

An Exploration of Advocacy in Perioperative Nursing Practice

by

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BScN, University of Victoria, 1998

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Supervisory Committee

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Abstract

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“The great aim of education is not knowledge but action.” -- Herbert Spence

The reality of nurses’ practice in the perioperative environment is seriously impacted by the power struggles and political influences present in today’s complex surgical settings; constraining the enactment of patient advocacy.

My purpose, in this paper, is to present an in-depth review of the literature on nursing advocacy, from early nurse contributors to recent publications, with a focus on advocacy in perioperative nursing practice. Examining the complex issues of historical aspects and concept interpretation can illuminate approaches to create change. A review of the ideologies present in the perioperative environments that affect the enactment of advocacy will be followed by a discussion of the multiple factors that both impede and support the practice of advocacy. Following this analysis, I propose several recommendations and strategies to facilitate nursing advocacy in the operating room.

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Chapter One

Introduction

Nursing advocacy plays a critical role in keeping patients safe throughout their encounters with the health care system. When a patient is undergoing surgery and anesthesia or is too ill or sedated to advocate for him or herself, advocacy by a nurse is imperative to a safe outcome.

The Oxford English Dictionary (2005) defines advocate as “a person who publicly supports or recommends a particular cause or policy and a person who pleads a case on someone else’s behalf” (p. 11). Perioperative nurses often serve in the role of patient advocate for patients undergoing sedation, anesthesia, and surgery. Beyea (2008) succinctly captures the philosophy of perioperative nurses “A nurse must speak for patients when they are unable to speak for themselves. Patient advocacy is one of the most important roles of a professional nurse” (p. 441). However, working in complex systems can make it challenging for nurses to act as advocates and there are arguments against nurses taking the position of the patient advocate. Bull and Fitzgerald (2004) provide reasons for a cautious approach “inadequate educational preparation for the role, potential damage to nurse/physician relations, and a lack of legal and organizational recognition for nurses acting as advocates” (p. 1265).

In my experience, the reality of nurses’ practice in the perioperative environment is seriously impacted by the power struggles and political influences present in today’s surgical settings. The main ones are the primacy of a skills led curriculum for specialty nursing education, the technological focus on healthcare, the continuing dominance of the

medical model and the gendered nature of the physician/nurse relationship. The practice environment for perioperative nurses can be described as fast paced, stressful, and resource compromised (staffing levels, equipment); with acutely ill, challenging patients; and with limited time for education of junior staff within the context of highly functional multidisciplinary teams.

Purpose

Despite the challenges and debates, I believe that patient advocacy is an integral part of perioperative nursing practice. While acting as patient advocates, perioperative nurses have contributed to patient safety through the resulting positive patient outcomes or even the prevention of medical errors. The complexity of patient care in the perioperative environment makes it critically important that nurses work in environments in which individuals can speak up and express concerns, facilitated by supportive administrative structures and conducive work settings.

Given the difficulty of perioperative registered nurses enacting advocacy in the complex context of the surgical setting I am undertaking a project which includes an in-depth review of the literature on nursing advocacy, from early nurse contributors to recent publications, with a focus on advocacy in perioperative nursing practice. Examining the complex issues of historical aspects and concept interpretation can illuminate approaches to create change. A review of the ideologies present in the perioperative environments that affect the enactment of advocacy will be followed by a discussion of the multiple factors that both impede and support the practice of advocacy. Recommendations and strategies to facilitate nursing advocacy in the operating room will be presented in the final section of the paper.

Problem Statement and Significance

Advocacy is one of the fundamental values of professional nursing (Hamric, 2000). The nursing literature usually identifies nurses as the most appropriate professional group for implementing this role (Curtin, 1990; Gadow, 1990a; Snowball, 1996). Over the past two decades, the word advocacy has appeared in the nursing literature with increasing frequency (Mallik, 1997a). The Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses* contains the statement of the ethical values of nurses and serves as the foundation for nurses' ethical practice. In this document, advocate is defined as "actively supporting a right and good cause; supporting others in speaking for themselves or speaking on behalf of those who cannot speak for themselves" (p. 22).

The question to direct my project is "What are the difficulties perioperative nurses have in advocating for patients and what changes in practice settings are required to facilitate advocacy?" I have chosen to examine the literature discussing the difficulties to enact patient advocacy by the nurse; the rationale strengthened with the following statement by Mallik (1997a) "While the moral pressure on the nurse to advocate is strong, the authority to do so is weak" (p. 136).

The literature review confirmed that while nurses know what advocacy is, and have the ability to advocate, difficulties surround its implementation. Many authors have undertaken studies on nurses' experiences and perceptions of advocacy in an attempt to investigate the role of nurses as patient advocates (Altun & Ersoy, 2003; Boyle, 2005; Mallik, 1997a; O'Connor & Kelly, 2005). The major problems identified following the literature review were the lack of consensus about what it means to be a patient advocate

and how well nurses fulfill the role.

Mallik (1997a) has analyzed the nursing literature on advocacy and identified these key themes: “patient advocacy is a traditional role, nurses are in the best position in the health care team, nurses have the knowledge to advocate and finally, nurses and patients can be partners in advocacy” (p. 130). However, the author, (1997a) upon further examination of the literature, concluded that advocacy is a potentially risky role to adopt and remains a moral choice for the individual nurse.

Perioperative nurses play an instrumental role in establishing a relationship with the patient and serving as the patient’s advocate when the patient can not act for himself or herself. Schroeter (2000), a perioperative nurse, in a historical review of advocacy in perioperative nursing practice, describes advocacy in nursing as consisting of two components: (a) to support the patient’s rights and (b) the ability to take action on behalf of the patient. This description confirms the challenges of nursing advocacy in perioperative settings. Specifically, the concept of advocacy becomes meaningless without the ability to ‘support the patient’ or ‘take action on behalf of the patient’.

Literature Search Methods

This exploration of advocacy takes a disciplinary focus, highlighting the perspective of the perioperative nurse. The type of literature review selected is a traditional or narrative review. Cronin, Ryan, and Coughlan (2008) define the rationale for the choice with the statement “This type of review critiques and summarizes a body of literature and draws conclusions about the topic in questions” (p. 38). The specific goal of the exploration is to investigate perioperative nursing advocacy through the identification

and analysis of key components, drawing further attention to areas of potential practice environment facilitators and barriers of patient advocacy enactment.

Fain's (2004) "rules for searching the literature" described the initial retrieval efforts as the stages of "identification, confirmation, skim and screen, retrieval, and review" (p.52) and provided the structure for the first literature review process. The key descriptor 'patient advocacy' was entered into an internet search engine and attempts were made to assess the resultant articles for relevance. This strategy was ineffective as most articles were unrelated to the project focus.

A more comprehensive search was necessary to fully access the state of existing knowledge of the concept of nursing advocacy, utilizing Polit and Beck's (2008) guidelines. The authors' (2008) statement describes the expanded search activities "If your goal is to 'own' the literature, you will be using a variety of databases, keywords, subject headings, and strategies in your endeavor to pursue every possible lead" (p. 117). The strategy selected included limiting the search size by narrowing the focus to primary sources with the following descriptors: nursing advocacy, advocate role, advocacy models, autonomy and perioperative. These terms were selected from the key words present in the selected articles from the initial broad literature search. The expanded search and review facilitated the discovery of distinct themes that were used to structure the project's framework.

Hamric (2000) clarifies the presence of advocacy in terms of history with the statement:

It is important to realize that this moral concept has not always been central to our

understanding of the nurse's professional role. In fact, it is a rather recent addition, emerging as a theme in nursing ethics literature in the 1980's. (p. 103)

Consequently, the period of 1979 – 2009 was selected to coincide with the publication of a landmark article: 'The Nurse as Advocate: A philosophical foundation for nursing' (Curtin, 1979). The electronic databases used were the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Medical Literature On-Line (Medline) accessed via the University of Victoria's (UVIC) distance education services. The UVIC library staff and UVIC infoline department were superb resource contacts, providing advice for search strategies and locating diverse readings that were not available via web link.

Ancestry searching or systematically reviewing citations from studies included in the results provided a secondary wealth of additional materials that were not found during the electronic database search. Other strategies included entering the names of significant nurse authors of advocacy materials and using the feature of related studies as an access point. The articles accessed were written in English, and involved nurses' advocacy roles in Australia, Canada, Finland, Iran, Ireland, Turkey, the United Kingdom and the USA

Perioperative colleagues also volunteered their recollection of advocacy education during general and specialty nursing education programs when their experience and knowledge of advocacy was requested.

