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Client advocacy in nursing: A contemporary perspective

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CLIENT ADVOCACY IN NURSING:

A CONTEMPORARY PERSPECTIVE

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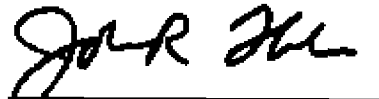
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Dedication

This report is dedicated to those students
who have gone before and have succeeded,
and to those who will come after, to
encourage the realization of their goal.

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ACKNOWLEDGEMENTS

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CHAPTER 1

INTRODUCTION

Nature and Significance of the Problem

Nursing has not achieved full-fledged professional status. Evidence on the part of organized nursing to pursue this goal can be found in the "Nurses Code" (American Nurses Association [ANA], 1976): "The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical or illegal practice of any person" (p. 8). In the interpretive statements accompanying this edition of the code of ethics, the behavior is termed "the role of [the nurse as] client advocate." This public acknowledgement of a commitment to the client manifests a significant step toward full-fledged professional status for nursing.

The struggle to attain full-fledged professional status began with the efforts of Florence Nightingale. Faced with a public image of nursing as represented by the drunken, dirty Sairy Gamp, the nurse depicted in Charles Dickens', Martin Chizzlewit, Nightingale adopted the discipline of the military in preparing young women to care for the sick. This image of the nurse as loyal soldier has prevailed in the mind of the public. Nightingale, in addition, sought to provide an adequate educational basis for the nurse.

When Nightingale returned from the Crimea in 1865, she established a school of nursing that would be a prototype of early schools in the United States. These schools were independent of the hospital and sought to maintain sound educational standards in order to prepare competent practitioners of nursing. The standards of practice resulting from such educational programs were professional in nature. The success of such programs was thwarted when it became common practice to use student nurses as cheap labor to staff hospitals. This practice continued well into the twentieth century.

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This situation, however, did not prevent nurses from considering themselves as professionals. The editors described the purpose of the first professional journal, the <u>American Journal of Nursing,</u> to provide a service to the emerging group of professional nurses (<u>American Journal of Nursing</u> [AJN], 1900).

While physicians generally supported the concept of nursing as a profession, others raised questions as to the possibility of this occurring. One such physician compared nursing to the medical profession and in doing do identified the following as criteria of a profession:

1. Be willing to subject yourselves to critical treatment.

2. Be prepared to accept a code of ethics.

3. Teach others to become successors.

4. Develop a body of knowledge.

5. Form a professional organization and a professional journal.

6. Admit that one does not know everything--that a basic education is just a beginning.

7. Have a genuine love for the calling.

8. Determine basic educational requirements and set standards of care (Worcester, 1902).

The weakness this physician identified was that nursing generally looked to the physician to educate newcomers to nursing. Professional status would only come as nursing developed a body of knowledge and was able to transmit this to newcomers.

In order to assess current professional status it is more meaningful to utilize criteria developed by Abraham Flexner and generally accepted today, as hallmarks of a profession. Flexner identified five major characteristics of a

profession: (a) a code of ethics; (b) peer colleagueship; (c) collaboration with others; (d) autonomy, and (e) a body of knowledge (Mastal, 1985).

Mastal (1985), in reviewing the progress of nursing in meeting these criteria, notes significant progress. Mastal found the greatest weakness, and at the same time the most difficult to achieve, was autonomy in practice. While nursing has been able to establish standards of practice and education, the ability to function as autonomous professionals has eluded practitioners. Nurses must be willing to accept accountability and responsibility to the client before significant progress toward autonomy in practice will be achieved. There is evidence in the literature to demonstrate that for a variety of reasons, not all nurses are ready and willing to take this step toward full-fledged professional recognition (Weiss & Remen, 1983). This inability to assume accountability and responsibility to the client makes the nurse's role as client advocate difficult and perhaps impossible to achieve.

Winslow (1984), in an extensive review of the nursing literature, found a general lack of agreement in the interpretation of the role of client advocate among nurses. This diversity of interpretation weakens the power nurses have, as the largest group of health care professionals, to affect quality health care. Finding at least seven different ways nurses define their role as client advocate, Winslow recommends the clarification of the meaning of the client advocate role. Unless this takes place, the central moral significance of the advocacy role, the power to shape actions intended to protect and enhance the personal autonomy of the client, will not occur. "Further clarification of this significance is essential if the metaphor [loyalty to the physician to become advocate for the client] is to rise above the level of a simple slogan" (p. 28).

The problem addressed by this study is the need to accurately understand prominent, contemporary meanings and rationales as a basis for developing consensus in nursing of the client advocate role. As a step toward this goal, this study will attempt to confirm or modify Winslow's typology of definitions and provide an in-depth analysis of these definitions.

Theoretical Framework

According to Winslow (1984), nursing is evolving from an ethical attitude of loyalty to the physician to one of advocacy for the client. In this evolution, however, Winslow found five ambiguities and potentials for criticism.

1. The meaning of advocacy needs clarification.

Winslow found at least seven different ways in which nurses define client advocacy: (a) doing what is best for the client; (b) helping the client to obtain needed health care; (c) assuring quality care; (d) serving as liaison between the client and the health care system; (e) defending the client's rights; (f) assuring exercise of self-determination on the part of the client, (g) assisting the client to deal with fear. The author does not identify specifically the source of the majority of these definitions. The first definition, doing the best for the client, is a broad, "construed" way that encompasses all nursing actions in general. The next four definitions are types of specific actions most nurses have in mind in relation to being a client advocate. Winslow finds assuring exercise of self-determination for the client as being the most well analyzed of the definitions. Gadow (1983) has written extensively in relation to this definition, and Winslow holds her work as a pattern to be followed in bringing clarification to the other definition. The last definition, assisting the client to deal with fear, falls under the same classification as those that nurses recognize as specific advocacy behaviors.

2. State nursing practice acts need revision to include this behavior.

Since few state nursing practice acts have been revised to include this behavior, many legal questions arise when the nurse acts as client advocate. At the present time, threat of retaliation and loss of professional and economic security are bound to have a deterrent effect on the nurse's willingness to act as client advocate.

3. Patients and families are often unprepared to accept the nurse as advocate.

Winslow finds patients and families view the nurse in the traditional role of loyal soldier, substitute parent, assistant physician, or even handmaiden. Although nursing laments this fact, the public image of the nurse will not readily change.

4. Advocacy is frequently associated with controversy.

Advocacy events are fraught with discord in any profession. The challenge is to refrain from being unduly contentious and to prepare new graduates to deal with the conflict associated with advocacy.

5. The advocacy role results in conflicting loyalties and interests.

The most difficult aspect of these ambiguities is a dilemma concerning when the role of advocacy must take precedence over the legitimate concerns of loyalty. An ethic of advocacy cannot be called adequate without a place for the virtue of loyalty. Winslow states these five concerns are impediments that must be overcome if nursing's new ethic of advocacy is to be effective.

Winslow offers no explanation for the divergence of opinions of the client advocacy role. Since he does not substantiate the existence of such a wide range of definitions, the purpose of this study is to determine whether or not these definitions adequately represent the way in which nurses define their

role as client advocate. In addition, consideration will be given to the existence of other contextual factors that play a part in the lack of consensus held by nurses of this role.

Main Research Question

Is Winslow's typology of meanings for nurse advocacy adequate to describe, and serve as a basis for explaining, the diversity of meanings given to it by registered nurses?

Winslow found, in an extensive review of the nursing literature, nurses define their role as client advocate in a variety of ways. The intent of this study is to determine whether or not these definitions represent the manner in which a random sample of registered nurses define the client advocacy role. A contemporary approach was used to determine the validity of Winslow's findings.

Research Questions

Is there evidence in the historical development of the nurses' code of ethics of elements/characteristics of client advocacy?

The term, client advocate, does not appear in the nursing literature until the 1976 revision of the "Nurses Code." Nurses recognized, however, in the early years of practice that confidence in the physician was often not merited or warranted. In the past, nurses have dealt with this problem by manipulating the environment rather than confronting the physician. The definitions identified by Winslow seem to support this behavior. Such words as doing the best for the client, obtaining needed care, and assuring quality care seem to indicate a passive response to the client's need. While words such as defending the client's rights and assuring self-determination for the client indicate a more active type of advocacy behavior.

Advocacy is defined (Webster, 1976) as the act of pleading the cause of another. An advocate is one who speaks or writes in support of a person or cause. Nurse authors (Kohnke, 1982; Adams, 1978) define client advocacy as the act of loving and caring, as defending the rights and best interests of the client. Traditionally, nurses were responsible to the client only through implementation of the medical care plan. Advocacy refocuses this responsibility to the client and, as such, represents a mature professionalism.

Professionalism has been defined in a variety of ways. Originally, the term referred to the profession of the religious person. During the latter half of the nineteenth century, a professional was one who had social status, education, and may not have worked for a living. Industrial society portrays a professional as one who serves a client based on a scientific body of knowledge, a peer colleagueship answering to none outside the profession, and a private, individual relationship with a client.

Autonomy, a characteristic of professionalism, indicates the degree to which an individual acts as an independent agent. This behavior in turn indicates an acceptance of responsibility and accountability to the client.

Does Winslow's typology of definitions accurately and comprehensively represent the diversity of advocacy interpretations by registered nurses?

1. Does Winslow's typology include all of the advocacy interpretations given by registered nurses?

2. Are any of the statements contained in Winslow's typology superfluous?

3. Is there a tendency for one or more advocacy interpretations to be dominant?

4. If it does appear, what is responsible for the discrepancy between Winslow's findings and research findings?

5. What is the relationship between the frequency of selection of a particular interpretation and one or more of the following: (a) type of basic educational program; (b) age; (c) date of completion of program; (d) level of educational preparation, and (e) area of practice (over past five years).

A typology is the study of, or study based on, the study and analysis or division of humanity based in terms of social types (Webster, 1976). Typologies are classification systems made up of categories dividing some aspect of the world into parts (Patton, 1980, p. 306). In this study, Winslow's definitions represent the way in which nurses define their role of client advocate. These definitions represent professional behavior as the actor's definition of human events. Factors influencing these opinions are age, basic educational preparation, and area of nursing practice over the past five years. A consensus around any one definition is of interest to the investigator.

What contextual factors exist that can help to account for the lack of consensus among nurses of their role as client advocates?

A contextual factor is a factor or phenomenon occurring before the 1976 revision of the "Nurses Code," and exists at the present time. Any contextual factor is relevant to the lack of consensus of nurses of their role as client advocate. Client advocacy is a complex concept that did not arrive at the present state of confusion without significant involvement of other factors affecting nursing. In analyzing the social interactions between nurses and other health care professionals, a major factor was identified as well as several contributory factors relating to the major factor.

Speculative Question

What meaning of advocacy has the most promise to give direction to nursing practice?

The purpose of gaining consensus of the practice of client advocacy in nursing is to improve quality of client care through a clearer understanding of the obligations of the role. Can it be assumed that the interpretation chosen most frequently is also the professional behavior that will assure this outcome? Have nurses chosen this behavior intuitively? What is the relationship between the interpretation chosen most frequently and the future of nursing? What is the relationship with quality client care?

Method of Inquiry

The variety of definitions found by Winslow in his review of the nursing literature were submitted to a random sample of registered nurses in the state of Virginia. The purpose was to determine whether or not the definitions found by Winslow were viewed by nurses as defining the role of the nurse as client advocate, adequately and accurately. Any additional ways nurses hold for defining this role, any definitions more significant than others, any definitions felt not to define the role, were determined.

A review of the professional nursing literature was carried out to identify contextual factors that contributed to the lack of consensus held by nurses of their role as client advocate. In addition, the nurses' code of ethics was analyzed for elements of client advocacy prior to the definitive statements in the 1976 version.

Contextual factors affecting the variety of definitions expressed by registered nurses included a major factor--the nurse-physician relationship and the role conflict involved in this relationship. In addition, certain elements of

the development of nursing as a profession were considered as contextual to the nurse-physician relationship and the variety of opinions held by nurses of their role as client advocate.

