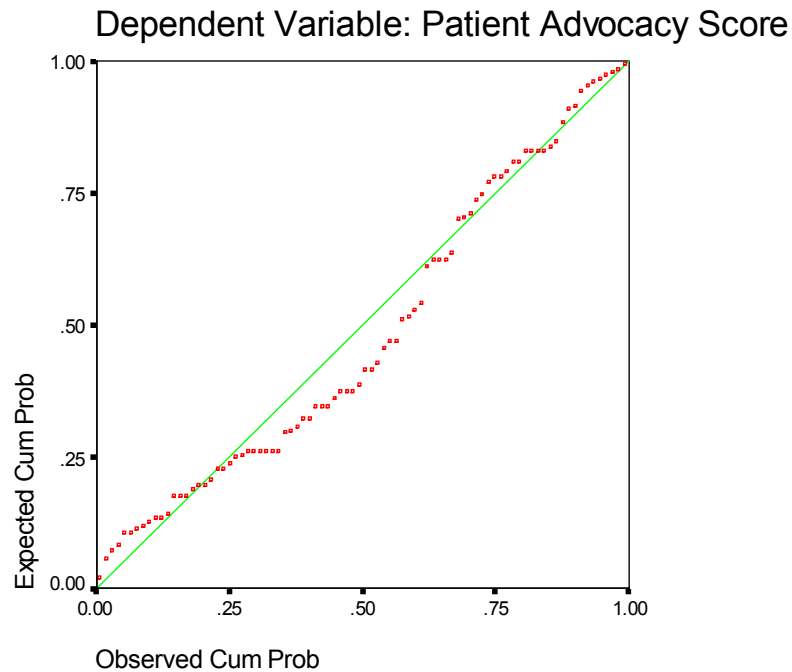


Figure 5: Normal P-P plot of regression standardised residuals

From the diagnostic data presented above it can be concluded that there are no serious violations of the assumptions of multiple regression analysis.

Methods for selecting variables

Hair *et al* (1995) identify three main approaches to variable selection and model building in multiple regression analysis: confirmatory specification, whereby the analyst specifies the variables for inclusion; sequential search approaches, where the software selectively adds and removes variables from the equation in accordance with certain criteria; and combinatorial (or all subsets regression) approaches, where all possible combinations of variables are used in generating large numbers of possible equations. Each of these general approaches offers advantages and disadvantages, and different equations may result depending on the method used, however some of these may result in spurious findings

because of the ways in which variables are selected or excluded. The decision as to which approach to use will inevitably result in some compromises.

Of the three general approaches identified above, the sequential search has an advantage in that it offers an objective method for selecting variables, whereas the other approaches require that the analyst selects the variables (confirmatory) or selects the most meaningful or appropriate equation (combinatorial). Sequential approaches attempt to select variables that maximise the predictive power of the equation with the smallest number of variables, and consequently upholds the requirement for model parsimony.

There are three main sequential search methods available (backward and forward elimination, and stepwise regression), which also offer advantages and disadvantages, however stepwise estimation is deemed to be the most popular of these (Hair *et al*, 1995). Despite the popularity of this method, which Howell suggests is the best of the approaches he discusses, he also suggests that when the researcher is more interested in theory testing (implying that the analyst should use a confirmatory approach, or select theoretically proposed variables, to test relationships predicted by theory) rather than prediction, then stepwise regression should perhaps be called “*unwise regression*” and he questions why he uses this method at all (Howell, 1997, p541), nevertheless he does.

In this study the focus is on explanation, and perhaps theory generation rather than theory testing, and as such it is probably inappropriate for the researcher to select the variables for analysis, beyond the selection made by virtue of instrument development, and stepwise regression is therefore deemed to be appropriate for use here.

With stepwise regression the independent variable with the smallest probability of F is entered into the equation, and in subsequent steps, the variable with the next lowest probability of F is added, if the probability is sufficiently small, and this proceeds until no more variables can be added. Variables that are already in the equation may subsequently be removed if the probability for F exceeds a predetermined value.

For this study the criteria for including and excluding variables were initially set at $p= 0.1$; and $p= 0.2$ respectively. These values are in keeping with Howell's (1997) recommendations. As can be seen in figure 6 this resulted in rejection of all variables with the exception of EDLEVEL (educational level). The R^2 coefficient this generated ($R^2 = 0.11106$) suggests that only a small proportion of the criterion variable (PAS, patient advocacy score) was predicted by EDLEVEL

```

**** MULTIPLE REGRESSION ****

Equation Number 1   Dependent Variable.. PAS   Patient Advocacy Score

Block Number 1. Method: Stepwise   Criteria PIN .1000 POUT .1500
EDLEVEL ETHICS GENDER GRADE NURSEYRS INSPECIA

Variable(s) Entered on Step Number
1.. EDLEVEL educational level

Multiple R           .33326
R Square             .11106
Adjusted R Square    .10048
Standard Error       9.40367

Analysis of Variance
      DF   Sum of Squares   Mean Square
Regression    1       928.02088       928.02088
Residual     84      7428.03726       88.42901

F = 10.49453   Signif F = .0017

----- Variables in the Equation -----

Variable          B           SE B           Beta           T           Sig T
EDLEVEL          3.306259    1.020600       .333256        3.240       .0017
(Constant)      104.704424  1.413670                          74.066       .0000

End Block Number 1 PIN = .100 Limits reached.

```

Figure 6: SPSS output for stepwise multiple regression analysis

The predictive power of the equation could be marginally improved by including ETHICS (completed an ethics course), giving $R^2 = 0.13839$ (see figure 7). It is suggested that the adjusted R^2 coefficient gives a better comparison between equations with different numbers of variables and the adjusted R^2 's were 0.10048 and 0.11762 respectively for EDLEVEL alone and EDLEVEL and ETHICS, suggesting only a minimal additional contribution to the equation. It can be seen from figures 6 and 7 that the F statistic for both equations are significant at the $p \leq 0.01$ level.

```

**** MULTIPLE REGRESSION ****

Equation Number 1  Dependent Variable.. PAS  Patient Advocacy Score

Block Number 1. Method: Enter  EDLEVEL ETHICS

Variable(s) Entered on Step Number
  1.. ETHICS  ethics courses
  2.. EDLEVEL  educational level

Multiple R          .37200
R Square            .13839
Adjusted R Square   .11762
Standard Error      9.31361

Analysis of Variance
      DF    Sum of Squares    Mean Square
Regression    2    1156.36614    578.18307
Residual     83    7199.69200    86.74328

F =    6.66545    Signif F = .0021

----- Variables in the Equation -----

Variable      B          SE B      Beta      T      Sig T
EDLEVEL    2.800884    1.057729    .282317    2.648    .0097
ETHICS     3.551250    2.188786    .172979    1.622    .1085
(Constant) 103.912069    1.482857          70.076    .0000

End Block Number 1  All requested variables entered.

```

Figure 7: SPSS Output for EDLEVEL & ETHICS equation

The regression equation and it's significance

With an R^2 of such a low value (0.13839), the regression equation will serve as a very poor predictor as there is a large proportion of the dependent variable which is unexplained, and as such it has little explanatory power for this study, however it is reported here for completeness.

The multiple regression equation from this analysis is derived from the constant (103.912069) and the B values (or slope) for the predictor variables (see figure 7), so that:

$$\text{PAS} = 103.912069 + (\text{EDLEVEL} \times 2.800884) + (\text{ETHICS} \times 3.551250)$$

so for example, for a subject with an EDLEVEL = 3 and ETHICS = 1, the predicted PAS would be

$$103.912069 + (3 \times 2.800884) + (1 \times 3.551250) = 113.06509$$

or a predicted PAS of 113.

When the regression model has been established, the significance of the overall model is tested (that is the null hypothesis that R^2 is zero, or that X and Y are not related) using the F ratio. Figure 7 above shows that $F = 6.66545$ $p = 0.0021$ for this equation, so is deemed to be significant at the level set for alpha for this study, $p \leq 0.05$.

Validating the results

Hair *et al* 1995) suggest that ideally the results of the multiple regression analysis can be validated for generalisability by taking a second sample from the same population. In the absence of this they suggest that the *adjusted R²* and the *R²* coefficients are compared, with large differences representing “overfitting” to the sample, therefore suggesting poor generalisability. In this analysis the *R²* was 0.13839, and the adjusted *R²* was 0.11762 (see figure 7), which does not differ greatly. Another method that Hair *et al* (1995) suggest is to randomly split the sample into two and perform the same analysis multiple regression analysis on each sub-sample. Again large discrepancies between the two results would suggest a threat to generalisability. Results from the analysis of two sub-samples for this study are presented in figure 8, below.