Chapter Two

Historical Aspects of Advocacy in Nursing

Advocacy has been widely discussed in the nursing literature and it is one of the fundamental values and essential components of professional nursing (Foley, Minick & Kee, 2000; Mallik, 1997a; O'Connor & Kelly, 2005; Vaartio & Leino-Kilpi, 2005). Many researchers credit Florence Nightingale's insistence on a clean patient care environment for the wounded soldiers as the early example of advocacy (Foley, Minick & Kee, 2002; Nelson, 1988). One of the earliest references directly linking advocacy and nursing is the introduction of the concept by International Council of Nurses (ICN) via their Professional Codes in 1973 (Vaartio and Leino-Kilpi, 2005). With particular relevance to perioperative nurses, the references to loyalty and obedience to the physician were also dropped at this time (Bramlett, Gueldner, & Sowell, 1989; Foley, Minick & Kee, 2002).

Mallik and Rafferty (2000) explored the growth and diffusion through the USA and UK literature of nurses' claims to patient advocacy and stated "nurses ... search for new interpretations of their key functions in relation to patients and clients. One function that has emerged over the last 25 years has been the 'patient advocate' role" (p. 399). The results of Mallik and Rafferty's (2000) examination located patient advocacy as a subject descriptor in the International Nursing Index (INI) in 1976. The authors (2000) also discovered one editorial connecting the term patient advocacy to the role of the nurse in this year.

Before the 1970's, there was little demand for patients' rights (Mallik, 1997a). Mallik and Rafferty (2000) describe the changes in the meanings attributed to nurses'

roles in patient advocacy as ethico-legal responsibility in the mid 1970's to a 'rights' framework in the 1980's. Differences in nursing participation in the changes are reported in the reviews of literature published in different countries. The UK continues the trend of the late 1970's with consumer organizations cited as advocates and citizen advocacy used for the mentally ill and handicapped (Mallik & Rafferty, 2000) while in the USA two lawyers involved in health care believed that nurses had an important part to play in according patients' rights (Annas & Healey, 1990).

Vaartio and Leino-Kilpi (2005) published an overview of the empirical research literature on nursing advocacy from 1990 – 2003. The authors (2005) provide a summary of the European experience of nursing advocacy in the 1990's with the statement "the patient's role was transformed to that of a consumer, the ultimate aim being empowered patients who are more aware of their rights" (p. 705). An explanation provided for the interest in nursing advocacy at this time was that the empowerment of patients, both active and nonactive, requires nursing advocacy (Vaartio and Leino-Kilpi, 2005).

The findings of this study correlates with the results of Mallik and Rafferty's (2000) concept analysis. In the early 1990's and continuing onward, the focus of American hospital personnel on patient-centered care is supporting the empowerment of patients as consumers and autonomous decision-makers (Mallik & Rafferty, 2000). In the UK consumerism was also present. However, the consolidation of advocacy as an innovation for nurses proceeded more cautiously, with debates focused on questioning the role and the risks involved (Mallik & Rafferty, 2000).

From the historical appraisal of the advocacy literature of the past 30 years, the patient advocacy role for nursing is becoming more important. Mallik (1997a) attributes

the rise of the advocacy movement in healthcare to the cultural conditions in the USA with the concurrent focus on autonomy and individual rights. Jugessur and Iles (2009) describe the evolution of nursing advocacy from a global perspective and state “With international healthcare reforms emphasizing human rights, the salience of advocacy in nursing has increased” (p. 187). The authors (2009) also note that in 2000 the ICN requested the membership to promote advocacy as a key role.

The concept of nursing advocacy has gained more prominence in the perioperative practice areas similarly to nursing in general. Essentially, patients and their families are demanding more information and control over their health care. The perioperative nurse is most often in the position to respond to these demands and can play a critical role in keeping patients safe throughout their healthcare encounters. Today the significance of this fact cannot be understated as health care reform has assumed centre stage and advocacy may be imperative for safe and quality patient care.

Professional Expectations and Obligations

Important to the discussion of advocacy in nursing is an examination of the profession’s expectation of advocacy. Patient advocacy is featured in most nursing curricula and is a cornerstone of the Canadian Nurses Association (CNA) *Code of Ethics for Nurses* (2008). Professional codes of ethics serve as a foundation for nurses’ ethical practice and describe the fundamental obligations for nurses’ moral conduct in practice. The *Code of Ethics for Nurses* (CNA, 2008) is based on seven primary nursing value statements, with the term advocate present in five of the values. The value statement, ‘Promoting and Respecting Informed Decision-making’ describes the obligation to advocate, one that is frequently acted upon by perioperative nurses (CNA, 2008, p. 11).

The Operating Room Nurses Association of Canada (ORNAC) *Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice* (2009) also contains a value statement for patient advocacy: “We promote the perioperative patient’s right to be informed and to make autonomous decisions regarding their care. We strive to protect the rights, health and safety of the patient throughout the perioperative experience” (p. 15).

With reference to the CNA code of ethics (2008), the ORNAC standards (2009) and the College of Registered Nurses of British Columbia (CRNBC) professional standards (2008) the message is clear that nurses should act as advocates. The significant detail that is missing in each of the documents is the discussion of how nurses can apply advocacy in practice. The questions to be addressed are “Do nurses understand the concept of advocacy in their practice?” and “Are nurses able to fulfill their obligation as patient advocates?” before the obligation and expectation to advocate for patients becomes a reality.

Antecedents of Patient Advocacy

The Oxford English Dictionary (2005) defines antecedent as “a thing that occurs or exists before another” (p. 27). Antecedents of patient advocacy, at the macrosocial and microsocial levels in the healthcare system, necessitate nurses advocating for patients.

The definitions for the terms advocacy, autonomy and the relationship between the concepts are important to the following discussion. Gadow (1990b) defines advocacy as:

the active assistance to patients in their self-determination concerning health alternatives. Advocacy not only safeguards but contributes positively to the

exercise of self-determination. It is the effort to help patients become clear about what they want in a situation, to assist them in discerning and clarifying their values and examining available options in light of those values. (p. 53)

The College of Registered Nurses of British Columbia (2008) references the term advocacy to the first Professional Standard: Responsibility and Accountability, Indicator Four “Takes action to promote the provision of safe, appropriate and ethical care to clients” with the addition of the footnote “taking action includes advocacy” (p. 6). A definition for advocacy with a perioperative context is aptly phrased by Schroeter (2000) as “safeguarding patients from the incompetence or misconduct of other health care professionals” (p. 1209).

Autonomy, one of the bioethical principles, is defined by Oberle and Bouchal (2009) as having “both the right and the ability to make meaningful choices about oneself (and one’s care)” (p. 14). Brown, Rodney, Pauly, Varcoe, and Smye (2004) demonstrate the interface between the concepts of advocacy and autonomy with the statement “ ... here we would like to note that the ethical obligations in nurses’ relationships with patients have been primarily explored through the concept of advocacy, which is premised on an individual’s right to autonomy” (p. 132). Gadow (1989) succinctly captures the symbiotic relationship between advocacy and autonomy with the declaration “Advocacy is the moral commitment to enhance patients’ autonomy” (p. 535).

On the macrosocial level, the environment of the hospital is one of the major antecedents of patient advocacy (Bu & Jezewski, 2006). Donovan (as cited in Bu & Jezewski, 2006) outlines the issues of advanced technology, healthcare costs, and changing health care policies as reasons for an overwhelmingly complex hospital

environment. Patients' autonomy and values can easily be ignored in such an environment, moving them higher on the "continuum of vulnerability", a term originating with Copp (1986).