Contemporary data were collected from a random sample of nurses registered to practice in the state of Virginia. These data determined the degree to which these nurses agreed with Winslow's typology of definitions and the expression of additional definitions. A survey tool was constructed, using a Likert-type scale to arrive at a numerical expression of this agreement. The tool gave the respondent an opportunity to define client advocacy in one's own words. The responses to these questions were content analyzed using Winslow's typology as a framework. The degree of agreement with the typology was noted and any additional definitions described. The degree of agreement with the typology of definitions was examined according to demographic and professional data supplied by the respondent.

Structure of the Chapters

Chapter 1 presents the nature and significance of the problem, theoretical framework, research questions and the method of inquiry. Chapter 2 is a review of the literature on client advocacy, role theory and professionalism. Chapter 3 is an analysis of the development of the nurses' code of ethics and the identification of elements or characteristics of client advocacy. Chapter 4 is an analysis of the findings of the survey of registered nurses in the state of Virginia. Chapter 5 examines contextual factors affecting the development of the role of the nurse as client advocate. Chapter 6 summarizes the findings of the socio-historical and contemporary analysis of the lack of consensus of nurses of their role as client advocate.

CHAPTER 2

REVIEW OF THE LITERATURE

The review of the literature will not be limited to that of client advocacy. Because of the use of the term "role" when referring to the nurse as client advocate, it is appropriate to review the literature of role theory, particuarly as it relates to role change. The concept of client advocacy assumes that nursing is a profession. Therefore, it is also appropriate to review literature clarifying the professional status of nursing. It is also pertinent to this study to include a review of the chronological development of the code of ethics by the professional nursing organization, and the revisions of the code.

Role

Biddle (1979) defines the subject matter of role theory "to concern behaviors that are characteristic of persons within contexts and the various processes that are used to predict and explain these behaviors" (p. 4). The major concepts of role theory are identified by Biddle as behavior, role, identity, position and expectation. Behavior is defined as things done by a person, that can be observed. Role consists of those behaviors characteristic of one or more persons in a context. Identity is a symbol used to designate a human being, while position is an identity that designates a commonly recognized set of persons and is different from role. Expectations are the behaviors expected of persons that fill a social position. These expectations can be norms, values and/or feelings. Conway (Hardy & Conway, 1978) views role theory as representing a collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role,

or under what circumstances certain type of behaviors can be expected. According to Conway, the word role has its roots in theatrical usage, and refers to a part one plays or is assigned in a drama. It began to appear in behavioral science literature as early as the 1920's, its usage increasing rapidly since that time. There is an associated body of terminology that has grown up with the concept. At least one author (Fried, 1978) declines to use the sociological approach to the use of the term "role." He does not find any hidden significance to the term but applies it in the context of his theory of right and wrong. Fried sees the term as drawing attention to two things: first that the theory of right and wrong leaves us discretion to determine how we shall live our lives; and second, that our choices do fall into patterns, determined in part by recurrent patterns in our circumstances and in part by the system of positive and negative rights. He associates judgment with roles such as the obligations of friendship or of kinship, the requirement of loyalty of a doctor or lawyer to those in his charge, the obligations of public officials to those they serve. Once one has assumed a role, it binds with the obligations of right and wrong.

Talcott Parsons (1951) views the elementary unit of the social system as the act. The act is a process of interaction between its author and other actors. Status role is seen as a higher order unit than the act. Status role is the structure of the relations between the actors, and the entire social system as a network of such relationships. The processual aspect is what the actor does in his relations with others, seen in the context of its functional significance for the social system. Parsons differentiates between status and role, the former is a positional aspect--that of where the act in question is located in the social system--in relation to the system; role is the orientation

to other actors, acting, not serving as an object. This is the status-role bundle, units of the social system.

Profession

Biddle (1979) finds professions are occupations whose roles involve interaction with human beings, whose performance is based on a long period of training and who is accounted expert. The associated roles tend to be performed in private and for which an explicit code of conduct in the form of rules governing the role, are set and enforced by its members. Occupation is defined as a social position based upon a role that is performed for remuneration. Exceptions may exist, but when all or most of the above criteria are met, Biddle states that the occupation is considered a profession. Social selection (they choose us) and personal selection (we choose them) begins the new identity. Socialization is the process whereby the neophyte assumes the behaviors characteristic of the social position and the role. Biddle finds social systems are slow to change.

The nursing literature identifies nursing as a profession as early as 1903. Sadie Heath Cabaniss, in an address given at the 1903 meeting of the Nurses' Associated Alumnae of the United States (forerunner of the American Nurses Association), made the following statement: "Possibly each of us has realized his full meaning; this seems the sentiment of a professional, the passing on to our successors of what we have gained, preserved or treasured." While the major topic of the meeting was, "The Science of Right Conduct," application was made to professional duties and obligations.

Mastal, writing in the Virginia Nurse (Winter 1985-86) states, "Nursing as a profession, is only emerging...and the process of attained professional maturity is painful" (p. 43). The primary issue before professional nursing today is organizing its educational preparation for practice.

To have nurses educated in an institution of higher learning is a goal that has been in the forefront of nursing since the early decades of this century. Economical and political forces continue to divide nursing education into three types of settings--the hospital, the community college and the four-year baccalaureate program. Since 1965, the professional organization holds the position that the baccalaureate degree should be the entry level into the profession.

In an attempt to clarify the professional issue, Mastal (1985) discusses the status of nursing as a profession using in a loose manner, five criteria attributed to Abraham Flexner--the existence of a code of ethics, peer colleagueship, collaboration with others, autonomy and a body of knowledge. She confirms the existence of a code of ethics, finds peer colleagueship has been attained at least in the area of quality of care, identifies the increased educational preparation as a way of improving collaboration with others, and nursing is moving toward autonomous practice and the establishment of a body of knowledge.

Two factors are identified as giving assurance of greater autonomy--the move by nurses in general to accept principles of authority, responsibility and accountability, and the emergence of independent practitioners. One indication of this is seen in that during the period from 1973 to 1985, 30 states have passed reimbursement legislation recognizing the services of a limited number of nurses practicing in specific areas such as nurse midwives, psychiatric nurses or nurse anesthetists (The American Nurse, 1986). Others within the profession see the role of the nurse in an extended or expanded arena of practice as the "Promise of Nursing." Loretta Ford, Ed.D., R.N., FAAN, writing in the same issue of The American Nurse, describes how she and a pediatrician, Henry Silve, M.D., began a program for what they identified as

"nurse practitioners" at the University of Colorado Medical Center in 1965. They modeled their program on the characteristics of the nursing profession as described in the professional journals of the day. Nursing was described as clinical in nature (practice and research), collegial and collaborative in relating to other professionals, and accountable and independent. Ford states that these objectives and requirements and this view of nursing are still central to the nurse practitioner movement and to the nursing profession.

Hall (1982) criticizes the "attribute approach" to defining a profession. He feels that there are other characteristics that are more contemporary than the traditional parameters identified by Flexner and others. Hall identifies power, the employed professionals and the professional association as the factors that should be looked at when one is determining the professional status of an occupational group. Power is paramount, providing the capacity to establish agreed upon credentials, and to demand and receive reasonable levels of compensation. Strains experienced in the work place often run counter to the highest standards of professional practice. The nurse often finds that there are other professional groups in the work place struggling to attain professional status. Power again is identified as the answer to this dilemma. Hall identifies the professional association as the only real source of power for establishing nursing as a profession and supporting its members as paid professionals.

Segal (1985), viewing the professional issue from a legal standpoint, identifies advantages of being held responsible for professional practice that results in malpractice rather than negligence charges. Malpractice charges involve statute of limitations that govern the time limit during which a lawsuit may be brought, standards of care upon which the defendent's actions

will be judged, and the calling of an expert witness to aid the court in determining the proper standard of care. The court does not recognize the fact that the nurse exercises any independent judgment on life and death matters, nor are there clearly established standards of care, particularly as they could relate to scope of practice. At times, the court will call another nurse as an expert witness, but legally all that is required, as the yardstick by which the nurse's actions are judged, is conduct that any prudent person would carry out in a similar situation. Segal makes a point for the establishment of the baccalaureate degree as the entry level into professional nursing since sometimes the educational preparation of the defendent decides the court's approach to an individual case.

Advocacy

The concept of client advocacy in nursing is supported by the "Nurses Code" as accepted and promulgated by the American Nurses Association (1976). This code contains three statements encouraging the nurse to protect the client's rights, to safeguard the client and the public against incompetent, unethical or illegal practice of any person, and to hold themselves responsible and accountable for individual nursing judgments and actions. Silva (1984) maintains that according to Levy's criteria--statement of purpose, specificity and inclusiveness and enforceability--it is a valid code.

The code was first promulgated in 1950, preceded in 1926 by a suggested code, and in 1940 by a tentative code. These codes more than likely were inspired by the "Nightingale Pledge," widely used by nursing since the turn of the century. A brief analysis of these codes as well as a copy of the Nightingale Pledge are included as Appendix A.

Nursing is not the only profession that functions in an advocacy role.

Law, social work, and persons who work with the mentally retarded also find themselves in an advocacy role.

Law

In criticism of the adversarial system extant in American courts, Ball (1981) states that the lawyer is an advocate for the client. In this role, he is to win if at all possible without violating the law. Truth and victory are virtually incompatible. Frank (1969) describes the adversarial system as one in which the judge is equal to an umpire and the opposing counsel has final authority. The adversarial system is designed to ensure the demise of the inquisitorial system. Contending forces and cross examination will reveal the truth. Cataldo (1973) states that the best answer can only be derived when two opposing sides are immersed in a real dispute and pit their full faculties against each other.

Social Work

Social workers are frequently placed in a position in which they serve as a client advocate in an adversarial process. The social worker tries to persuade a system to decide in favor of a client. This role is sometimes incompatible with their philosophy of self-determination for the client and social workers find themselves in an adversarial position with regard to lawyers. They would like to improve this relationship (O'Neil, 1984). Adams (1971) finds that it is sometimes necessary to co-opt the services of a generic agency that is not initially receptive to accepting the client who is mentally retarded. Mendelsohn (1980) defines a social work advocate as one who represents the consumer, often helping another agency provide more or better services to a consumer. As advocate, the social worker experiences role conflict since he/she represents the patient to the hospital authorities,

while also having the responsibility of informing the patient of his confidentiality rights. Siporin (1975) identifies two types of advocacy tasks—class advocacy action with a group of agency administrators, or case advocacy, calling attention of a community to the unmet service needs of a particular client or set of clients. This process, Siporin states, can make for strain and pressure on the professional social worker who is an employee of an agency. The author advises the worker to bring about change by "pyramided influence" through effective leadership and accountability arrangements—in face of administrative mismanagement, incompetent supervisors, unresponsive boards and intraorganizational tension. The social worker is encouraged to support legislative reform by providing data about social needs and problems.

The Mentally Retarded

Advocacy programs for the mentally retarded revolve around the goal of realizing the legal rights protecting dependent persons. Litigation is a major tool for access to justice. Alternative forums, such as administrative hearings, human rights committee, and other mechanisms for handling complaints are also needed to secure access to speedy and efficient remedies. Consumers, the advocacy movement, and self-advocates should continue to press for effective grievance procedures in residential care or other service settings. Three developments are identified by Birenbaum and Cohen (1985). First, retarded people, like all others in society, are acknowledged to have definable legal and human rights. Second, older views that permitted the summary divestment of human and legal rights are rejected. Third, organized society has taken the first step to increase the probability that the retarded will actually enjoy and exercise their legal rights. Yet implementation of programs to protect legal rights can lag behind statutory enactments and, in general, the support for quality advocacy has been woefully limited.

Client Advocacy in Nursing

The position of professional nursing regarding the assumption of the client advocacy role is similar to social work, identifying and attempting to meet the needs of the client. This stand also relates to work with the mentally retarded, assuring their rights are protected. However, nurses are cautioned when working as a client advocate not to become adversarial. Collaboration is stressed rather than confrontation.