Sub-sample 1 n=43	
Multiple R	.41645
R Square	.17343
Adjusted R Square	.15327
Standard Error	9.26560
F =	8.60280 Signif F = .0055
Sub-sample 2 n=43	
Multiple R	.38600
R Square	.14899
Adjusted R Square	.12824
Standard Error	7.59056
F =	7.17818 Signif F = .0106

Figure 8: SPSS output for multiple regression validation test

Results from the analysis of the two sub-samples, which were randomly selected from the whole sample using the SPSS select cases procedure, suggest that there are small differences in the *R²* and *adjusted R²* statistics (the adjusted coefficient is recommended for comparison by Hair *et al* 1995). The size of these differences do not suggest a threat to the

generalisability of the findings, however it must be remembered that every random sub-sample is likely to produce different results.

Post-hoc power analysis

As discussed in chapter 5, power analysis was used to determine the desired sample size prior to data collection. Post-hoc power analysis is no substitute for this, however it can help to explain results obtained given the actual response rate obtained. In this study, the desired sample size to obtain a power of 0.8 was 111 with 8 independent variables. The actual response rate achieved provided only 86 useable responses (though 90 were received). The R2 software was used to calculate the power achieved using the actual sample size ($n = 86$), 6 independent variables (therefore $K = 7$) and the R^2 derived from the regression analysis ($R^2 = 0.13839$), see figure 9, below.

```
Output from R2 -- Version 1.1
High Accuracy Algorithm is in use.
-----
Power Calculation
N:          86
K:           7
Rho Square: .13839
Alpha:      .05000
Power:      0.75437
```

Figure 9: Output from R2 software showing post-hoc power analysis

The power achieved (0.75437) is very close to the threshold of 0.8 desired. This implies that the risk of type II error is approximately 0.24, which indicates that the probability of failing to detect significant R^2 's of values below 0.13839 is $p = 0.24$. Given the small R^2 actually

detected this would be of little practical significance, and one could conclude that adequate power has therefore been achieved for what is a very small effect size.

Conclusions from Quantitative Data Analysis

The diagnostic procedures used suggest there are no major violations to the assumptions of the multiple regression analysis, and it was therefore an appropriate procedure to use with this data set. The analysis using a stepwise procedure suggested a regression equation including EDLEVEL as a predictor variable. When the criteria for inclusion were adjusted to appropriate levels, ETHICS was included in the equation, which added a small degree to the predictive power of the equation, the small difference probably reflecting the collinearity that existed between the two.

The small size of the R^2 coefficient obtained suggests that although this combination of independent variables provided the best prediction of PAS, it still accounts only a very small amount of the variance. Other, presumably unmeasured variables have a significant explanatory role in determining PAS scores for this sample.

Post-hoc power analysis suggests that the final sample size obtained was just short of the threshold required to meet the conventional level of 0.8 normally required. Given the small effect size involved, this shortfall is deemed to be of little practical significance. Validation of the equation by data-splitting suggests that the findings may be generalisable.

Qualitative Data:

Whilst the intention had been to interview 10 informants, given the difficulties involved in contacting and agreeing suitable appointments within the time scale available, only 7 informants were finally interviewed. Although fewer than originally planned, it is evident that those interviewed cover a reasonable range of the sample characteristics. As can be seen in the data matrix (figure 10a,b &c, appendix 11) informants with PAS scores close to the extremes were included (91 to 123) and there was a good spread of values for the independent variables EDLEVEL, GRADE, NURSEYR and INSPEC. It is also apparent that differing views and perceptions of patient advocacy are represented.

A frequently cited rationale for determining sample size in qualitative studies is the criteria of “data saturation” (LoBiondo-Wood & Haber, 1998), this is where no new themes ideas or meanings emerge from further sampling, however this approach is beyond the scope for this study. The aim of gathering qualitative data in this study was to facilitate some degree of triangulation in order to explain, contextualise and validate the quantitative data collected, as described previously in Chapter 5. To continue sampling to achieve saturation was not in keeping with the aims of this study, and may not have been achieved within the pool of volunteers available.

The interview data was transcribed by the researcher and significant statements and meaning units were entered in the data matrix. The data matrix is based on a model developed by Miles & Huberman, (1994). A data matrix is a method of data display that allows potential relationships amongst the data to be visualised in a graphic form. This can serve as a tool for analysis itself, or can assist with generating categories for further in depth analysis using

other approaches. Its use in this study permits comparisons between informants' descriptions of advocacy, at the same time as retaining links with other variables such as PAS score.

The data matrix is presented in tables 10a, 10b and 10c in appendix 11. The informants have been given pseudonyms to aid clarity.

Describing Patient Advocacy

Informants were asked to describe or explain their understanding of patient advocacy, whilst there was a great deal of common ground between informants, 5 distinct themes emerged (see figure 11, below).

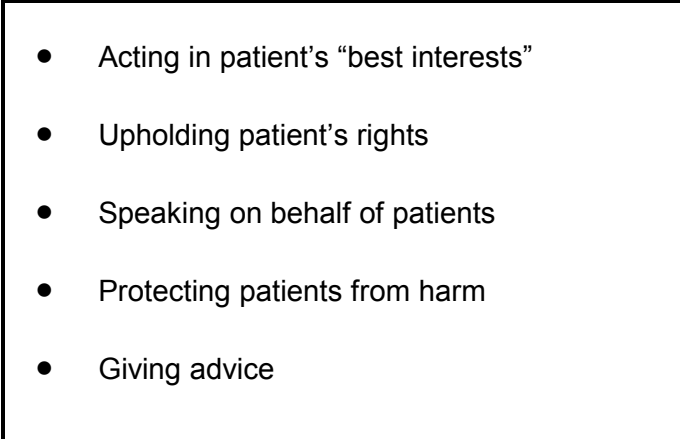
- 
- Acting in patient's "best interests"
 - Upholding patient's rights
 - Speaking on behalf of patients
 - Protecting patients from harm
 - Giving advice

Figure 11: Patient Advocacy themes

Best Interests

Two informants (Ann and Dawn) defined advocacy in terms of acting in the patients best interests. As identified in the literature review there is a difficulty with this notion “best interests”, often being defined in terms of the carers’ or professionals’ perspectives rather than that of the patient themselves, or focusing purely on medical issues rather than the patients general well-being.

Dawn seemed to equate “best interests” with carrying out the patient’s wishes, and in her example of the patient refusing blood products, Dawn argued that if the patient’s decision was made with full information and the patient was competent to decide, then this wish should be upheld.

Ann also spoke of “best interests” and she placed safety for the patient as a high priority. “Best interests” decisions in this context would appear to be those which maintain physical safety rather than complying with patient’s wishes, which may conflict with safety needs. This is illustrated in Ann’s example of the patient who wanted to go home, but adequate home care was unavailable and Ann perceived her advocacy role was to persuade the patient to stay in hospital, though she acknowledges the dilemma she faced, and her difficulty in resolving it.

Upholding Rights

Ann’s approach contrasts with Carol’s example, where she actually requested that a patient should go home, because that was what he really wanted, even though continuing hospital

care was necessary in terms of his physical well-being; this different approach may well reflect Carol's view of advocacy as being concerned with upholding rights.

Fiona also focused on protection of patient's rights. In her example of the patient being resuscitated at home, she felt that the patient's own wishes were not considered, the patient clearly could not express them, yet the continued resuscitation efforts were based on the relatives' wish that the patient should live, and the attending doctors' religious beliefs. This situation equates with the "*silent patient*" scenario as discussed by Gadow (1989). In this instance the issue central to an act of advocacy on behalf of the patient is whether the patient would want to be resuscitated to endure living for a few days or weeks more in a vegetative state with no hope of recovery. Fiona stated that the nurse is the patient's "ears, eyes and voice" and therefore it was important that (the nurse) is there to protect them from harm; ignoring a patient's (potential) wishes, and overzealous and unwarranted resuscitation attempts were such a harm.

Though these informants spoke of patient's rights, this was in a generalised sense, and no clear definitions of what these rights might be were offered.

Protection from harm:

Other informants identified protecting patients from harm as a function of patient advocacy. Carol cited an example where another nurse had given incorrect advice to a patient's family, and Elizabeth cited an example where a patient was "ill-advised" by a doctor. Georgina's view of advocacy focused particularly on protection from harm for her unconscious patients, and described a collective action involving the Rcn (Royal College of Nursing - the nurses

professional organisation) in a dispute over the safety of hospital buildings as an act of advocacy, as children were being put at risk during their journeys to and from theatres.