On the microsocial level, some patients' conditions are the antecedents of patient advocacy. Many authors have attributed patient vulnerability as the main condition demanding nurses' advocacy actions (Chafey, Rhea, Shannon, & Spencer, 1998; Martin, 1998; Snowball, 1996). Bu & Jezewski (2006) define vulnerable patients as those "who cannot fully represent and protect their own rights, needs, benefits and wishes, are unable to make appropriate decisions, or are unable to carry out their decisions" (p. 105). The usual approach is for the nurse to speak on behalf of the vulnerable patient. Copp (1986) expands on this response and states "More than speaking for another, advocacy requires intervention in some situations where vulnerable populations have need of it" (p. 255). Patients' vulnerability can be increased by illiteracy or lacking command of the English language, lack of awareness of rights to refuse treatment, and feelings of powerlessness because of limited knowledge about health care (Bu & Jezewski, 2006). The surgical experience can be a catalyst for vulnerability for even the least vulnerable patient. Mitchell and Bournes, (2000) provide the explanation "It is not the illness that patients identify as the reason for the vulnerability but, rather, the way that health care professionals relate with them - specifically, the disregard, dehumanizing, controlling, punitive, and judgmental practices of biomedical nursing" (p. 208). Of interest, Bu & Jezewski (2006) replace 'biomedical nursing' in the previous citation with 'biomedicine'.

There are additional antecedents where nurses may be required to advocate for patients. Of particular prevalence in the perioperative setting is the intimidation patients

experience under these circumstances as well as patients being treated unethically or incompetently by some members of the healthcare team. Val Cartmel, (2009), President of CRNBC, gave credence to Schroeter's (2000) definition during her address to the CRNBC annual general meeting in stating that "Registrants have a professional, legal and ethical responsibility to act as advocates on behalf of their patients when patient care is compromised through workplace conditions, or the impairment or incompetence of staff" (p. 7).

It may also be relevant to state what advocacy is not. A few years after Curtin (1979) suggested that both the "philosophical foundation and ideal of nursing is the nurse as *advocate*" (p. 2), she considered the advocacy role. Curtin (1990) turned to the nursing literature for enlightenment and provided the following summary: "I found the nurse as patient advocate depicted as a combination lawyer-theologian-psychologist-family counselor and dragon-slayer wrapped up in a white uniform. I might add that an ordinary mortal like me felt depressed – even oppressed – by this vision of super-nurse" (121). While it is clear that no-one can be all of these, it is even more evident by the antecedents discussed that more nurses must play some of the advocate roles.

Ideologies in the Perioperative Environment

Many of the ideologies that are operating within the perioperative environment directly influence nursing advocacy. The first is individualistic ideology which "views structural conditions as given and seeks only to maneuver within them" (Tesh as cited in Browne, 2001, p. 123). Rather than advocating for the change of structural oppressions, or even questioning their existence, nurses support an individualistic ideology by their

focus on enabling individuals to assume greater responsibility for their health and health care. Specifically to the perioperative setting, the business model of health care 'do more with less' has deleted the funding for the night before surgery admissions and decreased the hours for nurses to staff preadmission clinics. Patients scheduled for surgery must possess the knowledge and skills to advocate for themselves through surgery cancellations, inadequate/incorrect preoperative assessments, and errors based on missing patient information to facilitate a safe health care experience with a positive outcome. Nurses have contributed to this individualistic approach to health promotion and patient empowerment by creating checklists for patients to complete as they walk through the doors of the hospital. Accurate and complete preoperative patient-centered information that reflects individual patients' needs and vulnerabilities is an essential part of nursing advocacy actions and safe patient care.

A second ideology influencing the perioperative nurse's ability to advocate for patients and affecting the health and safety outcomes are corporate ideologies, such as cost containment and efficiency. Varcoe and Rodney (2002) define corporate ideology as "the beliefs, attitudes, and assumptions that bring a business model to health care" (p. 127). The authors (2002) confirmed the major presence of corporate and individual ideologies in changes and decisions affecting perioperative patient care and clarified the difficulty in accepting these ideologies as a *fait accompli*. The studies of Varcoe and Rodney (2002) and others warn that while overlooking the wellbeing of patients is not the intention of a corporate focus on outcomes, it is the result.

Another ideology influencing nursing advocacy and affecting patient safety, present in every perioperative nurse/surgical patient interaction, is egalitarianism.

Anderson and Reimer Kirkham (as cited in Browne, 2001) define the ideology “In Canada, and to a lesser extent, the US, the ideology of egalitarianism assumes that all people have an equal opportunity to achieve optimum health since everyone (supposedly) has equal access to health services” (p. 124). Browne (2001) continues with this line of reasoning with the statement “...failing to achieve good health or access health-care is viewed as an individual deficit, and as largely independent of social and structural constraints” (p. 124). At this time of continuing fiscal constraints and health care reviews, the patient requiring surgery is at the mercy of the health care system. Timely access is no longer the reality and many patients are held in a queue whether they are urgent or not. An easy deflection from the truth is to blame the patients for their life style choices and possible demise which may be a self protective action on behalf of the nurse.

Ideologies specific to nursing which influence the perioperative nurses advocacy practice are numerous. The first is ‘gender stereotyping’, a reality in the perioperative areas: males are doctors, not nurses and females are nurses, not doctors. This is based on the societal ideology that femininity means dependency and subordination in relation to masculinity and nursing is a subordinate to medicine. The following quote, although written on July 31, 1897, describes the gender relations in some health care settings:

My name and reputation as a man and surgeon depend on my ideas being carried out as I would have them carried out ... The nurse is not employed as consultant, as critic, as arbiter, she is strictly an executive officer. (Gamarnikow as cited in Davies, 2003, p. 724)

The nurse’s ability to advocate for every patient as required will only become a reality when every voice is respected in spite of gender or position.

A second nursing ideology present in the perioperative setting is the family structure where the nurse is the mother, (caring and nurturing); the Doctor is the father, (making decisions as the patriarch of the family); and the patient is the child, (dependent, doing as he/she is told). Pringle (as cited in Davies, 2003) provided the rationale “This patriarchal style did mean that in return for being prepared to behave as handmaidens nurses could expect gratitude and protection, the approval and recognition of powerful men” (p. 725). As the concept of advocacy has developed, the nurses’ loyalty has shifted from the institution and doctor/surgeon to the patient. This is important as the main responsibility of the perioperative nurse is advocating for the patient which may necessitate not abiding by the directions of the physician.

A third nursing ideology that is interwoven in the first two is the notion that nurses are powerless. Holmes and Gastaldo’s (2002) citation of Lunardi Filho clarifies the magnitude of this ideology:

Traditionally, nurses have described themselves, and have been depicted by others, as a powerless professional group, which lacks social prestige, is poorly paid, and experiences very limited professional autonomy because of physicians’ socially dominant role in providing health care to the population. (p. 557)

In reality, perioperative nurses can claim their importance and practice as an equal partner with physicians. Physicians are losing the dominant role as they are unable to maintain the provision of health care to the communities, are unable to provide timely care to the patients in facilities, and are struggling to maintain a presence as their numbers are decreasing. Quite simply perioperative nurses have power to advocate by

their presence as the surgeons and anesthesiologists do not work without two or more perioperative nurses also present.

Feminist Theory Analysis

A significant portion of the perioperative nurses interaction with patients is ensuring the autonomy of the patient and family. For example, the questions ‘was the patient’s voice heard’; ‘does the family require more information than the surgeon provided’ and ‘is the information understood’ are a reality of every perioperative nurse and patient/family encounter. This activity represents part of the advocacy role in nursing, and with Gadow’s (1990b) definition of advocacy in mind, is strongly influenced by feminist theory and ethics (Oberle & Bouchal, 2009). Analysis of the previous ideologies present in the context of the perioperative environment from a feminist theoretical perspective provides rich insight of the constraints of nursing advocacy practice.

McCormick and Roussy (as cited in Varcoe, 2003) provide a definition of feminist theory as “not one, but many, theories or perspectives” (p. 33). The authors (2003) continue “the various feminisms have in common valuing of women, their experiences, their roles, and their contributions to society, along with a commitment to end patriarchal domination, and identify and confront injustice and oppression based on gender” (p. 33). Chin and Wheeler (as cited in McCormack & Bunting, 2002) noted that patriarchal attitudes and dominance of a male world view in society has continued to affirm the oppression of women. Feminist theory is the preferred choice of a theoretical perspective for analysis as it focuses on the major perioperative issues: the majority of surgical teams are comprised of female nurses and the attitudes and dominance as

described profoundly affects the advocacy work of nurses and the team dynamics. Also, a strong gender analysis, incorporating the realities of perioperative nursing, past, present, and future, would enable us to make explicit the social conditions and power relations in which perioperative nurses' advocacy work takes place.