The nursing literature puts forth certain beliefs about the role of the nurse as client advocate. Gadow (1983), who has written extensively on the subject of advocacy, finds the phenomenon is a partnership, based on the ethical norm of truth telling, displacing any form of coercion. Curtin (1979) espouses a humanistic rather than a legalistic approach. She urges that the client be provided information how and when it is wanted. According to Curtin, the client loses humanity by not being able to make decisions and becomes less human when independence is lost. Kohnke (1980) agrees but urges that the person not only be informed but also be supported in the choice once it is made. This support is particularly needed when well meaning family and significant others, including the physician, seek to triangle the nurse into the situation. The nurse is urged to influence the client to change his/her mind about the decision. Donahue (1978) is concerned that assurance is given that the person has input into any decision affecting their health. She sees the nurse as the client's sponsor, supporter and counselor.

Leddy and Pepper (1985) summarize these concerns by identifying the primary purpose of the role of advocate as supporting the client's rights in three areas--a right to a nurse-patient relationship; a right to health care; and a right to the preservation of responsilbility for one's own health care.

These authors view advocacy as the use of the basic principle of truth telling, and the assurance that the person has the information needed to act in one's own behalf in a free, independent manner.

The literature addresses what happens when the nurse assumes the role of client advocate. Gadow (1983) states that priority should be given to the nurse-client relationship because the nurse is acting as a humanitarian. She defines nursing as a moral art and the end or purpose as the welfare of other human beings. She states it is the nurse's right to intervene and that the client's right to make informed decisions, in the face of disagreement on the part of others, reinforces the nurse's right.

Kohnke (1980) and Leddy and Pepper (1980) stress the problem of conflicting loyalties and the threat of repercussions as a result of these conflicts. These authors also stress maintaining an advocate and not an adversarial role. The 1940 code stressed loyalty to the physician. The 1950 official code, however, stresses loyalty to the hospital. By 1976, the nurse's loyalty moves to the client.

Smith (1980) described the hazards associated with acting as client advocate. Noting that the incidence of morbidity and mortality had risen significantly in maternal and infant statistics, Smith conferred with nurses and physicians, who agreed that a problem might exist. Smith proceeded to take steps to rectify the situation, even though the nurses and physicians subsequently chose to ignore the potential problem. When her support melted and she was told she was to be punished for her stand, she resigned her position.

Stanley (1979) describes the Tuma case of Twin Falls, Idaho. Widely publicized in the nursing literature, Tuma was deprived of her license and her

faculty position because she discussed with a patient dying of leukemia alternative approaches to treatment. Although the decision was eventually reversed by the Idaho Supreme Court, this nurse found her actions resulted in a total disruption of her personal and professional life.

Nowakowski (1984) describes the success of her efforts to allow patients to make decisions based on what they think is best for themselves. Functioning as a faculty person in an acute care setting, she and her students interact with patients at the request of a staff nurse. Nowakowski uses three major concepts in her approach to patients--self as doer, awareness and interpretation, and accountability. In reviewing her approach, the basis of her success is her ability to work within the system, without compromising her beliefs. She considers the rights of the physician as well as her employer. Her activity is based on the principle of human interaction, very similar to that described by Curtin (1979).

The literature also identifies what can be characterized as benefits to the nursing profession, as a result of assuming the client advocacy role. Leddy and Pepper (1985) see advocacy as a form of scholarly activity, giving legitimacy to nursing as a profession, and at the same time influencing in a positive manner the public image of the nurse. This will eventually assure autonomy and control over practice when advocacy is viewed as an ethical principle underlying nursing practice.

Curtin (1979) believes that advocacy is the basic concept of nursing. The profession, she feels, must take steps to change environmental factors that prevent the nurse from sharing information with the client. Donahue (1978) sees advocacy as the cost the profession must pay to accept a leadership role--to suffer calumny, surrender security, and risk both reputation

and fortune, as have nursing leaders of the past. She calls for a philosophical analysis of the ethical issues involved, addressing the fundamental nature of the relationship between a person who needs care and one who assumes responsibility for rendering that care.

Nursing literature published around the time that the ANA promulgated the 1976 "Nurses Code" focuses on the philosophical aspects of the assumption of the advocacy role. The more recent nursing literature reveals a trend to identify how these philosophical statements have affected the practice of nursing.

Swider, McElmurry and Yarling (1985) examined the priorities reflected in decisions reported by 775 senior baccalaureate nursing students when presented with a moral dilemma. The sample population represented 16 midwestern colleges and universities. Student analysis of the situation were categorized as patient-centered, physician-centered or bureaucratically-centered. The investigators drew the conclusion that while the majority of the students were bureaucratically-centered, the students were confused and unclear about the end point of the nurse's responsibility in such situations. The investigators further suggest that the same moral dilemma be administered to practicing nurses to determine similarities and/or differences with the nursing students. The investigators found that conflicting loyalties and responsibilities create problems in arriving at clear answers to moral dilemmas.

Weiss and Remen (1983) studied a stratified sample of nurses, consumers and physicians. These subjects met together consistently in a multidisciplinary dialogue for 20 months. The general topic for discussion was the roles and relationships of nurses, physicians and consumers. The subjects

were to make recommendtions as to how these persons could function more effectively. Their findings revealed that nurses demonstrate a lack of identification with the nursing profession, tend to invalidate their professional expertise, and show a reluctance to assume greater responsibility for their actions. While the investigators do not claim to make sweeping generalizations, they identify a need to carefully examine the beliefs and behaviors of mainstream nurses.

CHAPTER 3

THE DEVELOPMENT OF THE NURSE'S CODE OF ETHICS AND

THE PRESENCE OF CLIENT ADVOCACY ELEMENTS

Introduction

The purpose of this chapter is to review the various versions of the code

of ethics for nurses for the presence of advocacy behaviors prior to the 1976

version of the code.   The interpretive statements in the 1976 version

recommends that the nurse act the role of the client advocate.

A review of these versions of the code reveals that certain aspects of

advocacy behavior is present in all versions.   The presence of these various

aspects is not consistent in the various versions, and this helps to understand

the lack of consensus among nurses of their role as client advocate.

A Code of Ethics and Modern Nursing Era

Modern nursing began with Florence Nightingale and is based on a

professionalism that developed out of the need to assure quality care for the

client.   Nightingale believed in education of nurses and the desirability of a

degree of control over nursing practice.   The Nightingale system came to this

country and provided the basis for quality nursing practice.   A code of ethics

is usually indicated to assure the public of the moral intentions of the

profession.   Professional nursing, while in its infancy, decided against a code

of ethics because of the experience of the medical profession with the

institution of a code of ethics.

The medical profession developed a code in 1847.   The code caused much

contention and conflict and failed to serve adequate purpose.   The essence of

the problem arose from an inadequate understanding of such a code and the

purpose it would serve.   A code was felt to be a set of rules and regulations

that, if not followed, called for punitive steps to be taken. Nursing declined to adopt a code until well nto the twentieth century. However, in the place of such a code, a pledge was developed and became known as the Nightingale Pledge.

The Nightingale Pledge

Little is known about the author or origin of the pledge. It is associated with the Detroit Hospital School of Nursing, and was first used around the turn of the century. The pledge is found in Appendix A.

The pledge is divided into nine statements of obligation. The first statement, "I...will not knowingly administer any harmful drug," is the first of two statements that are related to advocacy behavior. Pharmacology, one of the basic medical sciences, is also basic to nursing. This information contributed to the nurse's ability to provide quality nursing care. The statement also indicated the nurse's willingness to accept increased responsibility and accountability to the client. There is no indication of procedures to follow should such a situation arise.

The second relevant statement, "With loyalty I will endeavor to...devote myself to the welfare of those committed to my care," acknowledges accountability to the client on the part of the nurse. There are no explanatory or interpretive statements to give understanding to these statements.

A code of ethics was accepted by the ANA in 1950. Prior to this, two versions were submitted to the House of Delegates of the ANA and, in both instances, were returned to the Committee on Ethics for revisions.

The 1926 Code of Ethics

In 1926, a code was developed in order "to crystalize into language those ethical principles which shall be a guide to conduct" (AJN, 1926, p. 599). This code is divided into broad paragraphs clarifying the relationship between the nurse and the patient, the medical profession, allied professions, to other nurses and to "her" profession.

The introductory remarks to this version of the code point out the responsibility of the nurse to maintain "her" own physical and mental health. Economic independence and self-realization are deemed equally important. The nurse is exhorted to become registered in one state and to be a member of her professional organization. No nurse should put "remuneration" above the "ideal of service." Much of this language refers to the threat of union organizing activity. The professional organization did not perceived itself as a union. Consequently, this activity was generally not acceptable to nurses and to the professional organization. The nurse is viewed and views "herself" as a "public servant" and union activity was seen as a threat to this service. In later years, collective bargaining would be recognized as a tool the nurse could use in becoming a client advocate.

The relationship of the nurse to the physician is described as one of mutual respect. The nurse should be aware of the provisions of the medical practice act in his/her own state. Intelligent and skilled nursing service will assure the nurse of co-worker status with the physician. These situations are related to client advocacy since two relevant characteristics of the client advocacy role are pointed out. First, to gain respect of the physician, the nurse must act intelligently in providing nursing service. Secondly, the nurse must be aware of the limitations set by the medical practice act. Loyalty to the physician is stressed, but loyalty to one's fellow nurse is also urged.

The loyalty to one's fellow nurse should not take precedence over loyalty owed to the larger community. Hence, the nurse should "bring to light any serious violation of the ideals expressed herein" (AJN, 1926, p. 601). This is an indication of client advocacy behavior for the client but directed toward nursing colleagues. Loyalty to the client, as such, is not mentioned. Social change in the 1930's resulted in a second draft of a code of ethics.

The 1940 Code of Ethics

The introduction to the article (AJN, 1940) presenting this code to members of the profession points out that the reason for a code is that it would be "useful to nurses in solving their basic professional problems" (p. 977). While these problems are not enumerated, it appears that defining nursing as a profession is one of the primary problems. The article includes six characteristics of a profession adapted from an article published in the Journal of the National Education Association (September, 1939). The AJN article enumerates some "fundamental attributes" abstracted from the teaching profession. These attributes refer to a sound educational preparation and a continuing education, service above gain, and a professional organization. The article does not clearly relate these characteristics to nursing. However, it points to several other factors. First, nursing should assume responsibility to protect the health of people. Secondly, while the body of nursing knowledge is small, it is essential to the whole of health care. Thirdly, the nurse has a dual function--to prevent disease and promote health. Finally, the nurse is essentially a teacher, an agent of health regardless of where "she" works. All of these statements acknowledge the nurse's responsibility for practice without specifically indicating loyalty to anyone, and accountability to the client.

This version of the code has eight articles dealing with relationship of

the nurse to the profession, to the patient, to the medical profession, other nurses, employer, public, others and "herself!"

Article A is a general statement of responsibility of the profession. The code exhorts nurses to secure and maintain nursing legislation for the protection of the patient. The nurse is encouraged to know the legal limits of the nurse practice act in "her" state. This knowledge sets legal limits to the activity of the nurse as a client advocate. These statements are relevant to practice as a client advocate.

Article B, on relationship of the nurse to the patient, does not refer to the nurse acting as a client advocate. There is, however, a sense of commitment to the client.

Section 1. The nurse should carry out professional commitments and activities with meticulous care, with a generous measure of performance, and with fidelity toward those whom she serves (AJN, 1940, p. 978).

Article C, relationship to the physician, calls for mutual understanding and respect based on loyalty to the physician. The nurse is exhorted to exercise reason and intelligence in carrying out physician's orders. The articles does not outline a procedure to take when physician's orders conflict with intelligence and reason of the nurse. Criticism of the physician should be shared first with "him" and, if necessary, to the "proper authorities" or to the local medical society. This article indicates the responsibility the nurse must assume for "her" actions. The nurse is again reminded to work within the legal limits set by medical and nurse practice acts.

This version of the code was developed in order to provide guidance for the "professional" nurse until a final edition was developed for acceptance by the profession. The committee developing a code "welcomed comments and

suggestions." This version of the code indicates a beginning awareness on the part of the nurse, of the growing sense of responsibility to the client.

The Official Code of Ethics - 1950

The 1950 code, accepted by the ANA House of Delegates, consists of 17 articles. The following articles relate to client advocacy.