Giving information and advice,

Several informants spoke about information giving and advice as part of advocacy. A frequently cited example was the situation where Doctors would explain, perhaps inadequately, the treatment plans or options to patients. Often the patients would appear to fail to understand, perhaps as Fiona suggested, because they were intimidated by, or were in awe of the doctors, or perhaps because the doctors did not relate well to the patients or use language that was familiar to them. It was also suggested that some patients accept what Doctors say without question, because, as Elizabeth suggests, of the traditional view that *“Doctor knows best”*.

Several informants would talk to patients after such interactions, and check understanding, repeat information, invite questions, describe options, and reinforce the idea that the patient actually had a choice. Often, following such interventions informants suggested that they may then have to voice the patients views or revised choices and / or arrange further meetings with the doctors concerned.

Speaking up for patients:

This was identified by some informants in the context of speaking for the “silent patient” as described above, and also, as Elizabeth stated, in *“interceding on the patients behalf”*, with

Doctors and relatives, where perhaps the patient was not “silent” but were vulnerable to being “*bulldozed*” by the views of others.

Examples of advocacy:

All but two of the informants (Barbara and Georgina) could readily offer examples of acts of patient advocacy that they had been involved in, though they were not all successful in achieving their aims. The examples were wide ranging and included challenging resuscitation decisions and prescriptions of drugs; empowering patients to decline treatment; seeking treatment for post-operative pain; requesting improvements to buildings for safety reasons; empowering patients to go home against advice; and persuading patients to remain in hospital.

Opinions regarding the nurse as a patient advocate:

None of the informants offered negative views relating to the concept of nurses acting as patient advocates (notwithstanding some of the difficulties they raised, discussed below), though some were far more enthusiastic than others. It may be of note that the informants that scored the lowest PAS scores (Ann and Barbara), were clearly least enthusiastic about patient advocacy. This could demonstrate some convergence between quantitative and qualitative data. All of the other informants spoke positively about an advocacy role for nurses, though this could to some extent reflect a form of bias (for example, evaluation apprehension - informants wishing to be seen in a good light by the researcher; or a selection effect; Burns & Grove, 1997). Sources of bias are discussed more fully in Chapter 7, “Discussion and Limitations”.

None of the informants argued that nurses should, or could not be patient advocates, although this is a common argument made in the literature. Four of the informants (Dawn, Elizabeth, Fiona and Georgina) held views suggesting that advocacy was a fundamental part of nursing, for example Elizabeth described it as “*a natural progression*” for nurses, and others suggested that advocacy was “*one of the main parts of the job*” (Dawn) and “*absolutely vital*” (Fiona).

Problems and limitations

Informants identified factors that could impair their ability to be patient advocates, or concerns that would limit their actions as advocates. Several suggested that they might have difficulties if they knew the patient personally, though it was not cited as a reason to desist, and one informant, (Elizabeth) suggested that this may make her fight even harder. Other problems identified were if the nurse had no rapport with the patient (Georgina) or if the issue was something very upsetting or “*too close to home*” (Carol).

Informants differed on how far they were prepared to take an act of advocacy if this brought them into conflict. Fiona was very clear that she would “*go to the ends of the earth*” to fight for a patient, and that she did not worry about the consequences to herself. She described an example from early in her nursing career when she challenged the clinical judgement of a doctor on behalf of a patient, and ultimately was proven correct. She believed this was a valuable formative experience that has assisted her to persist in the face of conflict and intimidation. Other informants spoke of consequences or repercussions arising from acts of advocacy, such as threatening promotion chances, and being unpopular (Carol).

Three informants recognised that they might have difficulty if challenged, Carol said she “*tends to back down*” then “*felt angry*” for keeping quiet. Dawn said she also tends to back down, but said “*if I knew I was right I would do it*”. Elizabeth said she could be “*a bit of a soft touch*” and that she could “*buckle under pressure*”.

Ann suggested that ultimately neither she nor the patient would have the final word as “*ultimately the consultant decides*”, and she said that if someone put a good argument to her she would hope to take it on board, and comply with that view. Barbara said only that “*you are just powerless in a big organisation*”.

Factors that assist with advocacy

Several factors were deemed to assist nurses with their advocacy role, including having supportive managers (Barbara, Carol and Elizabeth); Support of colleagues and the multi-disciplinary team (Ann and Elizabeth); having enough time (Ann and Carol) and a calm environment; and having adequate information and a good patient care model (Georgina).

Skills and qualities for advocacy

Most informants identified communication and relationship skills as being important to be effective advocates, such as: listening skills, building rapport and trust, empathy and assertiveness skills. In addition Barbara suggested counselling skills and a knowledge of

legal issues would help; and Georgina suggested managerial and diplomacy skills were necessary.

Conclusions from qualitative analysis

The data from the interviews demonstrates that there are varied perspectives of what patient advocacy is and what it involves, and a range of enthusiasm for the role. Some of the models of advocacy outlined in the literature review are in evidence in the interview data, and some of the problems and conflicts associated with patient advocacy have also been illustrated by the informants. To some extent the interview data does offer some convergence with the qualitative data, and those who appeared most enthusiastic proponents of patient advocacy also scored the highest PAS scores.

Discussion

From the questionnaire data it is evident that the vast majority of the informants are at least sympathetic to the idea of patient advocacy, and agree that it is a fundamental aspect of nursing. It is less clear, however, is how nurses understand advocacy, and as to what advocacy actually means and whether they their beliefs are actually converted into actions in their day to day practise.

In a statistical sense the multiple regression analysis was successful in identifying a combination of variables that could explain some of the variance in PAS scores. The small magnitude of the coefficient means that in practice it has little explanatory power. It is likely that advocacy beliefs and behaviours (purportedly measured by the PAS) are determined by a far more complex range of variables, or possibly, that some significant predictors were not included in the study.

The two predictor variables identified, though only contributing a small amount, do correspond with the findings in Mallik's (1997a) literature review, that nurses need preparation for patient advocacy in terms of education, particularly in ethical decision-making, communication skills, and dealing with conflict. It is arguable, therefore, that efforts could be made to improve preparation of nurses for their advocacy role through appropriate initial and post-basic education initiatives. Even though education may account for only a small portion of PAS, it may be the one variable over which there is potential for control. If there is a desire to enhance the nurses advocacy role, potentially to the ultimate benefit of patients, then educational initiatives may be the most effective strategy.

The interview data suggested a considerable variation of opinions concerning the nature of advocacy, though the models of advocacy identified in the literature review were in evidence, with the exception of the advocate as “champion of social justice”. None of the informants interviewed suggested any views that coincided with this model. Given current severe difficulties with shortages of staff and other resources at this hospital, this may seem surprising, it may not be so when one considers that the nursing profession has never been known for political activism. This might also reflect that nurses construe advocacy in the context of the individual nurse-patient relationship.

Some of the informants did describe notions relating to supporting patient autonomy, such as recognising the need to provide information on choices, communicating patients own wishes and decisions, and also an awareness of avoiding the imposition of the nurses own views. These ideas are in keeping with Kohnke’s (1982) principle tasks for the nurse of informing and supporting.

Other informants seemed to view advocacy more in terms of upholding rights. This model of advocacy may become increasingly significant with initiatives such as the Patient’s Charter (DOH 1991) and the rise of consumerism in health care and the associated litigation. Mallik (1997a) however, has argued that advocacy as upholding human rights owes much to the American origins of patient advocacy, where the concept developed alongside a vigorous human rights movement, and she suggests it may not be appropriate to the UK. The UK has not had the same tradition or constitutional concern with human rights, and this might explain the lack of clarity regarding what these rights might be.

Some informants identified a “best interests” focus for patient advocacy. Best interests were by one defined in terms of the patients own wishes, thus equating more with patient

autonomy, while another two informants related best interests to the medical needs and safety needs of the patient, regardless of their own wishes. This highlights the danger of a “best interests” argument, as these nurses saw their role as persuading patients to accept the treatment regimes on offer. This is perhaps representative of the paternalism described by Gadow (1983), in that the nurse was intent on providing a good (protection from harm, or a prolonged in-patient stay) that was unwanted by the recipient. In the context of the medical model under which many nurses work, this approach is seen as completely legitimate, and as such the potential for reflection or questioning is limited in such a setting. It could be argued that conflict between the nurse and the patient is more acceptable than conflict between the nurse and members of the health care team, as the nurse was prepared to deny the patient’s wishes even though self-discharge was likely.

Mallik’s (1997b) triadic model of advocacy can be related to some of the findings of this study. From the interview data it appeared that some informants anticipated, or were better prepared for, conflict as part of patient advocacy than others. For some informants it was an inevitable, if unpleasant consequence, whilst for others it was not an expectation that they would engage in conflict. In the latter case it may be that in taking a passive advocacy role, that is acting to the level permitted by the institution, overt conflict is avoided. It is of note that those informants who included conflict in their view of advocacy scored most highly on the PAS, this could be entirely an artefact of the PAS itself, however, which may be biased towards items related to conflict. This is not necessarily a threat to validity however, as the PAS is underpinned by certain models of advocacy, and there is still much debate in the literature concerning the very nature of advocacy, and there is no definitive answer as to which, if any is correct.