Three basic schools of thought within feminist theories are liberal, radical, and socialist feminist theories (Wittmann-Price, 2004). As defined by Wittmann-Price (2004) liberal feminist theory values individualism and considers that equal opportunities for women should be based on the same standards as men; radical feminist theory claims that systems, both micro and macro, are the oppression of women; and socialist feminist theory constructs oppression from the factors of biology, society, and physical environments. Regardless of the origin of the various feminist theoretical approaches, all concentrate on the oppression of women as a constant phenomenon and advocate for methods of change.

Power and domination over women within the ideologies of gender and patriarchal relationships combined with the resultant difficult work environments in the perioperative settings may create and/or support the factors that influence patient advocacy. Wittmann-Price (2004) supports the connection "Regardless of its origin, power or domination over women causes oppression and denies equality or 'voice'" (p. 440). The author (2004) made the connection to another important concept for perioperative nurses, empowerment, and the use of the metaphor for empowerment 'growth of voice' versus the term 'silence' as the symbol of oppression. The mantra 'silence to voice' is profoundly relevant for perioperative nurses within the context of perioperative patient advocacy. If perioperative nurses are going to step up to the issue of

patient harm their voices must be found and more importantly, must be used to protect vulnerable patients.

Chapter Three

Models of Patient Advocacy in Nursing

Since the 1970's, advocacy has increasingly been discussed as an essential component of nurses' professional role and many definitions have been proposed in the nursing literature (Bu & Jezewski, 2006). In spite of almost 40 years of the concept's prevalence in nursing, the authors (2006) were unable to find a systematic review of the concept of patient advocacy in the literature.

As aptly phrased by Grace (2001) "Advocacy has proven a slippery concept for the nursing profession" (p. 152). The author (2001) also succinctly summarizes the issue as follows "the problem with the concept of advocacy, as with many other concepts, for example 'trust', 'despair', or 'hope', is that it is resistant to formal definition" (p. 152). Grace (2001) analyzed the advocacy ambiguity issue and connected the practice problems that ultimately impact patient care to the poorly defined concept. Could this be the foundational reason for the difficulties in enacting nursing advocacy in the perioperative practice setting?

King (as cited in Seiloff, 2006) defines concepts as "abstract ideas that give meaning to our sense perceptions, permit generalizations, and tend to be stored in our memory for recall and use at a later time in new and different situations" (p. 299). A review of the literature confirms that the meaning and scope of the concept 'advocacy' is not a settled issue. The term appears to be a convenient label for diverse activities and even Curtin, one of the advocacy gurus, has been described by Snowball (1996) as having 'conceptual ambiguity'.

As the nursing profession has adopted the term patient advocacy to denote an ideal of practice and advocacy as the philosophical foundation of nursing, the profession requires the availability of appropriate methods, or models, for implementing the concept. Pearson and Vaughan (1986) provide a simple definition for model “as something which is not the real thing, but which matches or represents it as closely as possible” (p. 1) and connect the word to practice with the definition “a descriptive picture of practice which adequately represents the real thing” (p. 2). The authors (1986) also connect the term to nursing with the statement “a nursing model is made up of the components or ideas which go towards making up nursing – what it is, the beliefs, the values, and the theories and the concepts on which it is built” (p. 8). Fawcett (1984) confirms the significance of this term to nursing by offering the opinion of nursing model proponents that the use of a model provides a more unified approach to nursing practice, education, administration, and research and also facilitates communication among nurses.

The most prevalent advocacy models in the nursing literature are Curtin’s (1979) human advocacy model, Gadow’s (1990a) theory of existential advocacy, and Kohnke’s (1982) functional model of nursing advocacy. The basis of each model is a belief in personal autonomy or self-determination (Bu & Jezewski, 2006), but there are underlying connotations that differ between the three. Curtin’s (1979) model is considered a humanistic model that emphasizes common humanity, common needs and common human rights, i.e. patients’ benefits and nurses’ humanity. Gadow (as cited in Curtin, 1979) illuminated the human rights and nurse-patient relationship in a presentation in 1977 with the statement “Nurses are in a unique position among health professionals to

attend the patient/client as a unity because they are able to experience patients as human beings” (p. 4).

Gadow’s existential advocacy model and Kohnke’s functional advocacy model both emphasize patients’ self-determination, and also differ in the involvement of the nurse (Bu & Jezewski, 2006). With Gadow’s (1990a) model the nurse is more personally involved with the patients’ decisions by assisting the patients to discern their own values and make decisions based on those values. Kohnke’s (1982) model simplifies the role of the advocate with two functions: to inform and to support, leaving the nurse less personally involved with the patients’ decisions.

A fourth model by Fowler (as cited in Bu& Jezewski, 2006) encompasses the attributes of the first three and surpasses them by advancing the nurses’ concerns to participation in social criticism and social change. With consideration of the ideologies previously presented, an advocacy model focusing on social change might have merit in a perioperative environment

Patient advocacy has become a motto for nursing, with nurses accepting the concept as an ideal which characterizes nursing. However, without further analysis of the theoretical or practical implications, the role of advocacy is not operationalized. Corcoran (1988) has merged Gadow’s (1990b) model of ethical decision making and a decision theory model for structuring decision problems in order to operationalize one aspect of the advocacy role, that of helping another person to decide. The author (1988) encourages nurses to test and refine the model and to develop additional guidelines for other aspects of the role. Types of information that might be needed for informed decision making, one aspect of an advocacy role, along with important aspects of operationalization have been

recognized in the model. Mallik (1997a) noted that no evidence was located that Corcoran's model had actually been tested in practice. As another 10 plus years have passed since Mallik's (1997a) investigation, a worthwhile activity might be a national survey to determine the actual clinical implementation and practice results of this model.

A fifth model, (Jezewski, 1993), named 'culture brokering' provides a broad base to implement advocacy in nurses' practice. Jezewski (1993) defines culture brokering as "the act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change" (p. 80). Jezewski (1993) further explains the rationale behind the development of a model that is based on the philosophical foundation of nursing but also one that has evolved beyond the reduction of advocacy to a metaphor (Winslow, 1990), self-determination (Gadow, 1990a), an act of informing and supporting (Kohnke, 1980), or patient autonomy (Nelson, 1988). Jezewski (1993) confirms the applicability of the model for patient advocacy in a perioperative environment by defining the attributes of a culture broker as including "...the ability to function where unequal relationships exist, where noncompliance exists, and in situations where change and/or conflict occur and where innovation is needed or expected" (p. 80). An additional benefit of this model is that the advocacy extends beyond the relationship between the nurse and the patient to include 'others' in the environment.

Summary

The literature continues to promote the nurse's role as advocate for professional nurses, concentrating on reasons why nurses should embrace this career. Currently, the generation of new roles for perioperative nurses, (i.e. Registered Nurse First Assist,

Registered Nurse Anesthesia, Perioperative Liaison Nurse), and approaches of administration to clinical care may change not only the character of the patient advocacy concept, but also its implementation in practice through genuine opportunities to partner with patients. However, any attempt to innovate the nurse's role as advocate must clarify how this new development should be defined and interpreted as a functional model. Nurses could utilize their numbers within the health care system to recommend an advocacy model that collaborates with health care consumers to meet their individual needs and to impact the delivery of health care services.

Perioperative Interpretations of Nursing's Claim to Advocacy

The perceptions of the practicing nurse are complicated by nursing's claim to advocacy, supported by literature promoting this role for nurses. In Mallik's (1997a) literature analysis of advocacy in nursing, four key themes emerged in accounts attempting to justify the claim: "advocacy is a traditional role in nursing, nurses are in the best position to advocate, nurses know how to advocate, and nurses and patients are partners in advocacy" (p.134). A discussion follows to counter the validity of each theme.

In the first theme, "advocacy is a traditional role in nursing", there is an assumption that advocacy is an established practice. O'Connor and Kelly (2005) report that "...advocacy is inherent in the role of nurses and that nursing without advocacy is not possible" (p. 455). While the argument that advocacy is an adopted rather than an inherent role in nursing is beyond the scope of this paper, the issue remains how well are nurses advocating for patients. Witts and Courtney (as cited in Mallik, 1997a) found that nurses acted as informal advocates and advocacy "was taken up to the extent that circumstances allowed" (p. 134). The presence of the nursing ideologies discussed

previously have often left nurses with little option other than passive advocacy, described by Stein, Watts and Howell (as cited in Mallik, 1997a) as “using hidden strategies like soldiers in guerrilla warfare” (p. 134). A classic perioperative nursing example of passive advocacy is the surgical instrumentation is ‘misplaced’, allowing travel time for the family to reach the patient before the surgical event.