Article 2 stresses the need for the nurse to be adequately prepared to practice, and to maintain that adequacy "with continued reading, study, observations and investigations" (AJN, 1950, p. 196). This article points out the need not only for a sound educational basis but also the need to continue to build on that knowledge. Article 7 points out the need to follow physician's orders intelligently to "avoid misunderstandings or inaccuracies by verifying orders" (p. 196). This article also states that the nurse should refuse to participate in unethical practices. This is a new statement and gives the nurse the right to refuse to participate in morally questionable practices. Since there are no interpretive statements with this version of the code, unethical practices are not defined nor elaborated.

Article 8 describes the loyalty of the nurse to the physician and other members of the health care team. Any incompetency or unethical practices should be exposed "but only to the proper authority" (AJN, 1950, p. 196). Again, these terms are not defined or elaborated. The nurse is required to achieve a balance between loyalty to the physician, and to others, while deciding what behaviors on the part of these persons come under the category of incompetent or unethical practice. The article introduces the idea that the nurse is responsible to the client when such behavior occurs, and this plainly supersedes loyalty to the physician. This requires advocacy behavior on the part of the nurse.

Articles 15, 16 and 17 describe nurse behaviors that support the various laws affecting the nurse's practice, and rights and responsibilities as a professional, with regard to the health needs of the public at "state, national and international levels" (AJN, 1950, p. 196).

This published and accepted code of ethics opened the way for the ultimate level of advocacy behavior exhorted in later editions of the code. The code was developed through research and compilation of approximately 5,000 opinions of what should be included and what would be reasonable to implement. Interpretive statements would be forthcoming if the profession desired them. None of these behaviors called for in this version of the code of ethics caused any particular consternation on the part of nursing professionals, and the code was viewed as being implementable.

The First Revision - 1960

This version maintained the 17 articles of the first code. While many of the articles remained the same, the tone of the 1960 code of ethics directs the nurse to assume an increased responsibility for her/his actions. The articles referring to the nurse's participation in public affairs is moved from the last to the fifth article. The wording of another article emphasizes the nurse's responsibility to the client. The article referring to nurse-physician relationship is now included in a statement referring to the "nursing association and other members of the health care team, and the physician" (AJN, 1960, p. 79). This article moves from number 8 to number 16. The article referring to participation in unethical procedures and the reporting of incompetence and unethical actions to the proper authorities, remains essentially the same.

This first revision of the code reflects the attitudes of the 1960's rather than the preceding era. The language depicts a nurse who is functioning more

independently. Article 9 reflects this by pointing out the need for the nurse to "assume responsibility for individual professional actions." This language describes for the first time the individual functioning of the nurse. The latter part of this article continues to support the need for the nurse to know and uphold laws which affect the practice of nursing.

The Second Revision - 1968

For the first time, a revision of the code contains interpretive statements. There are only 10 articles to this version. Article 3 combines the recommendation to maintain professional competence and also accept individual responsibility for actions and judgments. The interpretive statement outlines the nurse's legal responsibilities for her/his own actions regardless of physician orders, or employer policies and procedures. This is a direct reference to client advocacy behavior and accepts that loyalty has moved away from the physician toward the client. Article 4 states, "The nurse acts to safeguard the patient when his care and safety are affected by incompetent, unethical or illegal conduct of any person" (AJN, 1968, p. 2582). The interpretive statement accompanying this article stresses the nurse's commitment to the patient's care and safety. It groups together for the first time incompetence, illegal and/or unethical behavior. "Any person" could include social worker, financial manager, nutritionist, etc. The nurse is urged to contact the other person involved before any recourse to appropriate authority. Should the need arise, a procedure to follow is outlined. Article 5 describes behavior with regard to the delegation of responsibility from the physician to the nurse and by the nurse to others of lesser education. This article points out the greater responsibility to be accepted by the nurse. Article 9 enjoins the nurse to become politically involved to "meet health care needs of the public."

The statements of this revision are brief. The interpretive statements are much lengthier and treat many things that will or might occur in the implementation of the articles. This revision is very close to the defined characteristics of client advocacy behavior. However, nowhere is the word advocate used. The nurse's commitment or loyalty, however, is oriented more clearly to the client.

The Third Revision – 1976

This revision is discussed elsewhere in this study, but it will be helpful to emphasize several points. Article 3 is similar to Article 4 of the 1968 revision. An exception is that the patient is now termed the client, and protection is extended to the general public. The interpretive statement regarding this article broadens the "person" referred to in prior versions to any member of the health care team or the health care system. The statement also is much broader since the behavior is to be recognized in anyone, regardless of professional identity. There is also a specific procedure to follow including reporting such behavior to the nurse's professional organization.

Article 4 also presents a unique and new obligation for the nurse to assume. This article urges the nurse to "assume responsibility and accountability for individual nursing judgments and actions" (ANA, 1976, p. 9). The interpretive statement here identifies the nurse as an autonomous practitioner and, as such, is to assume accountability for actions. The statement also includes "neither physician's prescriptions nor the employing agency's policies relieve the nurse of ethical or legal accountability for action taken and judgments made" (p. 10). These articles and interpretive statements represent the epitome of client advocacy behavior.

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Summary

Table 3.1 identifies the occurrence of client advocacy behaviors in the Nightingale Pledge and the various versions of the code of ethics. This categorization will be used to discuss the summary of information in this chapter.

The knowledge base and competency in practice is included in all versions. In addition, reference is made after the 1950 version of the code of ethics to the responsibility to participate in and conduct research to add to the body of knowledge of the discipline of nursing.

Responsibility for actions is mentioned in the pledge and in the 1940 suggested code of ethics. The statement returns to the code in 1960, and remains in subsequent versions. This may indicate that in earlier times when nurses cared for the sick in their homes, they may have been more acutely aware of responsibility for their actions. When nursing moved into the institution, the nurse may have felt less directly responsible. This results when more people assume responsibilities for the care of the client. When after 1960 quality of care may have declined, and clients' rights and other movements became strong, the nurse felt increased responsibility for professional actions.

Accountability for actions appears in the Nightingale Pledge and then does not reappear until the 1976 version of the code. Accountability for actions is a very important component of client advocacy behavior. Until this accountability is accepted by the nurse, the physician, and the public, client advocacy will not be an effective role.

Collegiality with the physician was more noticeable in the early versions. This collegiality may have been based on loyalty to the physician. As the nurse increased her sense of professionalism, loyalty and collegiality both

Table 3.1

Client Advocacy Behaviors and Their Occurrence in Historical Versions of the Code of Ethics for Nurses

Behavior	Code of Ethics						
	Pledge	1926	1940	1950	1960	1968	1976
Knowledge base	X	X	X	X	X	X	X
Responsibility for actions	X		X		X	X	X
Accountability	X						X
Collegiality	X	X	X				
Legal limitations			X		X		
Expose improper behavior				X(1)	X(2)	X(3)	X(4)

(1) associates in "her" profession

(2) in others

(3) of any person

(4) health care team and health care system

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declined. In an effort to attain independent practice in nursing, collegiality has received less emphasis.

Legal limitations are included in the 1940 and 1960 versions of the code of ethics. It should be remembered that in 1929 in the Phillipines, a nurse was found guilty of manslaughter in the death of a client. The death resulted when the nurse carried out a physician's order that she should have known was detrimental to the client. This may have precipitated the inclusion of such an article in the 1940 code, which was to help nurses deal with "their basic professional problems" (AJN, 1940, p. 977). Since the 1960 version begins to reflect the advent of an increased professionalism in nursing, the code reminds the nurse of the need to be aware of legal limitations. By 1968 and 1976, legality of practice had become a very generally accepted responsibility of the nurse.

All of the recognized versions of the code of ethics contain references to the nurse's obligation to expose harmful behavior on the part of the individuals, professional and nonprofessional, as well as the health care system. The 1950 version refers to "others," the 1968 version refers to "any person," and the 1976 version identifies any member of the health care team or the health care system. The latter is very broad but reflects a return to any person involved in the health care of the client.

A review of these versions of the code of ethics reveals that important characteristics of client advocacy behavior appears in all of the versions. Collegiality and legal limitations do not appear in the 1976 version. This omission has been discussed above and is reflective of the changing times and the attitudes of nursing about its professional status and image.

CHAPTER 4

SURVEY OF NURSES REGISTERED TO PRACTICE IN VIRGINIA

Introduction

The purpose of this survey was to determine if Winslow's typology of definitions accurately and comprehensively represent the diversity of advocacy interpretations held by nurses currently registered to practice in the state of Virginia. Other questions to be answered by this survey include: Does Winslow's typology include the full range of interpretations given by registered nurses? Are any of Winslow's definitions superfluous? Is there a tendency for one or more interpretations to be dominant and, if this is true, what is the explanation? The survey is also designed to elicit from respondents the age, level of basic educational preparation, highest degree obtained, and area of practice. This data is gathered to determine if there are substantial differences among respondents, and the respondents' agreement with Winslow's typology. A copy of the survey, cover letter and follow-up postcard are included as Appendix B.

Methodology

A random sample was selected from the population of registered nurses in the state of Virginia. The list of registered nurses was obtained from the Virginia Regulatory Board for Nursing. The list did not utilize any numbering system so one name was randomly taken from each 98 registrants. There were 44,758 nurses registered and a one percent sample, or 448 names were selected. Sufficient extra names were identified to replace any surveys returned because of incorrect address. After the initial mailing, a postcard follow-up was sent to those who did not respond within three weeks. All data were analyzed by

computing simple frequency counts and percentage differences to identify agreement with Winslow's typology.

The Survey Tool

The survey tool was constructed primarily to identify the degree of agreement of registered nurses with Winslow's typology of definitions of the client advocacy role in nursing. However, the tool also elicited demographic and professional data and respondents' personal definitions and an example of client advocacy in nursing practice.

The tool is composed of demographic and professional data and four questions. The first question asks the respondent to define the advocacy role. The second question asks for an example from clinical practice of the implementation of the role. The cover letter contains instructions not to turn to questions three and four, on the second page, until the first and second questions are completed. This instruction was given to prevent the information in questions three and four from influencing the responses to the first two questions.

The third question presented examples of the implementation of the client advocacy role, developed by the investigator from the clinical practice setting. During the pilot testing of the survey tool, respondents suggested the inclusion of these situations to help in interpreting the survey. The fourth question presented Winslow's typology of definitions to the respondent. Both questions three and four use a Likert scale to enable the respondent to indicate the degree of agreement with the statements. A copy of the cover letter and the tool is included in Appendix B.

Results of the Mailing

Four hundred surveys were mailed. One hundred thirty-eight responses, 34%, were eventually returned. Extrinsic factors may have affected the response. Two major snowstorms occurred immediately before mailing the survey, and there were indications of problems in the delivery of mail. Six of the responses were invalid due to the inactivity in nursing of these respondents. These were replaced. Four surveys were returned with a new forwarding address and were remailed. A copy of the follow-up postcard, mailed three weeks after the initial survey tool, is included in Appendix B.

Data Analysis

The data are analyzed in four parts. Part 1 presents demographic and professional characteristics of the sample population, age, basic level of education, highest degree obtained and area of practice over the past five years. Part 2 presents a content analysis of response to questions 1 and 2. Part 3 presents data gathered from responses to questions 3 and 4. Part 4 compares the respondents' definitions and practice situations and Winslow's typology and the investigator's practice situations.

Data Analysis: Part 1. Characteristics of

the Sample Population

Table 4.1 presents demographic data from the sample population. The largest percentage of respondents are in the 30 to 39 year age group. The second largest percentage of respondents are in the 40 to 49 year age group. These two groups probably represent the largest group of practicing nurses according to age.

Table 4.2 presents data on level of basic education for practice and highest degree obtained.

Table 4.1

Number and Percentages of Respondents by

Age (N=128)

Age	Number	Percent
20-29	23	18
30-39	47	37
40-49	34	26
50-59	14	11
60+	10	8

Table 4.2

Percentage of Respondents and Basic Educational

Preparation and Highest Degree Obtained (N=128)

	Number	Percent
Basic Educational Preparation		
Diploma	69	54
Associate degree	25	19
Baccalaureate degree	34	26
Highest Degree Obtained		
Baccalaureate degree-other	10	7
Master's degree	13	10

The largest percentage of respondents obtained educational preparation for practice in a diploma school of nursing. The second largest percentage were educated in a baccalaureate degree program. The smallest percentage received a baccalaureate after another basic educational program.