In addition to the findings discussed previously the study has also contributed to the further development of the PAS tool. Whilst some problems with the reversed items have been identified, the scale appears to have some validity and reliability, and there was some cross-validation with the interview data. With further development and testing the PAS could provide an easy to administer tool that could have application in further research and as a tool for audit and quality control. Some interest has already been shown in the development of clinical standards for patient advocacy, and some means of audit and evaluation will be necessary. It may also have potential use in pre and post-testing in relation to educational initiatives.

Limitations

A major limitation in this study was the poor response rate achieved. The possible reasons for this have been discussed, and a fair amount of non-response may be due solely to inaccuracies with the sampling frame. With such a low response rate the potential for sampling bias is greatly increased, and the generalisability of the findings is very limited as a result. The problems with the sampling frame are potentially resolvable in any future studies, and increased response rates would be anticipated.

In addition to the sampling bias introduced, the small sample also precluded analysis of various sub-groups within the sample. For example, analysis of PAS by ward or department and other categorical variables was not viable because of the very small numbers involved.

A further problem with the small sample and non-response problem was the lower than intended statistical power for the study, however as a small effect size was selected and the

power approached the desired level, this is perhaps not as important as the other effects of a small sample.

Sampling bias may have been further compounded by the purposive sampling for the interviews. It is likely that informants who volunteered for interview were most interested in patient advocacy, and although the interview data was not intended to be generalisable, it may be that important views and experiences were excluded from the study as a result.

It is evident from Item-Total analysis of the PAS that there are problems with some items. Although the overall alpha was acceptable, these problematic items could represent a significant threat to the validity and reliability of the instrument as it stands.

Conclusion

This study has assisted with the development of an instrument to measure patient advocacy, and some insights into the nature and extent of patient advocacy beliefs and practices amongst this population have been gained. There appears to be a wide range of understanding of the advocacy role, and differing levels of enthusiasm for undertaking acts of patient advocacy. Informants were motivated particularly by protecting patients rights, acting in their best interests, and promoting choice and autonomy. The multiple regression analysis suggests that educational level and attendance at ethics courses were related patient advocacy, though most of the variance is accounted for by other unknown variables. It may be that educational initiatives are still the most effective way to enhance the nurses role as a patient advocate.

Recommendations

On the basis of the experience of designing and implementing this study, and in consideration of the findings obtained, the following recommendations are made.

Research

- Further development and testing of the PAS instrument should be conducted as it has potential as a tool for future research and educational and clinical audit and evaluation.

- Further research should be conducted with a larger sample and a suitable sampling frame to validate the findings of this study and / or identify other predictors of patient advocacy.
- Further research should be conducted to investigate Mallick's triadic model of advocacy, and to determine if it does have applicability to nursing practice.

Education

- Consideration should be given to developing further the preparation of nurses for their advocacy role in initial nursing training, in particular by focusing on ethics, communication and conflict management.
- Consideration should be given to the development of post-qualification courses in ethics and advocacy skills.

Practice:

- The nurses role as an advocate should be legitimised in hospital policies and practice so that the role is acknowledged and supported by managers.
- Clinical audit should include assessment availability and effectiveness of advocacy for patients.

REFERENCES

- Abrams, N. (1978). A contrary view of the nurse as patient advocate. *Nursing Forum*. 17(3), pp 258-267.
- Allmark P. Klarzynski R. (1992). The case against nurse advocacy. *British Journal of Nursing*. 1(12), Oct 22-Nov 11, 33-6,
- ANA (1985). *Code for Nurses with Interpretive Statements*. Kansas City: American Nurses Association.
- Andrew, B.L. (1990). Patient advocacy in the postanesthesia care unit. *Journal of Post Anesthesia Nursing*. 5(6), December, pp 411-413.
- Becker, P. (1986). Advocacy in nursing: perils and possibilities. *Holistic Nursing Practice*. 1(1), pp 54-63.
- Bishop, A.H., & Scudder, J.R. (1990) *The Practical, Moral, and Personal Sense of Nursing: a Phenomenological Philosophy of Practice*. Albany: State University of New York Press.
- Burns, N., & Grove, S.K. (1993).(Second Edition). *The Practice of Nursing Research: Conduct, Critique & Utilization*. Philadelphia: Saunders.
- Carpenter, D. (1992). Open learning programme P9: Advocacy, Part (i): The 'what' and 'when' advocacy. *Nursing Times*. July 1. 82(27), pp i- viii.
- Carpenter, D. (1992). Open learning programme P9: Advocacy. Part (ii): The 'how' of advocacy. *Nursing Times*. June 24. 82(26), pp i- viii.
- Castledine, G. (1981). The nurse as the patient's advocate: pros and cons. *Nursing Mirror*. 153(20), pp 38-40.
- Cassidy, V.R. & Oddi, L.F. (1988). Professional autonomy and ethical decision making among graduate and undergraduate nursing majors. *Journal of Nursing Education*. 27(9), November, pp 405-410.
- Chadwick, R. & Tadd, R. (1992). *Ethics & Nursing Practice: A Case Study Approach*. Basingstoke: Macmillan.
- Cohen, J. (1988). *Statistical Power Analysis for the Behavioural Sciences*. (2nd edition). New York: Academic Press.
- Cohen, J. (1992). A power primer. *Psychological Bulletin*. 112(1)., pp 155-159.
- Cole, V.L. (1991). *The essential characteristics of advocacy associated with the nurse-client relationship: the clients perspective*. PhD Thesis. Ann Arbor University. Michigan.

- Curtin, L. & Flaherty, M.J. (1982). *Nursing Ethics: Theories and Pragmatics*. Englewood Cliffs: Prentice Hall.
- Czaja, R., & Blair, J. (1996). *Designing Surveys: A Guide to Decisions and Procedures*. Thousand Oaks: Pine Forge Press.
- Department of Health, (1992). *Local Research Ethics Committees*. HSG (91)5. London: Department of Health.
- Department of Health. (1991). *The patient's charter*. London: HMSO.
- Dimond, B. (1992). Not for resuscitative treatment. *British Journal of Nursing*. **1**(2), pp 93-94.
- Donahue, M.P. (1985). Advocacy. Chapter 24 **IN** Bulechek, G.M., & McKloskey, J.C. *Nursing Science and Nursing Care*. Philadelphia: Saunders.
- Dunman, P. (1994). *Report of the Patient Advocate - June 1994*. Brighton: Brighton Health Care NHS Trust.
- Elander, G., Drechsler, K., Persson, K.W. (1993). Ethical dilemmas in long term care settings; interviews with nurses in Sweden and England. *International Journal of Nursing Studies*. **30**(1), pp 91-97.
- Fahy, K. (1992). Advocacy in NICU. *Australian Nurses Journal*. **21**(11), 12-24.
- Fetsch, S.H. (1991). *Advocacy in Pediatric Nursing: A Qualitative Study*. Ph.D. Thesis. University of Kansas.
- Fowler, F.J., (1993). *Survey Research Methods*. (2nd Edition). Applied Social Research Methods Series. Volume 1. Newbury Park: Sage.
- Fowler, M.D.M. (1989). Ethical decision making in clinical practice. *Nursing Clinics of North America*. **24**(4), December, pp 955-965.
- Gadow, S (1980). Existential advocacy: Philosophical foundation of nursing. **IN** Spicker, S.F. & Gadow, S. (Eds). *Nursing, Images and Ideals: Opening Dialogue with the Humanities*. New York: Springer
- Gadow, S. (1979). Advocacy nursing and new meanings of ageing. *Nursing Clinics of North America*. **14**(1), pp 81-91.
- Gadow, S. (1983). Existential advocacy: philosophical foundation of nursing. **IN** Murphy, C., & Hunter, H. (Eds). *Ethical Problems in the Nurse-Patient Relationship*. Boston: Allyn & Bacon.
- Gadow, S. (1989). Clinical Subjectivity: advocacy with silent patients. *Nursing Clinics of North America*. **24**(2), June, pp 535-541.
- Gates, B. (1994). *Advocacy: A Nurses Guide*. London: Scutari Press.