In the second theme, “nurses are in the best position to advocate” the assumption refers to both the position on the health care team and the quality contact time with the patient. While the middle position between patient and physician can be advantageous, this creates moral dilemmas due to conflicting loyalties and accountabilities for the perioperative nurse. Morse (as cited in Mallik, 1997a) recognized that multiple caregivers and a lack of time, the reality of perioperative nursing practice, hindered the relationship that is vital to patient advocacy

The third theme is “nurses know how to advocate”. However, Webb (as cited in Mallik, 1997a) asserts that “knowledge is perceived as authority to advocate even if there is no guarantee that it will be used in a given situation” (p. 135). Kohnke (1982) connects the assertion to advocacy with the summary:

In the literature, the nurse is encouraged to be the patient’s advocate, and many nurses (and other health care professionals) have found that the public, too, expects this to be part of the nurse’s job. Despite the social pressure to go out and ‘rescue the Holy Grail,’ we nurses rarely find anyone telling us how to do so and how to avoid the risks involved. As a result, we see either very little advocacy or more reports of failures than reports of successes. (p. viii)

In the first module of the British Columbia Institute of Technology perioperative nursing specialty program, the concept of advocacy is introduced and explored in relation to individuals experiencing surgery and anesthesia. A more pragmatic approach to education for advocacy, as consolidated by Mallik (1997a), is the opinion that the best preparation of the student is the experience in actually ‘attempting’ advocacy.

The fourth and final theme seeking to justify nursing’s claim to advocacy is “nurses and patients are partners in advocacy”. Debates in the literature support the notion that the less powerful groups of patients and nurses, in comparison to the dominant groups such as medicine, can join together as allies (Mallik, 1997a; Winslow, 1990). Winslow (1990) explains “Finally, nurses and patients should make obvious and genuine allies since both groups have often suffered the indignities of powerlessness in the modern health care system. Who, then, could function better as a patient advocate than a nurse?” (p. 36). This explanation is open for interpretation as patients may not recognize nurses as their partners. As introduced in the discussion of nursing ideologies, nurses are still seen as ‘hand maidens’ to the physician, loyal to the hospital, and a substitute parent. The ‘them’ vs. ‘patient’ reality is reinforced by the identical scrub apparel for the surgical team; the patient is unable to recognize the perioperative nurse from the surgeon/anesthesiologist.

Perioperative Context of Patient Advocacy

The ideology of scarcity is prevalent in health care and the perioperative clinical settings have not escaped the impact. In the past two decades, perioperative nursing care has changed dramatically. For the majority of surgical procedures, the time factor allocated for the event has been reduced from days or weeks to a few hours. Today, as the

pressures from economic and government incentives accelerate, patients are being fast tracked through the surgical experience. The scarcity of resources and the increased needs of the patients and families that require surgical intervention are impacting the perioperative nurse's ability to advocate. Nortvedt (as cited in Brown, Rodney, Pauly, Varcoe, & Smye, 2004) questioned whether or not 'the' way to respect autonomy within nurse-patient relationships was patient advocacy. The author profoundly captures the reality of the present perioperative nurse-patient relationship as "not how to give the best care for one's patients, but instead how to minimize potential harm to patients created by socio-economic circumstances" (p. 133).

The following summary, from a study recently completed by Alfredsdottir and Bjornsdottir (2007), identifies what operating room nurses believe influences patient safety and how they see their role in enhancing patient safety. The findings as reported by the authors (2007) were:

The core of operating room nursing was identified as patient safety and the skilful and knowledgeable work performed by nurses vis-à-vis ensuring a safe transition through surgery. Its goal was described as providing patient-centered nursing so that patient safety and a positive outcome were ensured. When asked what characterized their nursing, participants described how a patient undergoing surgery is vulnerable and needs to be taken care of by skilled professionals who use nursing interventions in a preventative manner. (p. 31)

This example demonstrates the essence of nursing care in the perioperative environment - patient advocacy, as a vital component of the *raison d'être* of perioperative nurses.

Woodrow (as cited in Vaartio & Leino-Kilpi, 2005) recognizes the relevance of patient

advocacy to the perioperative nurse “True patient advocacy does not exist without caring: if the nursing profession fails to advocate for patients, it has little purpose beyond a technical role” (p. 713).

Patient Advocacy: Facilitators and Barriers

What would be necessary for nurses to be more effective advocates? Would a radically different health care system wherein the nurse is supported to advocate for patients without limitations amend nursing’s hesitation to advocate? Possibly. While this may be an option for patient advocacy in the future, there are significant prerequisites for effective advocacy that may be achievable in today’s health care setting: agreement on the meaning of advocacy, acceptance of a concept model that is applicable to a clinical setting, and clarification of the process to operationalize the model. The following discussion presents the numerous facilitators and barriers influencing the role of advocacy among nurses.

Advocacy Facilitators

O’Connor and Kelly (2005) offer a number of ideas about the skills required by nurses to engage in advocacy as “knowledge (both technical and the wishes of the patient), experience, assertiveness, empathy and communication skills” (p. 455). The authors (2005) emphasize that it is difficult to say exactly how these skills are transmitted in advocacy situations as they are human attributes. The participants in a study (Snowball, 1996) raised the issues regarding the need for educational achievement equivalent to that of other health care professionals to feel secure enough in their knowledge base to advocate in potential conflict situations. Boyle (2005) summarized the researcher’s conclusions as “nurses need to have a sound professional identity and a high

level of self-confidence and self-esteem to advocate in potentially risky situations” (p. 252). Each of the identified attributes and skills are vital to the success of advocacy efforts by the perioperative nurse. Bull (as cited in Bull & FitzGerald, 2004) selects the primary skill for a perioperative nurse by stating “To be a patient advocate in the OR takes a great deal of assertiveness” (p. 1267).

As defined by Mallik (1997b) intervening conditions are “those conditions which help and support nurses once they decide to advocate, and could also be used as justification or rationale for claiming this role” (p. 306). The main intervening conditions or themes that emerged are: “1) patient recognition of the role, 2) significance of the nurse – patient relationship, 3) emotional responses as initiators of advocacy, 4) moral justification, and 5) knowledge, expertise and position legitimacy” (Mallik, 1997b, p. 307). The fifth theme: “knowledge, expertise and position legitimacy” has particular merit in a perioperative environment and is often the catalyst to patient advocacy. Mallik (1997b) supplies the following definition “Specialist knowledge, which provided a powerful counterweight to the doctor’s wish, was used particularly with ‘silent’ patients” (p. 307). Negarandeh, Oskouie, Ahmadi, Nikraves, & Hallberg, (2006) outlined similar conditions that could be influential in adopting the advocacy role. The authors (2006) also identified the physician allies in advocacy that are required to stand up for the perioperative nurses and support the attempts to advocate for the patient or another team member.

Advocacy outcomes can be successful, resulting in positive feelings. However, as discovered in Mallik’s (1997b) examination of nurse advocacy reports, although the outcome may appear successful, there may be negative consequences for the nurse.

Barriers to Advocacy

The literature examination confirmed that patient advocacy is considered to be an essential component of nursing practice (Bramlett, Gueldner & Sowell, 1989) yet difficulties surround its implementation. In examining the obstacles to the implementation of the role, Murphy (as cited in Millette, 1993) constructed three models of advocacy that are named and defined as:

bureaucratic advocacy, through which the nurse owes allegiance primarily to the institution and the needs of both the patient and nurse are secondary; *physician advocacy*, in which the doctor is given the chief consideration and all other factors are subordinate; and *client advocacy*, in which the client is the primary focus, with all health providers acting together to attain the client's self-determined goal. (p. 608)

While the client advocacy model is the preferred model for the professional nurse, and all of the three may be appropriate in certain circumstances (Millette, 1993), the nurse may select a lesser model due to difficulties in advocating for the patient. Negarandeh et al. (2006) completed the lone study exploring the barriers and facilitators influencing the role of advocacy among nurses. The findings demonstrated that nurses can not act at an optimal level in most cases, and they will limit the advocacy response as necessary, replicating a previous study on nurses' views of client advocacy (Millette, 1993).