Seven percent of the respondents received a baccalaureate degree before or after their basic nursing education. These degrees were awarded in disciplines such as sociology or psychology, business, mathematics and music. Of these 7%, 42% reported having obtained a bachelor's degree in nursing after their basic nursing education. Thirteen of the respondents, 10%, reported having a master's degree. Ten of these degrees were in nursing. The three graduate degrees reported as not in nursing were in related areas or business.

Area of practice over the past five years is presented in Table 4.3. As expected, the largest number of respondents were from the medical-surgical nursing area. The second largest group represented a variety of critical care areas. The third largest group were community/public health nurses. For purpose of discussion and analysis of data, those nurses in practice areas from recovery room to the end of Table 4.3, or 16% of the total sample population, were classified as miscellaneous. For purpose of comparison, respondents to the present study were compared with a similar sample population obtained in connection with another study of registered nurses.

Table 4.3

Number and Percentage of Respondents by Area of
Clinical Practice Over the Past Five Years (N=121)

	Number	Percent
Intensive Care	23	19
Public Health	17	14
Pediatrics	10	8
Psych.-Mental Health	8	7
Medical-Surgical	26	21
Administration	6	4
Obstetrics/Gynecology	6	4
Geriatrics	6	4
Miscellaneous		
Recovery Room	3	2
Nurse Anesthesia	3	2
Operating Room	1	.8
Retired	2	1.6
Outpatient Department	2	1.6
Private Duty	2	1.6
Rehabilitation	1	.8
Nutrition Consultant	1	.8
Certified Biofeedback	1	.8
Education	3	2.0

Characteristics of the Virginia State Board of Nursing

Study Sample Population

The Virginia State Board of Nurse Examiners recently commissioned a study of registered and licensed practical nurses in Virginia. The major purpose of the State Board of Nursing study was to examine tasks being performed between these groups. The sample size, obtained by a random selection of nurses registered to practice in Virginia, was 2,000. Seventy-one percent returned the survey. Demographic and professional data collected by the State Board study provided a baseline by which to compare data collected in the present study. Table 4.4 compares data collected in the State Board and the present study according to age, setting of current practice, level of basic educational preparation and advanced degrees of respondents.

Comparison of Age of Sample Population

The respondents to this investigator's study differed in age distribution from the respondents to the State Board study. The investigator's sample population consisted of a larger percentage of nurses in the 36 through 40 year age group and a smaller percentage in the 50 through 64 year age group. This may demonstrate a greater interest in the investigator's topic of study in the 36 through 49 year age group.

Comparison of Areas of Clinical Practice of Sample Population

There were fewer responses from nurses in the medical-surgical nursing area of practice in the investigator's study than in the respondents to the State Board study. All other areas of practice represented in the investigator's study were larger than the State Board study. The greater percentage difference in the areas ranged from eight percent in critical care nursing to two percent in psychiatric nursing practice.

Table 4.4

Percentage of Respondents to Virginia State Board of Nusing Study and

Investigator's Study and Professional and Demographic Data

Data	Investigator's Study %	State Board Study %
Age		
Under 35	34	35
30-49	45	39
50-64	15	22
65+	5	4
Setting of Current Practice		
Medical-Surgical	21	26
Critical Care	19	11
Public Health	14	8
Pedlatrics	8	2
Psychiatric Nursing	7	5
Level of Basic Educational Practice		
Diploma	54	54
Associate Degree	19	21
Baccalaureate Degree	27	23

These differences may indicate a lesser degree of interest in or knowledge about client advocacy on the part of the medical-surgical nurses and a greater interest in or knowledge about the topic in the other clinical practice areas.

Comparison of Basic Educational Preparation of Sample Populations

The percentage of respondents from diploma programs are the same for both studies. The investigator's sample has a lower percentage of graduates from associate degree programs and a higher percentage of graduates responding who completed baccalaureate degree programs.

Comparison of Advanced Degrees of Sample Populations

The State Board study also gathered data of respondents' possession of an advanced degree. This is interpreted in the State Board study as a bachelor's degree after completing another basic educational program or a master's degree in nursing or other area. Table 4.5 presents data concerning advanced degrees in both sample populations.

There is a substantially higher percentage of respondents having advanced degrees in the investigator's sample, in both baccalaureate and master's degree. This may indicate a greater interest in, and knowledge of, nursing advocacy on the part of those respondents holding advanced degrees in nursing. This is consistent with the data from Table 4.4, demonstrating a higher percentage of baccalaureate graduates responding to the investigator's study than to the State Board study.

The State Board study represents a substantial number of nurses registered to practice in Virginia. A sample population of 2,000, and a 71% response rate, supports this statement. Using State Board data as a norm, it may be concluded that the respondents to the client advocacy study represent a somewhat distinctive group. Nurses between the ages of 36 and 49, with either

Table 4.5

Percentage of Respondents to Virginia State Board Study

and Investigator's Study by Highest Degree Obtained

Degree	Investigator's Study %	State Board Study %
Bachelor's Degree (Other)	8	1
Master's Degree (Nursing)	11	2
Master's Degree (Other)	2	1

a basic education from a baccalaureate program or an advanced degree seem to represent the population group within nursing most concerned about client advocacy in nursing.

Data Analysis: Part 2. Responses to Questions 1 and 2

Survey question 1 asked each respondent to define client advocacy in nursing. Question 2 asked each respondent to describe a nursing practice situation depicting client advocacy in clinical practice. Winslow's typology of definitions were used as a framework for analyzing the responses to these two questions. The client advocacy definitions identified by Winslow are:

1. doing what is best for the client;

2. helping the client to obtain needed health care;

3. assuring quality client care;

4. serving as liaison between the client and the health care system;

5. defending the client's rights;

6. assuring exercise of self-determination for the client, and

7. assisting the client to deal with fear (Winslow, 1984).

In analyzing the data, certain key words or phases were used to identify the respondent's intent in answering question 1. If the respondent used words such as doing best or best interest, it was recorded as definition 1, doing what is best for the client. The second definition, helping the client to obtain needed health care, was chosen if the respondent referred client problems to the physician. The physician is usually the nurse's first recourse in obtaining needed care for the client, and it was also necessary to differentiate the definition of obtaining needed care for the client from definition 4, serving as liaison. Definition 4 was chosen when the respondent indicated interaction on the part of the nurse with members of the health care team other than the physician.

If the respondent used the word quality in describing client advocacy behavior, definition 3 was selected as indicating advocacy behavior. Any responses that directly referred to client's rights, such as informed consent, were interpreted as definition 5. Although definition 6 is also an ethical consideration of client's rights, it was singled out if the respondent indicated behavior allowing clients to make decisions concerning their care. In those situations where the respondent used the term fear, the advocacy behavior was interpreted to be similar to definition 7.

Respondents Definitions of Advocacy and

Descriptions of Practice Situations

Data presented in Table 4.6 depict respondents' definitions and practice situations categorized according to Winslow's typology. Seventy percent of the respondents gave definitions that could be categorized according to the typology and 73% gave situations that were categorizable.

When defining client advocacy, respondents most frequently indicated obtaining needed care. The second definition given most frequently was acting in the liaison role. These responses indicate that 47% of the respondents define the advocacy role as intervening either with the physician or another member of the health care team.

The respondents most frequently described practice situations depicting the advocacy role as obtaining needed care for the client indicates the respondents still find advocacy behavior as intervening with the physician. However, 44% gave situations depicting violation of client's rights and inability to self-determine actions as depicting advocacy behavior in action.

There is a substantial difference in respondents' definitions and practice situation in doing best for the client and assuring quality care. Respondents

Table 4.6

Percentage of Respondents' Practice Situations and

Definitions (Questions 1 and 2) Categorized Acording

to Winslow's Typology

Definition	Definition (N=94)		Situation (N=91)	
	N	%	N	%
Best for client	16	17	1	1
Obtaining care	27	29	25	27
Quality care	9	9	1	1
Liaison	17	18	14	15
Client's rights	13	14	22	24
Self-determination	9	10	18	20
Assist with fear	3	3	10	11

less frequently gave situations depicting these behaviors as evidence of client advocacy behaviors.

It is difficult to determine the reason for the differences in responses to these open-ended questions. Further research may lead to a better understanding of how nurses do define their role as client advocate in definition and in clinical practice.

Respondents' Definitions and Practice Situations Not

Categorizable According to Winslow's Typology

Table 4.7 presents data gathered from responses to questions 1 and 2 that were not categorizable according to Winslow's typology. Twenty respondents, 17% of the sample population, gave definitions and described practice situations that could not be related to Winslow's typology.

The respondents most frequently defined client advocacy as achieving high level of wellness with teaching as a substantial second definition. In describing practice situations, respondents cited teaching most frequently as an example of client advocacy.

The remaining definitions and situations could not readily be categorizable. These definitions are presented Table 4.8, and practice situations are presented in Table 4.9. More definitions were given by respondents than were situations that could not be categorized.

Table 4.7

Respondents' Definitions and Practice Situations Not

Categorizable According to Winslow's Typology (N=20)

Categories	Definitions (N=20)	Situations (N=20)
Achieving high level of wellness	7	-
Teaching the client	6	12
Emotional support	2	1
Unethical medical behavior	-	2
Independence for client	2	-
Counseling	-	2
Role modeling	1	-
Incompetency (physician)	1	1
Medical malpractice	-	1
Autonomous nursing practice	-	1
Communicate with the client	1	-

Table 4.8

Respondents' Definitions Not Categorizable According to

Winslow's Typology

Statement:

Sees patient most often therefore cannot act as advocate.

Nurse present to assist client.

Be sure to answer patient's questions.

As a result of long and direct contact, nurse is in best position to determine if right action is taken where necessary.

Protect patient and nurse as a whole.

Accurate, timely, appropriate, cost effective care and purposeful.

Nurse should eventually put herself out of practice--make client independent.

Nursing process assures advocacy.

Multi-faceted--primary care with team implementation. Network with patient.

Investigates client's complaints.

Act in behalf of patient in matters of physical, emotional and spiritual care.

Table 4.9

Respondents' Descriptions of Practice Situations Not

Categorizable According to Winslow's Typology

Statement:

Bend the rules--allow blind man to take his cane to operating room.

Adequate home care referral.

Cambodian family adds animal protein to diet.

Act as coordinator of care, especially when client is not compliant.

Allow family to participate in physical care of comatose teenager.

Investigate client's complaints.

There is also some evidence to suggest that the respondents frequently associated the concept of advocacy in nursing with being an ombudsman. Terms such as investigate clients' complaints, determine if right action was taken, sees patient more often, answers patients' questions and coordinates care when client is not compliant, are examples of situations that would require an ombudsman.

One situation described by a respondent demonstrates the positive outcome of assuming an advocacy role:

An elderly patient who is still dependent for some self-care activities is being discharged to her home. The patient has told the physician that she has a household staff to care for her 'around the clock.' The nurse knows the patient's home situation and the fact that someone comes in to help her twice a week only. The nurse, as client advocate, speaks to the physician and social worker and together with the patient arrangements are made for the elderly patient to have home care after discharge from the hospital.

A second respondent shared the frustration experienced when an attempt to act as client advocate fails.

I work in Labor and Delivery--if I had a patient in labor needing pain medication I would get the patient to strongly plead with her physician if I felt the patient truly needed it, since I'd be working with the patient and the doctor just walked in to check on her. If this did not work, I'd again ask the doctor again.

In this situation, it is possible that the physician may have been medically correct in the care of this patient. A few words of

explanation, however, may have convinced the nurse that the physician had the best interest of the patient in mind by pursuing such a course of treatment. A client advocate must be a negotiator, one who is assertive, not aggressive or adversarial in the approach to a clinical situation.

<u>Respondents' Definitions and Practice Situations According to</u>

<u>Respondents' Age, Basic Educational Preparation and</u>

<u>Area of Clinical Practice</u>

The data obtained through content analysis of questions 1 and 2 were analyzed according to the demographic and professional characteristics of the sample population.