- Gillette J. (1988) Advocacy and nursing: implications for women's health care. *Australian Journal of Advanced Nursing*. Sep-Nov; 6 (1), pp 4-11
- Giorgi, A.(1985). Sketch of a psychological phenomenological method. **IN** Giorgi, A. (Ed). *Phenomenology and Psychological Research*. Pittsburgh: Dusquesne University Press.
- Graham, A. (1992). Advocacy: what the future holds. *British Journal of Nursing*. 1(3), pp 148-150.
- Greipp, M.E. (1992). Greipp's model of ethical decision making. *Journal of Advanced Nursing*. 17, pp 734-738.
- Hair, J.F., Anderson, R.E., Tatham, R.L., Black, W.C. (1995). *Multivariate Data Analysis*. (4th Edition). Englewood Cliffs: Prentice Hall.
- Harman, G. (1977). *The Nature of Morality: An Introduction to Ethics*. New York: Oxford University Press.
- Hatfield, P.G. (1991). *The relationship between levels of moral/ethical judgement, advocacy and autonomy among community health nurses*. Ph.D. Thesis. Michigan State University.
- Hind, M. (1993). Ethical dilemmas in qualitative research: how do we respect autonomy? *British Journal of Theatre Nursing*. Supplement, January, pp S1-S5.
- Howell, D.C. (1997). *Statistical Methods for Psychology*. (4th Edition). Belmont: Duxbury.
- Hudak, C.M., Gallo, B.M., & Benz, J.J. (1990). *Critical Care Nursing: A Holistic Approach*. (5th Edition). Philadelphia: Lippincott.
- Hunka, S.A. (1993). The right to refuse treatment - an ethical case study. *Intensive and Critical Care Nursing*. 9, pp 82-87.
- Hunt, G. (1994). *Whistle Blowing in the Health Service*. London: Edward Arnold.
- Ingram, R. (1993). *The Experience of Advocacy*. Unpublished bachelors dissertation. University of Manchester.
- Ingram, R. (1998). Power analysis and sample size estimation. *NT Research*. 3(2), March, pp 132-139.
- Jenny, J. (1979). Patient advocacy - another role for nursing? *International Nursing Review*. 26(6), pp 176-181.
- Kelly, B. (1991). The professional values of English nursing undergraduates. *Journal of Advanced Nursing*. 16, pp 867-872.
- Ketefian, S. (1989). Moral reasoning and ethical practice in nursing: measurement issues. *Nursing Clinics of North America*. 24(2), June, 509-521.

- Knapp, T.R. (1990). Treating ordinal pass as interval scales: an attempt to resolve the controversy. *Nursing Research*. Mar-Apr; **39** (2): 121-3.
- Knapp, T.R. (1993). Treating ordinal scales as ordinal scales. *Nursing Research*. May-Jun; **42**(3), pp 184-6
- Knapp, T.R. (1996). The overemphasis on power analysis. *Nursing Research*. **45**(6). November/December, pp 379-381.
- Kohnke, M.F. (1982). *Advocacy: Risk & Reality*. St Louis: Mosby.
- Kohnke, M.F. (1990). The nurse as advocate. *American Journal of Nursing*. **80**(11), November, pp 2038-2040.
- Kraemer, H.C. & Thiemann, S. (1987). *How many subjects? Statistical power analysis in research*. Newbury Park: Sage.
- LoBiondo-Wood, G. & Haber, J (1998). *Nursing Research: Methods, critical appraisal and utilization*. (4th Edition). St Louis: Mosby.
- Malby, R. (1992). Patient advocacy: what does it really mean? *British Journal of Nursing*. **1**(3), p 117.
- Mallik, M. (1997a). Advocacy in nursing - a review of the literature. *Journal of Advanced Nursing*. **25**(1), pp 130-138.
- Mallik, M. (1997b). Advocacy in nursing - perceptions of practising nurses. *Journal of Clinical Nursing*. **6**(4), July, pp 303-313
- Marshall, M. (1991). Advocacy within the multi-disciplinary team. *Nursing Standard*. **6**(10), November 27, pp 28-31.
- McKinley, S. (1986). An advocacy role for the critical care nurse. *Australian Journal of Advanced Nursing*. **4**(1), September-November, pp 3-12.
- McWhorter, J.H. (1988). The patient-advocate as adversary. *Journal of Medical Ethics*. **14**(1), p 55.
- Melia, K. (1987). Everyday ethics-whose side are you on? *Nursing Times*. **83**(29), pp 46-48.
- Miles, M.B., & Huberman, A.M. (1984). *Qualitative Data Analysis: A Sourcebook of New Methods*. Beverly Hills: Sage
- Miller, B.K., Mansen, T.J., & Lee, H. (1983). Patient advocacy: Do nurses have the power and authority to act as patient advocate? *Nursing Leadership*. **6**, pp 56-60.
- Millette, B. E. M. (1989). *An exploration of advocacy models and the moral orientation of nurses*. Ed. D. Thesis. University of Massachusetts
- Millette, B.E. (1993). Client advocacy and the moral orientation of nurses. *Western Journal of Nursing Research*. **15**(5), pp 607-618.

- Mitty, E.L. (1988). The nurse as advocate: issues in LTC. *Nursing & Health Care*. 12(10), December, pp 520-523.
- Morrison, A. (1991). The nurse's role in relation to advocacy. *Nursing Standard*. 5(41). July, pp 37-40.
- Morse, J.M. (1992). Negotiating commitment and involvement in the nurse-patient relationship. Chapter 19 **IN** Morse, J. *Qualitative Health Research*. Newbury Park: Sage.
- Morse, J.M. (1995). The significance of saturation. *Qualitative Health Research*. 5(2), p 147.
- Murphy, CP. (1983). Models of the nurse-patient relationship. **IN** Murphy, C.P. & Hunter, H. (Eds). *Ethical Problems in the Nurse Patient Relationship*. Boston: Allyn & Bacon.
- Nicklin, L.M. (1994). *The Go-between*. Unpublished bachelors dissertation. University of Huddersfield.
- Omery, A. (1989). Values, moral reasoning, and ethics. *Nursing Clinics of North America*. 24(2), June, pp 499-507.
- Oppenheim, A.N. (1992). *Questionnaire Design, Interviewing and Attitude Measurement*. (2nd Edition). London: Pinter.
- Oxford English Dictionary**. (1989).(2nd Edition), prepared by Simpson, J.A., & Weiner, E.S.L. Oxford: Clarendon Press.
- Pagana, K.D. (1987). Let's stop calling ourselves "Patient Advocates". *Nursing*. 17, p 51.
- Penn, K. (1994). Patient advocacy in palliative care. *British Journal of Nursing*. 3(1), pp 40-42.
- Penticuff, J.H. (1989). Infant suffering and nurse advocacy in neonatal intensive care. *Nursing Clinics of North America*. 24(4), December, pp 987-997.
- Polit, D.F., & Sherman, R.E. (1990). Statistical power in nursing research. *Nursing Research*. 39(6), pp 365-369.
- Prins, M.M. (1992). Patient advocacy: the role of nursing leadership. *Nursing Management*. 23(7), July, pp 78-80.
- Quinn, C.A. & Smith, M.D. (1987). *The Professional Commitment: Issues and Ethics in Nursing*. Philadelphia: Saunders.
- Raines, D. (1993). Deciding what to do when the patient can't speak: a preliminary analysis of an ethnographic study of professional nurses in the neonatal intensive care unit. *Neonatal Network*. 12(6). September, pp 43-48.
- Ramos, M.C. (1992). The nurse-patient relationship: themes and variations. *Journal of Advanced Nursing*. 17(4), pp 469-506.

- Royal College of Physicians, (1990). *Guidelines on the Practice of Ethics Committees in Medical Research Involving Human Subjects*. London: Royal College of Physicians.
- Rushton, C.H. (1993). Child/Family advocacy: ethical issues, practical strategies. *Critical Care Medicine*. **21**(9), Supplement, pp S387-S388.
- Salladay, S.A. & McDonnell, M.M. (1989). Spiritual care, ethical choices, and patient advocacy. *Nursing Clinics of North America*. **24**(2), June, pp 543-549.
- Sang, B & O'Brian, J. (1984). *Advocacy: The UK and American Experience*. Kings Fund Project Paper 51. London: Kings Fund.
- Savage, P. (1993). Ethical boundaries. *Senior Nurse*. **13**(3), May/June, pp 5-6.
- Snell, J. (1991). Union reaction. *Nursing Times*. **87**(29), p 5.
- Steiger, J.H., & Fouladi, R.T. (1992). R2: A computer program for interval estimation, power calculation, and hypothesis testing for the squared multiple correlation. *Behavior Research Methods, Instruments, and Computers*. **4**, pp 581-582.
- Stevens, J. (1992). *Applied Multivariate Statistics for the Social Sciences*. (2nd Edition). New Jersey: Lawrence Erlbaum Associates.
- Tadd, V. (1994). Professional codes: an exercise in tokenism. *Nursing Ethics*. **1**(1), pp 15-23.
- Tingle, J.H. (1989). Ethical, legal issues for nurses: further perspectives. *British Journal of Theatre Nursing*. NATNEWS. Jan. **26**(1), pp 16-17.
- Trandel-Korechuk, D., & Trandel-Korechuk, K. (1983). Nursing advocacy of patient's rights: myth or reality? *Nurse Practitioner*. **8**, pp 40-42.
- UKCC (1984). *Code of Professional Conduct*. London. United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
- UKCC (1992). *Code of Professional Conduct*. (2nd Edition). London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
- Walsh, P. (1985). Speaking up for the patient. *Nursing Times*. **81**(18), pp 24-6.
- Waterworth, S. & Luker, K.A. (1990). Reluctant collaborators: do patients want to be involved in decisions concerning care? *Journal of Advanced Nursing*. **15**, pp 971-976.
- Zusman, J. (1982). Want some good advice? - think twice about being a patient advocate. *Nursing Life*. **2**, pp 46-50.