External constraints (i.e. those of the institution) are barriers to the implementation of the patient advocate role. When the competing forces of the current health care system, especially institutional pressures, are operating, nurses may chose to function in a less preferred model of advocacy (Millette, 1993). Chafey et al (1998) and

other researchers (Mallik, 1998; Schroeter, 2000) also noted that institutional strains may effectively undermine the empowerment of practicing nurses.

The nurse may repeat the decision to select a lesser preferred model of advocacy or none at all, when internal constraints (i.e. the nurse's level of moral development and/or an ethical dilemma) are present as the nurse is especially vulnerable under such circumstances (Murphy as cited in Millette, 1993). Mallik (1997a) provides a rationale with the statement "Decisions to advocate can not be taken lightly and in the face of all the barriers; it remains an individual moral choice for the nurse" (p. 136).

In a study by Chafey et al, (1998) physicians contributed to nurses' willingness or reluctance to advocate depending on their availability, openness to patients and nurses, and their personal demeanor and control (yelling, throwing instruments, intimidation). According to Savage (as cited in Hewitt, 2002) nursing advocacy often attracts medical hostility. While Marshall (as cited in Hewitt, 2002) made the assertion "Doctors have felt threatened by nursing advocacy and its encroachment on their traditional role as information givers" (p. 441) decades ago, it is still accurate today. Nurses have been fearful to speak out for patients, even when the patient may be suffering, due to the concern that the repercussions of this hostility may be directed towards the nurse professionally and personally. Although not replicated in a study, personal communication with perioperative colleagues validates this finding. Bull & FitzGerald (2004) succinctly explained the reality of the perioperative practice environment with the statement "Barriers to advocate in the OR are directly related to power – professional power and power that is generated by personalities" (p. 1270).

Although not frequently noted in the studies, nurses did report the limitations or absence of traits such as knowledge of process to advocate, experience, self-confidence and dedication to position as possible reasons why advocacy might not occur.

Nursing's claim to advocacy has created confusion for the practicing nurse as their perceived responsibility to advocate usually has a degree of risk attached. Grace (2001) outlines the risks as "things as reprobation from peers, which can take an emotional toll, and the possibility of job loss" (p. 152). If the nurse is not able to fulfill the advocacy responsibilities, a feeling of powerlessness combined with a condition of moral distress may be the result.

Summary

Although advocacy is frequently highlighted in nursing, it is often used more as a catch phrase than a true role put into practice. Implementing an advocacy role is difficult and sometimes risky, because it promotes patients' self-determination (Corcoran, 1988). Patriarchal emphasis on loyalty and obedience to institutions and physicians is no longer acceptable as nursing establishes itself in the 21st century. Unfortunately, the policies or regulations of the health care facility may not be compatible with the professional's moral rights and obligations to patient care. Chambliss (as cited in Grace, 2001) has spent several years observing nurses who practice in hospital settings and noted "the nurse often knows what is the right thing to do but is prevented from accomplishing this by institutional obstacles" (p. 161). The obstacles or barriers that impede the nurse's ability to advocate for patients can rarely be vanquished by the efforts of single individuals.

Chapter Four

Recommendations

Nursing Practice

The early attempts to conceptualize models for advocacy in nursing were provided by authors such as Curtin (1979), Gadow (1990a) and Kohnke (1982). These models, discussed earlier in this paper, were based on the patients' right to self-determination and counseling approaches to support the patient's decision-making. O'Connor and Kelly (2005) assert that this approach does little more than provide information to patients while Mallik (1997b) criticizes that these models do not contribute practical advice on how to advocate for practicing nurses. Internationally, investigations were undertaken to study nurses' perceptions of advocacy. The researchers' findings (Chafey et al., 1998; Mallik, 1997b; and O'Connor & Kelly, 2005) confirmed that the concept of advocacy is expanded in practice from the nurse and the patient relationship to a triadic or group of three: the patient, the nurse, and others in the environment. O'Connor and Kelly, (2005) explain the nurses role in this relationship "Nurses therefore become actively involved in representing the patient to others" (p. 455).

The additional models, Fowler (as cited in Bu& Jezewski, 2006), Corcoran (1988), and Jezewski, (1993), also discussed previously provide options for nursing advocacy models. However, with the exception of Jezewski (1993), the other models maintain a dyadic or nurse/patient focus. The review of the literature revealed that nurses view advocacy as 'bridging the gap' between the patient and others – precisely the focus of patient advocacy by perioperative nurses.

It was not the intention of this student to construct a theoretical framework of advocacy in perioperative nursing, given that the paper was restricted to exploring the practice of advocacy. It would be appropriate for future studies to help determine a clearly relevant model of nursing advocacy in perioperative nursing environments and for the voice of the patients and families that have been through a surgical event to offer some insight into their experiences. *The recommendation is the alignment between the culture specific nature of perioperative nursing with a working model that can and will be used in the practice setting.* This suggestion for action would comprise a request for future consideration and collaboration between nurses in health authorities and academic institutions.

Multidisciplinary Teams

The complexity of patient care in the perioperative setting makes it critically important that nurses work in environments in which individuals can speak up, express concerns, and advocate for patients. Effective communication and teamwork are vital for the enactment of advocacy which is essential for the delivery of high quality, safe patient care. The mandate behind the World Health Organization's (2009) "Safe Surgery Saves Lives" campaign is to improve the safety of surgery, every patient and every procedure. *The introduction and implementation of the Canadian adaption of the "Safe Surgery Saves Lives" checklist, (see appendix), as a standardized communication tool in a health authority, will facilitate team collaboration and cohesion, providing nurses with a voice on behalf of vulnerable, 'silent' patients.* Hewitt (2002) validates this recommendation "A voice within a multidisciplinary team would advocate more effectively for patients and avoids an insular approach to care" (p. 441). The 'checklist' procedure includes a

request for every member of the surgical team to ‘speak up’, and provides the opportunity to actually be heard. This activity will comply with the classic statement also by Hewitt (2002) “Nurses need to be empowered first, if they are to empower their patients” (p. 439).

Education

Nurses advocate for patients in every practice setting. Kohnke (1982) suggests that nursing advocacy is a form of caring and compassion and that it is a learned skill. Foley, Minick & Kee (2002) support this implication and state “Patient advocacy is assumed to be an inherent part of all nursing curricula and present in clinical practice settings” (p. 181).

The dominant position reported in the nursing literature is that ambiguity surrounding the term advocacy results in multiple interpretations of how to implement or operationalize the advocacy role in practice situations (Chafey et al., 1998; Kohnke, 1982; Mallik, 1997a; Snowball, 1996). Hewitt (2002) summarizes the dilemma as “most of the literature on the topic of advocacy appears to be philosophical in nature and offers little practical guidance on how the role of advocacy should be interpreted by the nurse in clinical practice” (p. 439). This fact should be the precipitating factor that encourages nursing researchers to undertake studies on how to enact advocacy.

Kohnke (1982), author of the classic book ‘Advocacy: Risk and Reality’, addressed the preparation for advocacy, recommending the following: “The importance of advocacy for self (or call it professional survival), a knowledge of systems assessment, and an awareness of the many factors involved in advocacy are all essential tools” (p. 183). Dock and Stewart (as cited in Donahue, 1978), in a nursing book published in 1925,

proposed three elements necessary for the delivery of nursing care: 1) motivation, 2) skill and expertise, and 3) knowledge (p. 150). Donahue (1978) states “It is my belief that it is this third element, knowledge, which is the key to nurse’s attainment of the role of patient advocacy” (p. 150). Findings from a study (Foley, Minick, & Kee, 2000) completed 80 plus years after Dock and Stewart’s recommendations confirm that practicing nurses understood what advocacy was, and incorporated it into practice, even though the learning process was haphazard. Specifically, *nurse educators consciously teaching advocacy and new graduates being supported in the work environment by nurse administrators would foster a stronger foundation of advocacy* (Foley, Minick, & Kee, 2000). With the exception of this study, no other empirical article on advocacy containing information on how advocacy is taught or how advocacy is learned was located during the literature search.

The findings from the studies exploring nurses’ perceptions of advocacy were consistent. If a universal and explicit definition for patient advocacy is not constructed, nurses will practice this role with variations and difficulties. Negarandeh, Oskouie, Ahmadi & Nikraves (2008) offer suggestions to advocate optimally for patients: “nurses need to know in which kinds of situations patients will require an advocate, what patients’ best interests are in particular situations, and what kinds of actions need to be taken to preserve, represent, and/or safeguard patients” (p. 465). These suggestions may be helpful in bridging the theory-practice gap for practicing nurses.