Age of Respondent

Table 4.10 presents data relevant to respondents' definitions and practice situations by age of respondents. The definitions highest in frequency given by the 20 to 29 year age group were assuring quality care and acting as liaison. The 30 to 39 year age group most frequently gave definitions similar to obtaining needed care, as did the 40 to 49 year age group and the 50 to 59 year age group. The respondents over 60 most frequently gave a definition that depicted the role of liaison as client advocacy in nursing.

The situations described most frequently by respondents in the 20 to 29 year age group depicted the advocacy role as defending the clients' rights. The 30 to 39 and 40 to 49 year age groups most frequently described situations depicting obtaining needed care. The situations described by the 50 to 59 year age group are evenly divided among five of the definitions of Winslow's typology. These five definitions are: assure quality care; serve as liaison; defend clients' rights; assure self-determination, and assist client to deal with fears. The over 60 age group also described situations depicting defending

clients' rights as the role of the nurse as client advocate.

There is little difference in how the various age groups defined client advocacy. The youngest and the oldest age groups chose situations involving defending clients' rights more frequently to describe client advocacy in nursing. The 30 to 49 year old age groups most frequently gave definitions and described practice situations depicting client advocacy as obtaining needed health care for the client. These differences may indicate that young graduates may be more idealistic and view advocacy in terms of ethical behavior, while the more mature nurse, having experienced the frustrations of clinical practice, interprets behavior seeking to improve client care as more realistically defining client advocacy. This difference between younger and older nurses raises questions about the ability of nursing to become a full-fledged, autonomous profession. The older respondent may be indicating the inability to act in practice in an ethical manner.

Basic Educational Preparation

Table 4.11 presents data relevant to the respondents' definitions and practice situations by their beginning educational preparation. Diploma graduates' most frequent definition could be categorized as obtaining needed care for the client. The associate degree graduate gave definitions in terms related to doing best for the client and defending the clients' rights. The largest number of baccalaureate graduates gave definitions relating to obtaining needed care.

Practice situations described by respondents reflected situations depicting the need to defend the clients' rights. The second most frequently described situation related to obtaining needed care and assuring self-determination for the client. The associate degree graduate depicted practice situations most

Table 4.10

Respondents' Definitions and Practice Situations by Age of Respondents

Age	Definitions %									Situations %								
	N=94	%	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fears	N=91	%	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fears
20-29	19	20	20	15	25	25	15	0	0	20	22	0	15	5	10	30	25	15
30-39	38	41	19	25	5	17	17	5	2	34	37	0	41	0	15	20	24	0
40-49	24	26	11	42	4	25	8	11	0	22	24	4	27	0	23	18	14	14
50-59	10	11	9	36	9	9	9	0	18	10	11	0	20	0	20	20	20	20
60+	3	3	0	33	0	66	0	0	0	5	5	0	0	0	0	60	0	40

Table 4.11

Respondents' Definitions and Situations by Basic Educational Preparation

By Beginning Level of Education

	N= 113	Definitions %							Situations %						
		Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear
Diploma	63	11	24	6	19	8	9	3	–	19	–	14	20	19	10
Associate degree	21	19	14	14	–	19	9	4	–	24	–	9	24	19	–
Baccalaureate	29	17	31	7	19	19	7	5	5	31	–	8	17	19	8

frequently related to an incident of obtaining needed care as well as defending the clients' rights. The largest number of baccalaureate graduates described practice situations relating to obtaining needed care. It is difficult to determine any distinctive pattern between the respondents in relation to their basic level of educational preparation.

Area of Practice

Table 4.12 presents data relating the definitions and practice situations given by respondents according to the area of practice over the past five years. Respondents from the medical-surgical area of practice showed no inclination toward any one definition or practice situation, depicting client advocacy in nursing. Critical care nurses and those employed in public health, psychiatry and administration chose to define client advocacy as obtaining needed care for the client. Pediatric nurses defined the role as assuring quality care, but frequently defined it as doing best for the client, as did the obstetric nurses.

Critical care nurses most frequently gave situations depicting the advocacy role as obtaining needed care. Pediatric nurses and those employed in administrative positions portrayed situations of client advocacy as defending the clients' rights. The remaining groups of nurses did not choose primarily one type of situation relevant to their understanding of client advocacy in nursing. Medical-surgical nurses in this study practice on general duty units (as opposed to intensive care units). These units may not encounter as many incidents involving the need to act as client advocate. When such situations do occur, the nature of the event will probably not be life-threatening.

Obtaining needed health care, utilized in this study to describe the situations when the nurse sought care from the physician, was chosen by

Table 4.12

Respondents Definitions and Situations by Area of Clinical Practice

Practice Area	Definitions %										Situations %									
	N=90	%	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear		N=76	%	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear
Medical-Surgical	18	20	22	22	11	17	22	5	-		16	18	5	25	-	15	25	20	10
Critical Care	20	22	15	30	5	20	10	15	5		11	13	-	37	-	12	13	31	6
Public Health	14	15	7	43	-	7	12	13	12		8	9	-	27	-	18	27	18	9
Pediatrics	7	7	28	14	29	14	24	-	-		6	7	-	25	-	-	50	25	-
Psychiatry	6	6	17	50	-	17	-	17	-		6	7	-	33	-	17	33	17	-
Administration	5	6	20	40	-	20	20	-	-		5	6	-	20	-	16	50	-	-
Obstetrics	5	6	40	20	-	20	20	-	-		5	6	-	20	-	20	20	20	20
Miscellaneous	15	17	1	20	20	26	13	13	-		19	22	-	16	-	21	16	26	21

critical care, psychiatric nurses and those in administrative positions. These practice settings are more crisis-oriented and the nurse has more frequent physician interaction. Public health nurses, who usually function more independently of the physician, may be responding to needs of clients in special practice areas within public health or from previous clinical practice settings.

Pediatric nurses most frequently defined the role as doing best for the client and obtaining quality care. Obstetric nurses most frequently defined the role as doing best for the client. Pediatric and obstetric nurses may view the client in a more dependent role and thus chose doing the best for the client.

It is remarkable that the situations depicted by a substantial number of respondents in all areas of practice were related to defending the clients' rights. Critical care nurses were the only group not giving substantial support to this description of the client advocacy role.

There is some indication from these data that nurses define the advocacy role in relation to their area of practice. This area may benefit from further research since the practice situation plays a vital part in the implementation of the role of the nurse as client advocate. Research questions might be directed toward whether or not advocacy decisions are made more frequently on general duty units or in areas associated with crisis situations. This research would strengthen the nurse in carrying out the advocacy role in clinical practice.

Data Analysis: Part 3. Responses to Questions 3 and 4: Respondents'

Degree of Agreement with Winslow's Typology and

Investigator's Practice Situations

Questions 3 and 4 were designed to determine respondents' agreement with Winslow's advocacy typology. Question 3 presented seven situations describing nurse advocacy in the nursing practice setting, based on Winslow's typology. Question 4 presented the definitions that Winslow found, in reviewing the nursing literature, to be the variety of ways nurses define client advocacy. A Likert scale was used to give the respondents an opportunity to indicate their strength of agreement with Winslow's typology and the investigator's practice situations. The survey also asked the respondents to rank order those items with which they most strongly agreed.

Before discussing these data it will be helpful to include the definitions and practice situations as presented to the respondent. Table 4.13 presents Winslow's typology of definitions and the investigator's practice situations.

The situations were presented to the respondent first. The survey situations were not in the same order as the definitions.

Winslow's Typology and Investigator's Practice Situations with which

the Respondents Strongly Agreed and Ranked First

Table 4.14 presents data concerning the item that the total respondents strongly agreed with and rank ordered as number one for both the situations presented and Winslow's typology of definitions.

Among the situations described, the respondents most frequently chose assuring quality care as behavior indicating client advocacy. Their second most frequent choice was doing best for the client.

Table 4.13

Winslow's Typology and the Investigator's Practice Situations

as Presented to the Respondent

Definition:	Situation:
a. doing what is best for the client.	a. sets priority on listening to an anxious client.
b. helping the client to obtain needed health care.	b. investigates the possibility of rural home health care for the client.
c. assuring quality client care.	c. maintains own competence.
d. serving as liaison between the client and the health care system.	d. contacts the social worker because the client has financial problems.
e. defending the client's rights.	e. advises the client of other forms of therapeutic intervention that have not been made known by other health care professionals.
f. assuring exercise for self-determination for the client.	f. encourages client to seek additional information about proposed surgery.
g. assisting the client to deal with fears.	g. helps the client to express fears about impending surgery.

Table 4.14

Percentage of Items of Winslow's Typology and Investigator's
Practice Situations with which Respondents Strongly Agreed
and Ranked as First Choice

	Total	
Item	Situation (N=108) %	Definition (N=112) %
Doing best for client	32	18
Obtaining health care	2	11
Assure quality care	38	27
Serve as liaison	2	16
Defend client's rights	5	8
Assure self-determination	2	8
Assist in dealing with fear	5	2
No opinion	14	10

Among the definitions the same pattern emerges. The percentages, however, are lower and the respondents gave more attention to serving as liaison and obtaining needed health care. Under the definitions, there was not as strong an indication of any one behavior as being synonymous with client advocacy in nursing.

A substantial number of respondents, 14%, had no opinion about the situations, and 10% had no opinion about the definitions. This may indicate a lack of knowledge about the meaning of advocacy in nursing. Assisting the client to deal with fear was the least likely interpretation of the client advocacy role chosen as a definition by the respondents. These responses demonstrate that nurses are more likely to choose definitions and practice situations that relate to client nursing care rather than those definitions and practice situations relating to clients' rights.

Age of Respondents

Table 4.15 presents the frequency of those responses that showed strong agreement with Winslow's typology and were ranked highest by respondents, according to age of the respondents.

It is apparent from Table 4.15 that there is little substantial difference among the respondents on the basis of age. The most frequently chosen practice situation for all respondents was either doing best for the client or obtaining needed care. The preference for a definition depicting client advocacy in nursing was evenly divided and did not show substantially a trend toward any one particular definition. More definitions that supported clients' rights were chosen as appropriate, especially among the youngest and the oldest age groups. It is difficult to attribute any specific reason for these choices.

Table 4.15

Percentage of Items of Winslow's Typology and Investigator's Practice Situations With Which Respondents Strongly Agreed and Ranked as First Choice by Age of Respondent

Age	Situations									Definitions								
	Total No.	%	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear	Total No.	%	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear
20-29	21	19	38	33	14	9	–	–	5	22	20	4	9	50	14	23	–	–
30-39	38	35	21	39	10	5	5	5	5	37	32	16	11	30	22	11	6	3
40-49	27	25	33	37	7	11	–	–	11	31	24	20	10	29	16	–	13	3
50-59	14	13	28	64	7	–	–	–	–	15	13	20	27	20	20	–	7	6
60+	8	7	62	13	12	12	–	–	–	7	6	43	14	–	14	14	14	–

Basic Educational Preparation

Table 4.16 presents data relevant to the percentage of the respondents who strongly agreed with Winslow's typology and the investigator's practice situations by level of beginning nursing education.

Diploma graduates most frequently chose assuring quality care in the practice situations. Associate degree graduates chose most frequently best for client and quality of care from the practice situations. The baccalaureate graduates also chose most frequently quality of care from the practice situations. Diploma graduates most frequently defined client advocacy as assuring quality care, as did baccalaureate and associate degree graduates. However, the latter also showed some preference for doing best for the client.

All levels of educational preparation selected more frequently the definition of the liaison role in the typology of definitions rather than in the practice situations. The same response is noted in the definition of obtaining needed care for the client. There is no substantial preference for definitions or practice situations that relate to clients' rights.

There appears to be no substantial difference in the basic educational program the respondents attended and their selection of a primary definition. The baccalaureate graduates did, however, attach more importance to the best for client definition than the other respondents. Since 53% of these graduates were in the 20 to 29 year age group, this term may have been chosen because it has a rather idealistic connotation.