APPENDICES

- 1 PAS (Patient Advocacy Scale)**
- 2 PDS (Personal Data Sheet)**
- 3 NABP (Nursing Advocacy Beliefs and Practices)**
- 4 Pilot PAS**
- 5 Item-Total analysis**
- 6 Interview Schedule**
- 7 Introductory Letter**
- 8 Information Sheet**
- 9 Approval from LREC**
- 10 Consent Form**
- 11 Data Matrix**

APPENDIX 1

Patient Advocacy Scale

Patient Advocacy Scale

Instructions:

Please complete all items.

Please place an ✗ or a ✓ in the box under the column that represents your response to each statement.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. Nurses should go against relatives wishes if necessary					
2. Patients have a right to know their own prognosis					
3. Nurses should be held accountable for their promises to the patient					
4. Nurses should assist patients to complain where necessary					
5. Patients should be able to refuse care					
6. Patients have a right to know their diagnosis					
7. Nurses should always tell the truth to patients					
8. The relationship of the nurse and the patient is a partnership					
9. All persons should have equal access to care based on potential benefit or need.					
10. The nurse should protect information that the patient gives in confidence					
11. Patients should be persuaded to take their medication					
12. The multi-disciplinary team always act in the patients best interests					
13. Nurses should persuade patients to accept treatment when this is best for them					
14. Nurses should never talk to the press about poor standards of care					
15. Nurses should uphold the patient's right to refuse treatment					
16. Nurses should strive to end inequalities in health care					
17. It is sometimes best to withhold information from patients					
18. The nurse should represent the patients wishes even if they conflict with the nurses own views					
19. Patients should always be consulted on not for resuscitation decisions					
20. Nurses should only speak up for patients where it does not bring them into conflict with other professionals					
21. Patient advocacy is fundamental to the role of the nurse					

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
22. The patient's relatives are the best advocates					
23. Nurses should not break hospital policies when acting as patient advocates.					
24. Nurses have a duty to implement all decisions about patient care that their managers make					
25. Nurses should refuse to carry out treatment if they think it is against the patients wishes					
26. Nurses should speak up for patients who cannot do so themselves					
27. Patients have a right to be told if they are going to die					
28. Patient's questions should always be answered honestly					

Thank you,

now please turn the page and complete the remaining questions

Appendix 2

Personal Data Sheet

Personal Data Sheet

Please complete all questions.

1

Gender
(tick one box)

female

male

2

Age at Last Birthday

(Insert age in years)

3

How long have you worked
as a qualified nurse?

4

Please state your job title:

5

Please state your grade (e.g. **D, F** etc.)

6

What type of ward / department or
speciality do you work in?

(E.g.: *Orthopaedics; coronary care, etc.*)

7

How long have you worked
in this speciality?

please continue overleaf

8

Please list any other specialities you have worked in for more than 1 year, with dates.

Speciality	From:	To:

9

Have you had a break from nursing?
If so state dates for each break

From:	To:

10

Have you ever had any careers or jobs for more than 1 year, other than nursing?
If so state what and when

Job / career	From:	To:

please continue overleaf

11

Please state the nursing qualifications that you hold, with the dates you qualified.

E.g.

Qualification	Date obtained
RMN	January 1983
RGN	July 1986

Qualification	Date obtained

12

Please list below the other nursing or nursing-related qualifications you have, for example, ENB clinical courses, Certificate, Diploma or Degree courses.

Course Name	Qualification	Awarding Body <i>(e.g. ENB, University, etc.)</i>	Date completed

13

Have you ever attended any courses, lectures or study days on ethics or patient advocacy?

Yes

No

(please tick one box)

please continue overleaf

Thank you for completing this questionnaire.

To help with our research we are looking for volunteers who are willing to take part in a 30 minute interview about patient advocacy.

If you are willing to take part please enter your name, work address and phone number below and I will be in contact with you to arrange this. Your name and address will be treated as confidential.

Name	
Ward or Department	
Phone number / extension	

Please return the completed questionnaires in the envelope provided using the hospital internal post.

Appendix 3

NABP

Nursing Advocacy / Beliefs & Practices

Instructions: Place an X in the box next to the question using the scale below to represent your answer

1 = Strongly Agree	2 = Agree	3 = Undecided	4 = Disagree	5 = Strongly disagree
--------------------	-----------	---------------	--------------	-----------------------

	1	2	3	4	5
1 Patients have the right to make their own choices					
2 The agency policy supports the concept of patient's rights					
3 As a professional, I make the decisions about the appropriate nursing care					
4 Patients have a right to know their own prognosis					
5 Nurses should be held accountable for their promises to the patient					
6 The nurse has a duty to protect the patient from harm regardless of which professional is involved in the care					
7 The agency encourages and supports my continuing education needs					
8 the nurse is responsible for patient safety					
9 Teaching self care increases their autonomy					
10 as a nurse, I am responsible for my actions					
11 Patients should be able to refuse care					
12 Patients have a right to information about their diagnosis					
13 The cultural orientation of the patient should be respected even when it conflicts with your own values					
14 Nurses should tell the truth to patients					
15 The nursing care plan is the nurses responsibility					

1 = Strongly Agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly disagree

	1	2	3	4	5
16 I have a responsibility to talk with the doctor, when I feel that the patient's rights have not been considered					
17 I know what is best for my patients					
18 Nurses are autonomous agents, i.e., determine their own actions					
19 Agency policies regarding the amount of time spent on a visit reduces the nurses ability to address the ethical concerns of practice					
20 The relationship of the nurse and the patient is a partnership					
21 I am able to try new techniques with patients without getting permission from my supervisor					
22 All persons should have equal access to care based on potential benefit or need.					
23 The nurse should protect information shared by the patient					
24 Nurses have an obligation to ensure that their knowledge base is current and accurate					
25 Supervisors in the agency stimulate thinking about dilemmas of practice					
26 Supervisors encourage and support my continuing education needs					
27 The agency provides help when I am dealing with an ethical dilemma in my practice.					
28 Supervisors encourage my use of new techniques in patient care without the need for permission					

Appendix 4

Pilot PAS

Patient Advocacy Scale Pilot Instrument

Instructions:

Please place an X in the box under the column that represents your response to each statement

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. Patients have the right to make their own choices					
2. Nurse should go against relatives wishes if necessary					
3. Patients have a right to know their own prognosis					
4. Nurses should be held accountable for their promises to the patient					
5. The nurse has a duty to protect the patient from harm regardless of which professional is involved in the care					
6. Nurses have a duty to campaign for better health care for all					
7. Nurses should assist patients to complain where necessary					
8. Patients should be able to refuse care					
9. Patients have a right to know their diagnosis					
10. Nurses must always uphold patient choice even when this puts the patient at risk					
11. The cultural orientation of the patient should be respected even when it conflicts with your own values					
12. Nurses should always tell the truth to patients					
13. Patients should not be told that they are going to die if the relatives do not agree					
14. The nurse has responsibility to talk with the doctor if patient's rights have not been considered					
15. The relationship of the nurse and the patient is a partnership					
16. Patients have the right to choose when to die					
17. All persons should have equal access to care based on potential benefit or need.					
18. The nurse should protect information that the patient gives in confidence					
19. Nurses are best placed to make decisions for patients who cannot communicate					
20. Patients should be persuaded to take their medication					