Research

All of the studies were limited by the number of incidents the respondents were asked to provide. Not only does this prevent an exploration of the frequency of the

respondents' action as advocates but also eliminates the opportunity to report the occasions where advocacy was indicated and no action was taken. *Expanding the research to include these key areas may illuminate the supports and barriers for perioperative patient advocacy, providing areas for focused improvement.* Mallik (1997b) provides recommendations for the undertaking of observational studies that would prospectively label the examples of non-action in situations where advocacy was deemed to be warranted and the review of the consequences.

Jugessur & Iles (2009) also noted the lack of articles analyzing the legal implications and repercussions of the advocacy role for nurses, in spite of the concept of advocacy being rife with dilemmas, conflicts, confusion and risk. Studies to address the implications of these problems would be beneficial to the practicing nurses' future advocacy endeavors

Strategies for Patient Advocacy

The patient advocacy role is the essence of perioperative nursing. The Operating Room Nurses Association of Canada's (ORNAC) definition of advocacy confirms the responsibility of the perioperative nurse by describing "the unique position of the perioperative Registered Nurse as a member of the health care team to speak on behalf of patients and interpret individual needs and responses to others who participate in their care" (p. 339).

To facilitate a greater awareness of patient advocacy, the following goals should be addressed:

- Promote and facilitate the incorporation of advocacy principles into nursing curricula; offer to provide sessions on advocacy enactment for the perioperative specialty program.
- Incorporate the term *patient advocate* and articulate its role performance in the perioperative nurses' job description and institutional philosophy.
- Preserve the role's viability with research; include advocacy in patient acuity and wellness models, i.e. clinical pathways.
- Educate the public about the advocacy role.

Conclusion

The term advocacy is prone to ambiguity of interpretation. Is it a question or an answer? Is it a response to trying to keep one step ahead of the evolution of nursing or a risk so great that it must be avoided at any cost? Inconsistent definitions of patient advocacy may confuse nurses and impede the role application. The concept of advocacy has received international recognition over the last three decades as an important concept in nursing. Advocacy is frequently used to describe the nurse/patient relationship. My conclusions from reviewing these studies are that advocacy is a natural but risky role for the nurse, and all nursing advocacy actions start from the assumptions that patients do indeed need advocates. Researchers (Segesten, 1993) claim that vulnerability or powerlessness of a patient is the trigger for advocacy, the reality of every perioperative nurse and patient interaction.

From examining empirical articles, I have also determined that the concept of advocacy is complex, and the operationalization is difficult. These findings support the recommendations by many authors for further research into the interpretation of the

patient advocate role by nurses (Mallik, 1997a) combined with research on patients' perspectives of nursing advocacy in general hospital settings (Vaartio & Leino-Kilpi, 2005).

In this paper, I discussed patient advocacy as a nursing role at the time when the safety of patients is paramount in every health discussion. The need is great for nurses to understand and undertake this important role. I have provided a step in that direction through exploring the barriers and facilitators to advocacy. Kohnke (1982) in the classic reference on advocacy stated:

In order to be an effective advocate, you need to know what advocacy is, how to do it, and how to do it well and safely. For just as you cannot venture into a minefield without a mine detector, you cannot venture into advocacy without knowledge and foresight. In the words of the New Testament, advocates should be "as wise as serpents and as gentle as doves". (p. 2)

References

- Alfredsdottir, H., & Bjornsdottir, K. (2008). Nursing and patient safety in the operating room. *Journal of Advanced Nursing*, *61*(1), 29-37.
- Altun, I., & Ersoy, N. (2003). Undertaking the role of patient advocate: A longitudinal study of nursing students. *Nursing Ethics*, *10*(5), 462-471.
- Annas, G. & Healey, J. (1990). The patient rights advocate. In T. Pence, & J. Cantrall (Eds.), *Ethics in Nursing: An Anthology* (pp. 75-82). New York: National League for Nursing. (Original work published 1974)
- Beyea, S. (2008). Are you “just a nurse”? *Association of periOperative Registered Nurses Journal*, *87*(2), 441-442, 444.
- Boyle, H. (2005). Patient advocacy in the perioperative setting. *Association of periOperative Registered Nurses Journal*, *82*(2), 250-262.
- Bramlett, M., Gueldner, S., & Sowell, R. (1989). Consumer – centric advocacy: Its connection to nursing frameworks. *Nursing Science Quarterly*, *3*(4), 156-161.
- Brown, H., Rodney, P., Pauly, B., Varcoe, C., & Smye, V. (2004). In J.L. Storch, P. Rodney, & R. Starzomski (Eds.), *Toward a moral horizon: Nursing ethics for leadership and practice* (pp. 126-153). Toronto, ON: Pearson Education.
- Browne, A. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry*, *8*(2), 118-129.
- Bu, X., & Jezewski, M.A. (2006). Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing*, *57*(1), 101-110.
- Bull, R., & Fitzgerald, M. (2004). Nurses’ advocacy in an Australian operating

- department. *Association of periOperative Registered Nurses Journal*, 79(6), 1265-1268, 1270, 1273-1274.
- Canadian Nurses Association. (2008). *Code of ethics for Registered Nurses* (Centennial Ed.). Ottawa: Author.
- Canadian Patient Safety Institute. (2009). *Surgical Safety Checklist: Canada, Version 1*. Edmonton, AB: Author.
- Cartmel, V. (2009, June 5). *President's speech*. Paper presented at the 2009 annual general meeting College of Registered Nurses of British Columbia. Retrieved July 5, 2009, from http://www.crnbc.ca/downloads/presidentspeech_agm_2009.pdf
- Chafey, K., Rhea, M., Shannon, A., & Spencer, S. (1998). Characteristics of advocacy by practicing nurses. *Journal of Professional Nursing*, 14(1), 43-52.
- College of Registered Nurses of British Columbia. (2008). *Professional standards for registered nurses and nurse practitioners, June 2008* (No. 128). British Columbia: Author.
- Copp, L. (1986). The nurse as advocate for vulnerable persons. *Journal of Advanced Nursing*, 11, 255-263.
- Corcoran, S. (1988). Toward operationalizing an advocacy role. *Journal of Professional Nursing*, 4(4), 242-248.
- Cronin, P., Ryan, F., & Coughlan, M. (2008). Undertaking a literature review: a step-by-step approach. *British Journal of Nursing* 17(1) 38-43.
- Curtin, L. (1979). The nurse as advocate: A philosophical foundation for nursing. *Advances in Nursing Science*, 1(3), 1-10.
- Curtin, L. (1990). The nurse as advocate: A cantankerous critique. In T. Pence, &

- J. Cantrall (Eds.), *Ethics in Nursing: An Anthology* (pp. 121-123). New York: National League for Nursing. (Original work published 1983)
- Davies, K. (2003). The body and doing gender: the relations between doctors and nurses in hospital work. *Sociology of Health & Illness*, 25(7), 720-742.
- Donahue, M. (1978). The Nurse – A patient advocate. *Nursing Forum*, 17,2. 143-151.
- Fain, J. (2004). Selecting and defining the problem. In J Fain (Ed), *Reading, Understanding, and applying Nursing Research, a text and workbook* (2nd ed.) (pp52). Philadelphia: Davis.
- Fawcett, J. (1984). Conceptual models and theories. *Analysis and evaluation of conceptual models of nursing*. (pp. 6, 7). Philadelphia: F. A. Davis
- Foley, B., Minick, P., & Kee, C. (2000). Nursing advocacy during a military operation. *Western Journal of Nursing Research*, 22(4), 492-507.
- Foley, B., Minick, P., & Kee, C. (2002). How nurses learn advocacy. *Journal of Nursing Scholarship*, 34(2), 181-186.
- Gadow, S. (1989) Clinical Subjectivity Advocacy with silent patients. *Nursing Clinics of North America*, 24(2), 535-541.
- Gadow, S. (1990a). Existential advocacy: Philosophical foundations of nursing. In T. Pence, & J. Cantrall (Eds.), *Ethics in Nursing: an Anthology* (pp. 41-51). New York: National League of Nursing. (Original work published 1980)
- Gadow, S. (1990b). A model for ethical decision making. In T. Pence, & J. Cantrall (Eds.), *Ethics in Nursing: an Anthology* (pp. 52-55). New York: National League of Nursing. (Original work published 1980)