Area of Clinical Practice

Table 4.17 presents data relevant to responses strongly agreed with and ranked number one by area of practice of respondents over the past five years.

Table 4.16

Percentage of Items of Winslow's Typology and Investigator's Practice Situations with which Respondents Strongly Agreed and Ranked as First Choice by Basic Educational Preparation

Educational Preparation	No.	%	Situations %							Definitions %						
			Best for Client (a)	Obtain Care (b)	Quality Care (c)	Liaison (d)	Clients' Rights (e)	Self-determination (f)	Assist with Fear (g)	Best for Client (a)	Obtain Care (b)	Quality Care (c)	Liaison (d)	Clients' Rights (e)	Self-determination (f)	Assist with Fear (g)
Diploma	52	42	35	1	40	-	8	10	8	5	17	43	21	7	9	-
Associate degree	22	23	36	5	30	-	4	14	1	4	13	39	22	4	13	4
Baccalaureate	43	32	32	-	35	3	10	16	3	28	9	28	15	15	3	-

Table 4.17

Percentage of Items of Winslow's Typology and Investigator's Practice Situations with which

Respondents Strongly Agreed and Ranked as First Choice by Area of Clinical Practice (N=121)

Area of Practice	Situations %							Definitions %						
	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear	Best for Client	Obtain Care	Quality Care	Liaison	Clients' Rights	Self-determination	Assist with Fear
Medical-Surgical	43	-	38	5	10	9	5	9	9	18	36	18	14	9
Critical Care	25	5	50	5	-	10	5	10	10	55	15	10	5	-
Public Health	23	-	62	-	-	8	8	38	21	21	7	7	7	+
Pediatrics	27	9	36	-	-	18	9	20	-	40	10	30	-	-
Psychiatry	-	-	43	-	28	28	-	14	14	28	14	-	28	-
Administration	-	-	-	-	50	50	-	33	33	-	-	33	-	-
Geriatrics	75	-	-	-	+	-	25	20	-	40	20	20	-	-
Obstetrics	-	-	50	-	-	-	50	-	20	60	-	20	+	-
Miscellaneous	48	-	39	-	-	9	4	29	16	25	16	-	12	-

In responding to the investigator's practice situations, medical-surgical nurses most frequently chose doing best for the client as the appropriate portrayal of the advocacy role. These nurses chose quality of care with the second highest frequency. Nurses employed in critical care areas, public health, pediatric nursing and psychiatric nursing most frequently ranked assuring quality care as the situation most accurately depicting the role of the nurse as client advocate. Psychiatric nurses and those employed in administration chose most frequently clients' rights and self-determination as portraying the advocacy role in nursing. Nurses employed in obstetrics and geriatrics were small in number in the sample population, and it is difficult to attach much importance to their choice of assisting the client to deal with fear as the situation most frequently describing advocacy.

Respondents' choices were more evenly distributed in relation to Winslow's typology of definitions. Respondents did, however, chose most frequently assuring quality care as their first or second (most frequently) ranked definition of advocacy in nursing. Pediatric, psychiatric, medical-surgical and administrative nurses demonstrated support for defending clients' rights and assuring self-determination for the client over nurses from other clinical areas of practice. Data in this category are divided between care for the client and clients' rights.

Overall, the respondents chose more frequently those practice situations and items from Winslow's typology that relate to care of the client as appropriate definitions of client advocacy. There were no substantial differences based on area of practice.

Data Analysis: Part 4. Comparison of Respondents' Definitions

and Practice Situations and Winslow's Typology and

Investigator's Practice Situations

Table 4.18 presents data relevant to the respondents' definitions and practice situations and Winslow's Typology of definitions and the investigator's practice situations.

The respondents' definitions could be classified among five of the definition categories. The strongest agreement is with the liaison role and doing best for the client. The respondents gave more frequently definitions matching the definition of client advocacy as defending the clients' rights and assuring self-determination for the client. Respondents agreed with four of the definitions in Winslow's typology. However, respondents agreed more strongly with Winslow's definition of client advocacy as assuring quality care than incidents of respondents giving this definition. Obtaining needed care and assuring quality of care remains the most frequent definition given under both circumstances.

The practice situations described most frequently by respondents had to do with obtaining needed care. The investigator's practice situations chosen most frequently were doing the best for the client and assuring quality care. The respondents' practice situations, however, were more evenly distributed and more frequently gave examples of situations depicting defending clients' rights and assuring self-determination for the client.

A comparison of these data demonstrates nurses most frequently, under both circumstances, defined and gave or chose situations depicting advocacy as administering needed care or else procuring needed care. The one exception to this is the respondents' preference in defining and describing practice

Table 4.18

A Comparison by Percentages of Respondents' Definitions and Practice
Situations and Winslow's Typology and the Investigator's Practice
Situations

| Item | Definitions | | Situations | |
	Respondents' %	Winslow's Typology %	Respondents' %	Investigator's %
Doing best for client	17	18	1	32
Obtain care	29	11	27	2
Quality care	9	27	1	38
Liaison	18	16	15	2
Clients' rights	14	8	24	5
Self-determination	10	8	20	2
Assist with fear	3	2	11	5

situations relating to client advocacy as relating to ethical perspectives. The reason for this is not clear. However, nurses may be avoiding use of words such as defend the clients' rights and assure self-determination contained in Winslow's typology. In their own words, however, nurses are not reluctant to describe advocacy behavior as relating to ethical considerations. This difference may demonstrate the need for further research in this area since this is essential to establishing the client advocacy role in nursing.

Summary

The purpose of this survey was to determine if Winslow's typology of definitions accurately and comprehensively represent the diversity of opinions held by nurses of the definition of the role of the nurse as client advocate. Other questions asked of the data gathered are:

1. Does Winslow's typology include the full range of interpretations of advocacy given by registered nurses?

2. Are any of the definitions contained in Winslow's typology superfluous?

3. Is there a tendency for one or more of the interpretations of advocacy to be dominant? and,

4. If this is true, what is the explanation?

Demographic and professional data were also gathered to determine if respondents' interpretations of the role of the nurse as client advocate differ according to their personal and professional status. The following discussion responds to each of these questions.

1. Does Winslow's typology include the full range of interpretations of the role of client advocate held by the respondents?

Questions 1 and 2 of the survey asked the respondents to define client advocacy in nursing and to give an example from a clinical practice situation depicting the implementation of the role in clinical practice. Seventy-three percent of the respondents' situations could be related to Winslow's typology.

Seven nurses gave definitions related to achieving a high level of wellness for the client, and six nurses defined advocacy as teaching the client. Twelve nurses described situations depicting the advocacy role as teaching the client.

From these data it can be stated that the majority of respondents interpreted advocacy according to the definitions given in Winslow's typology.

2.   Are any of the definitions contained in Winslow's typology superfluous?

The first question submitted to the respondents asked for a definition of client advocacy. These data were content analyzed using Winslow's typology of definitions. There were few definitions categorizable as assisting the patient to deal with fear. The responses to question 4, which presented Winslow's typology of definitions to the sample population, indicated assisting the client to deal with fear was also the definition least frequently chosen, and ranked first among the definitions with which the respondents strongly agreed.

Only three percent of the respondents' definitions of client advocacy in nursing related to assisting the client to deal with fear. Only two percent of the responses to opinions about Winslow's definition of client advocacy as assisting the client to deal with fear were strongly agreed with and ranked first by respondents. While this definition was not ignored, it did not receive as much attention from the respondents as the remainder of the definitions in the typology. No definitions of Winslow's typology were superfluous.

3. Is there a tendency for one or more of the interpretations to be dominant?

Respondents' definitions and practice situations most frequently interpreted client advocacy in nursing to be related to obtaining needed care for the client. When asked for an opinion about Winslow's typology of definitions, however, the respondents ranked assuring quality care highest, in both the definitions and the investigator's practice situations. The second highest frequency in respondents' opinions about client advocacy is related to doing the best for the client. The majority of the respondents defined client advocacy in nursing as obtaining needed health care and assuring quality care for the client. There was no single dominant definition.

4. What is the explanation of the tendency for these definitions to be dominant?

The two dominant definitions represent first, the nurses interaction with the physician, recognized by the nurse as the person who will most frequently solve problems arising in the care of the client. The second dominant definition, assuring quality care for the client, can be interpreted as the control the nurse has over clinical practice. These definitions indicate almost one-third of the respondents' view of the advocacy role as basic to the clinical nursing practice situation.

5. Are there any substantial differences in responses given and the age, basic educational preparation and area of practice of the respondent?

Age. In answering questions 1 and 2, respondents in the 20 to 29 year age group gave more situations related to Winslow's definition of client advocacy as defending the client's rights and assuring self-determination for the client. The same opinion was given by this age group in response to question 4, asking the respondent to rank the definition with which they most strongly agreed.

The nurse in the younger age group recognized the importance of defending the clients' rights while the nurse in the older age group tended to define advocacy as relating to direct client care. This again may indicate a more idealistic mode in the younger, less experienced practitioner and a more realistic approach mode in the older, more experienced practitioner.

Basic Educational Preparation. The definitions and practice situations depicted to be advocacy in nursing did not reveal any particular relationship to basic educational preparation. The opinions of respondents of the investigator's practice situations and Winslow's typology of definitions did not demonstrate any substantial difference, according to basic educational preparation.

Area of Practice. In answering questions 1 and 2, those nurses working in clinical areas such as obstetrics, psychiatry, public health and pediatrics defined advocacy in terms of direct client care. Nurses occupied in administration and critical care areas of practice gave situations of advocacy behavior related to intervening with others participating in client care. The latter group also described situations depicting defending clients' rights and assuring client self-determination more frequently.

Nurses who work in the clinical practice areas such as psychiatric and public health nursing are more frequently in situations of direct client care over a long period of time. Obstetrics and pediatric nurses are in a more maternalistic nurturing role. Nurses practicing in administration and critical care positions frequently interact with other health care professionals and view themselves as advocates through their interactions with other involved in care of the client. These factors may influence the respondents' view of advocacy behavior.

The results of the survey support Winslow's categorization of the variety of interpretations and opinions of behavior constituting client advocacy in nursing.

CHAPTER 5

SOCIAL AND HISTORICAL CONTEXTUAL FACTORS AND RELATIONSHIP

TO THE LACK OF CONSENSUS OF CLIENT ADVOCACY ROLE

AMONG NURSES

Introduction

In an extensive review of the nursing literature, Winslow (1984) found that nurses define their role as client advocate in a variety of ways. The major purpose of this study is to determine whether or not Winslow's typology of definitions of client advocacy in nursing accurately portray the variety of opinion of nurses, currently registered to practice in the state of Virginia, of their role as client advocate. The survey carried out in this study confirmed Winslow's findings.

A secondary purpose of this study was to identify and examine factors contributing to the lack of consensus among nurses of their role as client advocate. This chapter will examine one major and several contributory factors.

In a review of the literature, one major contextual factor, the nurse-physician relationship, was identified. This chapter will deal with the nurse-physician relationship and the lack of consensus of nurses of their role as client advocate. Several contributory factors will also be examined. These are the history of the nurse-physician relationship, male-female role behaviors and the professionalization of nursing. The latter will include the development of a professional organization and the educationa. preparation for practice.

These factors will be analyzed primarily in regard to interaction in the nurse-physician relationship and the association with a lack of consensus held by nurses with regard to their role as client advocate.

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History of the Nurse-Physician Relationship

The modern era of the nurse-physician relationship began in the United States as long ago as the Civil War. This war, fought with modern weaponry, brought injury and death to a large number of soldiers. Hospitals were quickly organized and in many instances contributed to, rather than decreasing, the incidence of disease and death. In 1862, Abraham Lincoln, recognizing the need for a more organized, efficient approach to the care of the sick and wounded, established the U. S. Sanitary Commission. The commission called upon Dorothea Dix to organize a group of women to care for the soldiers. Dix was chosen because of her success in organizing care for the needy in New York City. She became the first superintendent of women nurses in the U. S. Army.

To raise the standard of care, Dix identified the need for trained care givers and began recruiting candidates for her program. These candidates were chosen on the basis of age, 30 to 40 years of age, good health and endurance, and a matronly demeanor. Dix sought experience and good character in these women. When selected, the candidates were sent for training to Bellevue Hospital in New York City.