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
21. The multi-disciplinary team always act in the patients best interests					
22. Nurses must do as their employer requires, even when this conflicts with the patients wishes.					
23. Nurses should persuade patients to accept treatment when this is best for them					
24. Nurses should never talk to the press about poor standards of care					
25. Nurses must accept the doctors decisions about patient's treatment					
26. Nurses should uphold the patient's right to refuse treatment					
27. Nurses know what is best for patients					
28. Nurses should strive to end inequalities in health care					
29. The nurse is not a suitable person to act as a patient advocate					
30. It is sometimes best to withhold information from patients					
31. Patients have the right to eat what they want in hospital					
32. The nurse should represent the patients wishes even if they conflict with the nurses own views					
33. Patients should always be consulted on not for resuscitation decisions					
34. Nurses should only speak up for patients where it does not bring them into conflict with other professionals					
35. Nurses should accept the resources they are provided with					
36. It is the nurses responsibility to uphold patients' rights					
37. Patient advocacy is fundamental to the role of the nurse					
38. Nurses should report poor care even where other nurses may face disciplinary action					
39. Patients need advocates					
40. The patient's relatives are the best advocates					
41. Nurses should not break hospital policies when acting as patient advocates.					
42. Only senior nurses should act as patient advocates					
43. Nurses have a duty to implement all decisions about patient care that their managers make					

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
44. Nurses should refuse to carry out treatment if they think it is against the patients wishes					
45. Nurses should speak up for patients who cannot do so themselves					
46. Acting as a patient's advocate is a rewarding experience for the nurse					
47. Nurses must always inform patients of their rights and choices					
48. Patients have a right to be told if they are going to die					
49. Patient's questions should always be answered honestly					
50. Nurses should pursue political change to improve patient care					

Thank you for taking the time to complete this questionnaire, please return it to me in the envelope provided

APPENDIX 5

Item-Totals Analysis for PAS

N of Cases = 86.0

Statistics for Mean Variance Std Dev Variables
 Scale 107.5000 103.4529 10.1712 28

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item- Total Correlation	Squared Multiple Correlation	Alpha if Item Deleted
VAR00001	104.0698	96.5363	.3158	.	.8594
VAR00002	103.0698	96.9598	.5145	.	.8541
VAR00003	103.7326	96.6688	.3489	.	.8579
VAR00004	103.5116	94.3705	.5637	.	.8516
VAR00005	103.1744	95.8163	.6394	.	.8516
VAR00006	102.9535	96.5155	.6192	.	.8525
VAR00007	103.5465	95.1919	.4135	.	.8559
VAR00008	103.0465	97.2449	.6032	.	.8534
VAR00009	103.1744	95.3927	.6316	.	.8513
VAR00010	103.6163	96.4510	.3569	.	.8577
VAR00011	103.2791	99.1447	.3060	.	.8586
VAR00012	104.8140	100.8826	.1276	.	.8636
VAR00013	104.3837	98.8275	.1793	.	.8645
VAR00014	104.8721	98.0187	.2337	.	.8622
VAR00015	103.3953	96.0066	.4911	.	.8539
VAR00016	103.2558	97.2750	.3377	.	.8581
VAR00017	104.5000	91.7118	.5213	.	.8522
VAR00018	103.3605	97.7391	.3541	.	.8575
VAR00019	103.9186	94.2639	.4159	.	.8561
VAR00020	103.4419	93.3554	.5537	.	.8514
VAR00021	103.3605	95.9744	.5875	.	.8524
VAR00022	103.3488	96.3945	.4689	.	.8546
VAR00023	104.8023	100.1605	.1357	.	.8648
VAR00024	104.0233	97.2700	.3324	.	.8583
VAR00025	103.8256	97.5575	.3952	.	.8565
VAR00026	103.2907	98.3733	.3100	.	.8587
VAR00027	103.5116	95.9234	.4912	.	.8539
VAR00028	103.2209	97.3271	.4491	.	.8553

Appendix 6

Interview Schedule

Interview Schedule

Introductions

Information and consent procedures

Can you tell me about the work you do here?

How would you describe patient advocacy?

What do you understand by the term?

what sort of activities or actions might it involve?

Can you give me an example of a nurse acting as a patient advocate?

Can you tell me about any examples where you have acted as a patient advocate?

What are your views or feelings about nurses acting as patient advocates?

Are there any things that interfere your ability to be a patient advocate?

What factors are there that enable you to act as a patient advocate?

**Professional
Organisational
Unit / Ward
Personal**

What do you think are the skills required to be a patient advocate?

Appendix 7

Introductory Letter

(Faculty headed paper)
(Date)

Dear colleague

I am conducting a study to investigate the topic of patient advocacy in nursing. There has been little research undertaken on this topic, and I believe it is an important area for study in our profession.

You have been selected at random from all of the nurses working at this hospital, and I would like to invite you to volunteer as an informant for this study.

The study will have two stages, the first is a postal questionnaire distributed to approximately 180 nurses, one of which is enclosed with this letter. The second stage will be brief interviews with approximately 10 of the nurses who have been selected for the study, subject to their explicit agreement.

Unless you chose to add your name to the questionnaire, I will not be able to identify you in any way, and the information that you provide will be anonymous and confidential. If you would be willing to be interviewed or would like to be informed about the findings of the study please add your name and work address to the questionnaire. The information sheet attached provides full details of what you will be asked to do, and how information will be used, but if you have any further queries, please don't hesitate to contact me.

I hope you will be prepared to help me with this study, may I thank you for your participation.

Yours faithfully

Richard Ingram
Nurse Teacher / Senior Lecturer

Appendix 8

Information Sheet

Information Sheet for Research Volunteers

Study Title:

The Nurse as the Patient's Advocate

Duration of the study:

Questionnaires being distributed in the Autumn of 1997, and the study will be completed by the Summer of 1998.

What is the purpose of the study?

The purpose of the study is to determine the extent to which patient advocacy is a part of day to day nursing practice, and to identify any characteristics of nurses that make them more or less likely to act as patient advocates.

What will I be asked to do?

You will be asked to complete a two part questionnaire and return it via the internal post to the researcher. You will also be invited to give your name and work address if you are willing to participate in a brief interview. It is perfectly acceptable to complete the questionnaire without volunteering for an interview.

The interview will last 15 to 30 minutes and will be conducted in private close to your place of work, and as part of your working hours. The exact time and place will be agreed with the researcher. The researcher may wish to take notes or use a tape recorder during the interview.

Are there any risks, costs or benefits to me?

The main cost to you is the time and effort involved in completing the questionnaire, and attending the interview if applicable, though this will be during your paid working hours. No significant risks can be identified or are anticipated.

There is no payment for participation in the study, but it is hoped that participating in the study will be an interesting and rewarding experience.

What about Confidentiality and Anonymity?

The researcher has no way of identifying the people who have completed the questionnaires, unless they complete their name and address, which is optional. A member of the human resources / personnel department will have selected potential participants at random, and will distribute the initial questionnaire, but will not see any of the returned questionnaires or be able to link information with participants.

Although a summary of the information collected will be presented in written form, and may be published in a nursing journal, individual people will not be linked to the information in any way. Only the researcher will know of the identity of those agreeing to be interviewed.

How do I give my consent?

By completing and returning the questionnaire you are consenting to your participation in the study.

Agreement to be approached for an interviews is requested specifically at the bottom of the questionnaire, and participants will be asked to sign a consent form immediately prior to commencing the interview if they wish to proceed.

Can I change my mind and withdraw from the study?

At any time until the study is completed, any participant may change their mind and withdraw from the study without giving any reason, and with no penalty. If you wish to withdraw, please contact the researcher at the address given at the end of this information sheet. Any information already collected will be destroyed unless it has been given anonymously, and this will be confirmed in writing to the participant. Participants may decline to answer any questions on the questionnaire or during the interview without giving a reason, and may withdraw from the interview at any time.

Dissemination of the Research Findings:

The study will be presented by the researcher as a dissertation to the University of Portsmouth for the award of an MSc in Research Methods. The dissertation will be made available to the library at the University of Portsmouth and libraries in the participating Health Authorities and the University of the West of England. Abridged reports and articles will be submitted to relevant journals for publication, and a report will be submitted to the South & West Regional Health Authority Research and Development Directorate, who have partially funded the study. Individual participants will not be identifiable in any way in any of the reports presented.

How can I find out more about the study?

If you wish to find out more about the study, or wish to ask any questions or make comments, please contact the researcher at the address below. If you wish to receive a summary of the study's findings this will be sent to you if you forward a written request to the researcher.