- Grace, P. (2001). Professional advocacy: widening the scope of accountability. *Nursing Philosophy*, 2, 151-162.
- Hamric, A. (2000). What is happening to advocacy? *Nursing Outlook*, 48(3), 103-104.
- Hewitt, J. (2002). A critical review of the arguments debating the role of the nurse advocate. *Journal of Advanced Nursing*, 37(4), 439-445.
- Holmes, D., & Gastaldo, D. (2002). Nursing as a means of governmentality. *Journal of Advanced Nursing*, 38(6), 557-565.
- Jezewski, M.A. (1993). Culture brokering as a model for advocacy. *Nursing & Health Care*, 14(2), 78-85.
- Jugessur, T., & Iles, I. (2009) Advocacy in mental health. *Journal of Psychiatric and Mental Health Nursing*. 16 187-195
- Kohnke, M. (1980). The nurse as advocate. *American Journal of Nursing*, November, 1980, pp. 2038-2040.
- Kohnke, M. (1982). *Advocacy Risk and Reality*. St. Louis: Mosby.
- Mallik, M. (1997a). Advocacy in nursing, a review of the literature. *Journal of Advanced Nursing*, 25, 130-138.
- Mallik, M. (1997b). Advocacy in nursing – perceptions of practicing nurses. *Journal of Clinical Nursing*, 6, 303-313.
- Mallik, M. (1998). Advocacy in nursing: perceptions and attitudes of the nursing elite in the United Kingdom. *Journal of Advanced Nursing*, 28(5), 1001-1011.
- Mallik, M. & Rafferty, A.M. (2000). Diffusion of the concept of patient advocacy. *Journal of Nursing Scholarship*, 32(4), 399-404
- Martin, G. (1998). Communication breakdown or ideal speech situation: the problem of

- nurse advocacy. *Nursing Ethics*, 5(2), 147-157.
- McCormack, K., & Bunting, S. (2002). Application of feminist theory in nursing research: The case of women and cardiovascular disease. *Health Care for Women International*, 23, 820-834.
- Millette, B. (1993). Client advocacy and the moral orientation of nurses. *Western Journal of Nursing Research*, 15(5), 607-618.
- Mitchell, G. & Bourne, d. (2000). Nurse as patient advocate? In search of straight thinking. *Nursing Science quarterly*, 13(3) 204-209.
- Negarandeh, R., Oskouie, F., Ahmadi, F., & Nikraves, M. (2008). The meaning of patient advocacy for Iranian nurses. *Nursing ethics*, 15(4), 457-467.
- Negarandeh, R., Oskouie, F., Ahmadi, F., Nikraves, M., & Hallberg, I. (2006). Patient advocacy: barriers and facilitators. *BMC Nursing*, 5(3), Retrieved May 23, 2008, from <http://www.biomedicalcentral.com/1472-6955/5/3>
- Nelson, M. (1988). Advocacy in nursing. *Nursing Outlook*, 36(3), 136-141.
- Oberle, K., & Raffin Bouchal, S. (2009). *Ethics in Canadian nursing practice*. Toronto: Pearson.
- O'Connor, T., & Kelly, B. (2005). Bridging the gap: A study of general nurses' perceptions of patient advocacy in Ireland. *Nursing Ethics*, 12(5), 453-467.
- Operating Room Nurses Association of Canada. (2009). *Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice*. (9th ed.). Toronto: Author.
- Pearson, A., & Vaughan, B. (1986). Models for Practice. *Nursing models for practice*. (pp. 1-25). Maryland: Aspen.

- Polit, D. F., & Beck, C. T. (2008). *Nursing research, Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Schroeter, K. (2000). Advocacy in perioperative nursing practice. *Journal of the Association of periOperative Registered Nurses*, 71(6), 1207-1222.
- Sieloff, C. (2006). Imogene King: Interacting systems framework and middle range theory of goal attainment. In A.M. Tomey & M. R. Alligood (Ed), *Nursing theorists and their work* (6th ed.) (pp 297-317). St. Louis. MO: Mosby.
- Segesten, K. (1993). Patient advocacy – an important part of the daily work of the expert nurse. *Scholarly Inquiry for Nursing Practice: An International Journal*, 7(2), 129-135.
- Snowball, J. (1996). Asking nurses about advocating for patients: ‘reactive’ or ‘proactive’ accounts. *Journal of Advanced Nursing*, 24, 67-75.
- Soanes, C., Hawker, S., & Elliott, J. (Eds.). (2005). *Paperback Oxford English Dictionary* (6th ed. pp.156). New York: Oxford University Press.
- Vaartio, H., & Leino-Kilpi, H. (2005). Nursing advocacy – a review of the empirical research 1990-2003. *International Journal of Nursing Studies*, 42, 705-714.
- Varcoe, C. (2003). The Context of Health and Health Care. *NURA 513, Course manual* (pp. 1-72). Victoria: University of Victoria.
- Varcoe, C. & Rodney, P. (2002). Constrained agency: The social structure of nurses’ work. In B.S. Bolaria & H.D. Dickinson (Eds.), *Health, Illness and health care in Canada* (3rd ed., pp. 102-128). Toronto: Nelson.

- Winslow, (1990). From loyalty to advocacy: a new metaphor for nursing. In T. Pence, & J. Cantrall (Eds.), *Ethics in Nursing: An Anthology* (pp. 30-40). New York: National League for Nursing. (Original work published 1984)
- Wittmann-Price, R. (2004). Emancipation in decision-making in women's health care. *Journal of Advanced Nursing*, 47 (4), 437-445.
- World Health Organization (2009). *Safe Surgery Saves Lives*. Retrieved August 1, 2009, from <http://www.who.int/patientsafety/safesurgery/en>

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BRIEFING – Before induction of anesthesia

Hand-off from ER, Nursing Unit or ICU

- Anesthesia equipment safety check completed
 - Patient information confirmed
 - Identity (2 identifiers)
 - Consent(s)
 - Site and procedure
 - Site, side and level marked
 - Clinical documentation
 - History, physical, labs, biopsy and x-rays
 - Review final test results
 - Confirm essential imaging displayed
 - ASA Class
 - Allergies
 - Medications
 - Antibiotic prophylaxis: double dose?
 - Glycemic control
 - Beta blockers
 - Anticoagulant therapy (e.g., Warfarin)?
 - VTE Prophylaxis
 - Anticoagulant
 - Mechanical
 - Difficult Airway / Aspiration Risk
 - Confirm equipment and assistance available
 - Monitoring
 - Pulse oximetry, ECG, BP, arterial line, CVP, temperature and urine catheter
 - Blood loss
 - Anticipated to be more than 500 ml (adult) or more than 7 ml/kg (child)
 - Blood products required and available
 - Patient grouped, screened and cross matched
-
- Surgeon(s) review(s)
 - Specific patient concerns, critical steps, and special instruments or implants
 - Anesthesiologist(s) review(s)
 - Specific patient concerns and critical resuscitation plans
 - Nurses(s) review(s)
 - Specific patient concerns, sterility indicator results and equipment / implant issues
 - Patient positioning and support / Warming devices
 - Special precautions
 - Expected procedure time / Postoperative destination

TIME OUT – Before skin incision

- All team members introduce themselves by name and role
- Surgeon, Anesthesiologist, and Nurse verbally confirm
 - Patient
 - Site, side and level
 - Procedure
 - Antibiotic prophylaxis: repeat dose?
 - Final optimal positioning of patient
- “Does anyone have any other questions or concerns before proceeding?”

DEBRIEFING – Before patient leaves OR

- Surgeon reviews with entire team
 - Procedure
 - Important intra-operative events
 - Fluid balance / management
- Anesthesiologist reviews with entire team
 - Important intra-operative events
 - Recovery plans (including postoperative ventilation, pain management, glucose and temperature)
- Nurse(s) review(s) with entire team
 - Instrument / sponge / needle counts
 - Specimen labeling and management
 - Important intraoperative events (including equipment malfunction)
- Changes to post-operative destination?
- What are the KEY concerns for this patient’s recovery and management?
- Could anything have been done to make this case safer or more efficient?

Hand-off to PACU / RR, Nursing Unit or ICU

PATIENT INFORMATION

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