Researcher:

Richard Ingram Nurse Teacher / Senior Lecturer Faculty of Health & Social Care Education Centre Royal United Hospital Bath BA1 3NG	Tel:
---	-------------

Appendix 9
LREC Approval

APPENDIX 10

Consent Form

Consent Form

Project Title:

The Nurse as the Patient's Advocate

*Please cross out
as necessary*

Have you read the information sheet? Yes / No

Have you had an opportunity to ask questions and discuss this study? Yes / No

Have you received satisfactory answers to all your questions? Yes / No

Have you received enough information about the study? Yes / No

Do you understand that you are free to withdraw from the study:

- at any time Yes / No
- without having to give a reason Yes / No
- and without any penalty or displeasure? Yes / No

Do you agree to participate in this study? Yes / No

Signed Date

(Name in block letters)

	Informant 1 "Ann"	Informant 2 "Barbara"	Informant 3 "Carol"	Informant 4 "Dawn"	Informant 5 "Elizabeth"	Informant 6 "Fiona"	Informant 7 "Georgina"
PAS	98	91	117	107	123	113	101
Job Title Ward / Department	Staff Nurse/ Medicine / elderly care	Staff Nurse, Ophthalmology out- patients dept.	Health Advisor Genito-Urinary Medicine Staff nurse / A&E	Staff Nurse, Trauma / orthopaedics	Senior Staff Nurse Surgical	Ward Manager, Cardiology	Staff Nurse, Theatres, recovery
AGE	47	44	55	23	44	31	51
ETHICS (Y/N)	Y	N	Y	Y	N	Y	N
EDLEVEL	Certificate	< Certificate	Certificate	Diploma	Certificate	Post-grad	Certificate
GRADE	E	D	H	D	F	G	E
NURSEYR	26	18	14.75	1.5	23	8.3	4.9
INSPEC	8	8.5	13	1.5	8	5	4.5
Describing Patient Advocacy	speaking for the patient perhaps advice and liaison	trying to work on their behalf, it's not a word we use in outpatients.	patients have rights, as a nurse you have to uphold those rights ...if a patient can't speak for themselves you have to revert to that role... speaking up for them, protecting the patient	acting in their best interests and carrying out their wishes, taking the time to listen to what it is that they actually want, and doing your best to carry that out without any detrimental effect for them. You've got to look at it from all angles.	Looking out for people who can't look out for themselves, because they're old or confused, or sometimes ill-advised by medical staff...they shouldn't be bulldozed. I think also to help with their morale.	The patients protector the nurse's duty is to make sure the patient's rights are at the top of the agenda, and fight the patient's case along with the family.	The patient is vulnerable because they are unconscious, so we have to protect them from harm, and ensure they are safe and their dignity is preserved at all times.
Acts of advocacy	Advising patients what is in their best interests, liaising with social workers, district nurses, carers	The doctors don't explain very well, I have a little chat afterwards, make sure they understand, see if they want to ask anything, I can explain in greater detail	If their rights are being usurped you have to step in and say " <i>this isn't right</i> "	Make sure their wishes are documented...support the patient in their decision	Encouraging them to have help when they're discharged, Intercede on their behalf with doctors, and maybe their relatives. Make them aware of other choices.	Its important to have the guts and stand up and say that's not the right decision for the patient, and back that up with logical rational discussion.	If we need to get a surgeon or anaesthetist to give something to assist with pain, I've asked the ward for cot sides, or a drugs chart (to ensure safety).

Figure 10a: Data Matrix showing qualitative data from interviews

Examples of Advocacy	<p>“Ann”</p> <p>persuading (patient) and his wife that his best interests were to stay in hospital.</p> <p>...not telling him what to do, but advising him what is best for him to do its not my decision, and its not his decision unless he self-discharges.</p> <p>Ultimately the consultant decides</p> <p>I know him so well, I know what he wants, I know it's not the right thing</p>	<p>“Barbara”</p> <p>not really, I can't think of any</p>	<p>“Carol”</p> <p>referring poor advice (from another nurse to a patient) to the manager to protect future patients.</p> <p>Informing managers of concerns about injuries an elderly patient sustained (perhaps from her son), they both needed help.</p>	<p>“Dawn”</p> <p>lady who refused a blood transfusion... she knew what she wanted...doctors came to her saying you've got to have them or you may die from the surgery...</p> <p>the nurses have to step in and explain to the patient the risks and then go back to the doctor and explain that she does understand all the risks... we cant force it on her. If she's of sound mind then its up to her (She didn't have them).</p>	<p>“Elizabeth”</p> <p>We had a very sick patient who was really depressed...he wanted to go home for a few days, even though he needed to be in hospital.</p> <p>He missed his home...I spoke to the doctor and arranged it...he was very grateful and came back feeling better.</p>	<p>“Fiona”</p> <p>Arguing with a doctor to stop resuscitation where the patient had no hope... to stop days of lingering, though the patients relatives didn't want to let him die, I was trying to think what the patient would want.</p> <p>Questioning a doctors clinical judgement about a drug dose, calling in the consultant when he disagreed.</p>	<p>“Georgina”</p> <p>The children have to go through a dangerous tunnel to theatres, that's not safe, the Ren is involved, that's an advocacy issue.</p>
Views of nurses as advocates	<p>people need advocates to fight their causes</p>	<p>I think you have to act on their behalf as much as you can</p>	<p>It's right and proper as long as you are not imposing your own views or needs on people.</p>	<p>I think it's one of the main parts of the job really, I think if you're there to listen to their opinions, and respect their opinions as far as you can, then just be there to explain reasons why you are doing things.</p>	<p>I think we are advocates, I think because of what we do and how we care, it's a natural progression for us.</p>	<p>I think it's absolutely vital, I think its a role that's undervalued and under-used.</p>	<p>As far as the UKCC is concerned, that's (advocacy is) part of it...getting registration... it is the nurses responsibility, she is responsible for her patients.</p>

Figure 10b: Data Matrix showing qualitative data from interviews

Problems and limitations	<p>“Ann”</p> <p>Patient’s safety is paramount.</p> <p>its balancing right and wrong, and knowing what they want; I’m struggling to know what is the best thing</p> <p>If I was 80% sure, but someone put an argument against...I hope I would take that on board and change my mind</p>	<p>“Barbara”</p> <p>If you knew somebody personally it would be difficult.</p> <p>You are just powerless in a big organisation.</p>	<p>“Carol”</p> <p>Fear of repercussions, missing promotion, being unpopular.</p> <p>Difficult to challenge superiors, I tend to back down, but if I knew I was right I would do it.</p> <p>Being personally involved with someone (e.g. friend of the family).</p> <p>Something very upsetting, too close to home.</p>	<p>“Dawn”</p> <p>there’s nothing that tells you how far you can push it.</p> <p>I can be a bit of a soft touch, I can buckle under the pressure, I don’t like to rock the boat.</p> <p>If it was something I believed in myself, I would put more fire into it.</p>	<p>“Elizabeth”</p> <p>perhaps if I was related to the person, I would have much more of a dilemma.</p>	<p>“Fiona”</p> <p>A lot of nurses are under-confident, and if they stand up to a senior that may go against them, perhaps seen as whistleblowers, or go against them for promotion, its never worried me.</p> <p>If it’s in the patient’s best interests I’ll go to the ends of the earth to fight the case, I wouldn’t care if I got trod on.</p>	<p>“Georgina”</p> <p>If I knew a patient personally, or if I had no rapport with the patient.</p>
Factors that assist with advocacy	<p>continuing education, time to talk to patients (not too busy)</p> <p>We (the MDT) tend to sit down and thrash things out, we work well together, I know I have their support</p>	<p>you’ve got your senior colleagues to back you up</p>	<p>personal experience, feeling supported from above. Not getting negative feedback. A calm environment, not rushing, having time.</p>	<p>as long as you have all the information, everyone is aware, and it’s documented taking time to listen</p>	<p>working in a small team helps, I’d try to get people on my side, having a supportive manager,</p>	<p>Trying to look at the patient holistically, situations where the patient gets to know you on a more personal basis.</p>	<p>More information about the patient, a good patient care model.</p>
Skills and qualities for advocacy	<p>experience, experience in dealing with people talking, rapport, good communication, trust, building relationships, knowledge of the facts.</p>	<p>Counselling skills, being assertive, knowing more about the legal side of things.</p>	<p>Interpersonal skills, to talk, relate and hear what they are saying. If you don’t know (the facts) how can you take it on board ?</p>	<p>To be quite assertive to put your point across - one of the biggest parts of it. I need to know all the information before I go headlong into anything. Be a good listener, ability to explain things, to see from all points of view - the whole scenario</p>	<p>(I’m rather overly) assertive, good listening skills, understanding what they really want. Good communication skills. Knowing where to go if you can’t handle it.</p>	<p>being able to empathise, to realise other people have different points of view, understanding their wishes, empowering them to be as independent as possible.</p>	<p>Communication, empathy, diplomacy, managerial skills I suppose.</p>

Figure 10c: Data Matrix showing qualitative data from interviews