When these "ladies," as they became known, arrived at the Army hospitals they were not received with enthusiasm by military medical personnel. Perhaps due to their increased knowledge, they became critical of the manner in which care was being delivered to the soldiers. The "ladies" wrote to influential friends and the newspapers at home, seeking to improve conditions in the hospitals. As a result, physicians preferred the religious sisters to care for the soldiers. These sisters had fewer needs and took orders without question. The "ladies" became the first nurses to act the role of

client advocate when incompetent care was jeopardizing the lives of the soldiers. They also became the first nurses to experience conflict with the physicians who saw themselves as "captain of the ship" and expected the nurses to maintain the traditional female role behaviors of acceptance and compliance (Austin, 1976).

The current lack of consensus over the role of the nurse as client advocate may have existed at the time. The seeming compliance of the religious nurse may have actually been the implementation of a more passive advocacy role. It is hard to believe that these religious women were not also interested in improving care. They simply may have gone about their client advocate role in a less assertive manner. This situation may also have led to the first conflict among nurses as to the manner of acting as client advocate. The "lady" nurses chose the more active client advocate role, while the religious nurses may have chosen a passive manner of response. No doubt there were nurses in both situations who differed from the majority opinion.

During the same period, in another part of the world, a similar conflict was occurring. This conflict would also have a lasting effect on the nurse-physician relationship. The English government was not satisfied with the care being received by sick and wounded soldiers during the Crimean War, and called upon Florence Nightingale to utilize her skills to improve these conditions. The military medical personnel responsible for such conditions did not welcome Nightingale, who arrived with 40 women trained by her as nurses. In responding to the government's request, Nightingale recognized that her nurses would be assigned to tasks and supervised by the military medical physician. However, she maintained control over hiring and dismissal of the nurses.

The relationship between the situation in the Crimea and the current lack of consensus of the advocacy role can be related to the introduction into nursing of a division of responsibilities of the nurse. If the nursing supervisor is responsible for hiring and discharge of nurses and the physician is responsible for assigning nurses, then conflict in the situation is inevitable. The ability to employ and dismiss nurses is a strength for nursing. This assures the nurse that when acting in the best interest of the client, from the nurse's perception, it will not necessarily follow that the nurse will suffer the loss of employment. In this situation, responsibility to the nursing supervisor may encourage nurses to be a more active client advocate.

Nightingale was successful in demonstrating that morbidity and mortality could be reduced through more sanitary conditions and a healthier overall environment. When she returned in triumph to England, the government supported the establishment of a school of nursing under her direction.

The Nightingale school of nursing provided education for students outside the hospital setting. Students applied theory in the hospital environment, but the school remained independent of the hospital. Nightingale, however, maintained control in the hospital for hiring and dismissal of nurses. There is little evidence of the manner in which this system was received by the physician, but there is also little doubt that conflict arose when the physician was not in complete charge of the situation. Nightingale's reputation soon became known world-wide and nurses from the United States went to England to benefit from these advances in nursing education.

The Nightingale system of nursing education and service was brought to this country during the 1870's. The system stressed two major components-- organized education for nurses outside the practice setting, and some degree of control of nursing by nurses. The Nightingale movement in this country was

rather quickly overtaken by the realization that student nurses were cheap labor for a burgeoning hospital industry. Schools of nursing multiplied quickly and the general practice was that the superintendent of the nursing school was also the superintendent of the hospital. This practice continued until the advent of World War II.

It can be demonstrated that physicians supported and participated in the education of nurses throughout the first half of the twentieth century. However, some physicians during the early days, recognized that if nursing was to achieve true professional status it must assume the major responsibility for the education of newcomers (Worcester, 1902). Other physicians, however, held different opinions about the educational preparation of nurses. This in turn affected the manner in which nurses perceived their educational needs.

Supported by physicians, during the period from 1880 through the 1940's, hospitals were staffed primarily by student nurses. When organized nursing sought to improve quality of care through standards of education for nurses, physicians successfully multiplied levels of education for nurses in shorter periods of time and in apprenticeship programs. Eventually, these programs would lead to the various levels of nursing existing today--nurses aides, licensed vocational nurses and technicians--in a variety of medical and specialty areas.

When physicians took a stand such as this, it resulted in increased divisiveness between these two professions. The effect of this was felt by practicing nurses. These nurses found (and still find) themselves aligned with medicine or their own profession. In the former, nurses maintained a positive attitude toward the physician and dealt with the need for the advocacy behavior in a passive, "best interest of the client" mode. Accepting the educational premise of their profession and seeking to promote their own

educational preparation, served to create a negative environment, both with their colleagues and the physician. This behavior can be related to the more active, "defending the client's rights," mode of client advocacy. Thus it can be demonstrated that this situation contributed to the division among nurses about their role as client advocate.

During this early period in nursing, the majority of physicians were men and a larger majority, if not all, nurses were women. Traditional male-female role behaviors have had a lasting effect on the nurse-physician relationship.

Male-Female Role Behaviors

Masculine-feminine roles in society are developed through a socialization process. Women are socialized to carry out certain behaviors by familial relationships with mother and sisters and other female role models. Men are influenced by father and brothers and other male role models. This process results in certain learned behaviors respective to each role. In society, the role played by men and women have certain recognized, expected behaviors. The male role is generally recognized as dominant, competitive, independent, aggressive and objective. The female role is traditionally depicted as compliant, accepting, dependent, passive and emotional (Vance, 1987). The client advocacy role does not require the nurse to assume male role behaviors, but to modify traditional female role behaviors. Examining these behaviors and identifying necessary modifications will be helpful in understanding the client advocacy role and the nurse-physician relationship.

As client advocate, the nurse accepts and complies with the physician's care plan as long as this care plan does not, in the opinion of the nurse, bring about results that are detrimental to the client. When such an outcome threatens, the nurse acts independently, in an assertive, nonaggressive manner, rejecting compliant, accepting role behaviors. If the nurse becomes aggressive,

then an adversarial encounter can occur. Adversarial roles do not accomplish a positive outcome for the nurse as client advocate, for the nurse-physician relationship, nor for the betterment of the client. The nurse acts from an enlightened, objective, emotionalism. Modifying these behaviors often places the nurse in a conflict situation with the physician.

A unique aspect of the male-female role behaviors arises when each assumes a behavior in relation to those for whom the respective party has a particular responsibility. Physicians are most often paternalistic with regard to their patients and nurses react in a maternalistic manner. Paternalism signifies a protective, decision-making behavior, while maternalism is seen as nurturing and caring, but also in a protective mode. Each of these role behaviors can have undesirable extremes and these extremes affect the nurse-physican relationship.

Physicians frequently act in a paternalistic role believing themselves in a better position to make decisions about the course of treatment than the client. The client is limited, in the physician's view, by an inability to understand complex medical problems. In the traditional female maternalistic role, nurses are viewed as being concerned primarily for nurturing and caring for the client. However, the nurse as client advocate is concerned about the client's right to self-determination. This difference in role concept results in role conflict for the nurse.

In acting as client advocate, the goal of the nurse is to allow the client to exercise the right of self-determination. This effort is often thwarted by the goal of the physician—to limit this right to decisions the physician has identified as ones the physician determines the client is able to make. The nurse seeks that the client be given the opportunity to make an informed decision.

Client advocacy role confusion results when the nurse must choose between recognizing the physician as "captain of the ship" or accepting the role of accountability to the client. The latter behavior requires the nurse to assure self-determination for the client. The nurse can retreat from the situation and recognize the physician as the only person accountable to the client or the nurse can assume a more professional client accountability.

Lack of consensus of the client advocacy role by nurses reflects these role conflicts. The nurse assumes the degree and characteristic of the client advocate role that he/she is comfortable with and which seems to bring about the desired outcome.

The nurse-physician relationship considered historically and from a role conflict perspective presents one aspect of the relationship. The professionalization of nursing also has significance when considering the nurse-physician relationship.

Professional Status of Nursing

A contributory factor to the lack of consensus among nurses of the client advocacy role may be found in the process of the professionalization of nursing and the nurse-physician relationship. This increase in professional status affects the nurse-physician relationship by producing a nurse who is more autonomous in practice and therefore less under the control of the physician.

The desire to be recognized as a profession began with the modern era of nursing. Florence Nightingale was instrumental in moving the nursing profession toward full-fledged professional status. Nightingale desired to raise the standard of care received by the sick and wounded. She was successful in demonstrating that this could be accomplished through better education of nurses.

To be a professional in England during the latter half of the nineteenth century not only meant a sound educational basis but that the individuals in the profession were at least from a morally acceptable segment of society. While Nightingale's early recruits did not come primarily from the same social class as the physician, their moral character was generally acceptable. The fact that nurses today generally come from a different socioeconomic group than the physician has a detrimental effect on the ability of the nurse to assume a collegial relationship with the physician.

For the purposes of this study the status of nursing as a profession will be discussed through the use of two generally accepted characteristics of a profession. These characteristics are the existence of the professional organization, and the education of newcomers to the profession. These characteristics will be analyzed with regard to their effect on nurses and the nurse-physician relationship, resulting in a variety of opinions held by nurses of the client advocate role.

The Professional Organization

In 1894, directors of schools of nursing formed the first professional organization, the Association of Superintendents of Schools of Nursing. This group realized if they were to have an impact on quality of client care, practicing nurses needed an organization to establish a base from which to voice the profession's goals to the people served (Styles, 1987). The Associated Alumnae of Schools of Nursing was established in 1896 by the Superintendents as the first major professional organization. The organization moved quickly and published the initial professional journal in 1900. This journal was to be a vehicle for "communicating needs and problems encountered in the caring for the sick" (AJN, 1900, p. 6). It was also to be a means for sharing ways of dealing with these needs and problems.

As the ability to communicate increased, nurses became aware of common problems often centering around the care provided for the client by the physician. Nurses began to recognize that they were frequently scapegoated and/or required to remain loyal to the physician when this loyalty was not warranted nor was it in the best interest of the client (Cabaniss,1903; AJN, 1910). The appearance of these concerns in the professional journal indicated the nurse, through an increased sense of professionalism, was beginning to transfer accountability from the physician to the client.

There is no recorded data on how this realization affected the relationship of the nurse and the physician. The physician played an important part in securing employment for nurses since most clients were cared for in the home. Nurses were frequently employed by families on recommendation of the physician, who knew from previous cases the capabilities of the nurse. Nurses may have dealt with this situation in a passive, covert manner. Job security prevented the nurse from being an active advocate.

The ability of nurses to communicate with colleagues their concern over quality of care has played an important part in the recognition of the need for the client advocacy role. Unfortunately, it has not contributed toward unifying nurses so that they are able to effectively use this power. Today, only 30% of registered nurses belong to the official professional organization. Many nurses belong to other nursing organizations frequently associated with similar medical organizations and oriented more toward the medical rather than the nursing aspects of client care problems. This results in nurses dealing with the need for the client advocate role in a variety of ways. Nurses who have a closer relationship with physicians are less likely to challenge or confront the physician in an active advocacy manner.

If the pioneers of modern nursing were concerned over the organization of nursing as a profession, they were at least equally preoccupied with an adequate knowledge base for nursing and the manner in which this knowledge was passed on to newcomers in the profession.

Educational Preparation for Practice

To be recognized as a profession it is necessary to educate newcomers in the university setting. At the present time, nursing presents a confused educational image not only to the physician but also to the general public. University-based education was added to the existing hospital diploma programs in 1916. In the 1960's the associate degree program was established in the community college. As a result, each nurse may voice her concerns over clients' advocacy needs from a different educational perspective.

Nurses educated in a hospital-based diploma program have a closer relationship with the physician. As a result, physicians usually view diploma school graduates more favorably. Nurses educated in institutions of higher learning do not experience the same relationship nor are they held in the same favorable regard by physicians.

The ability of nurses to speak with one voice on such issues as the need for client advocacy is affected by this variety in educational programs. Nurses educated in hospital diploma programs may not be as apt to assume an active client advocate role. Nurses educated in a baccalaureate degree program, because of a broader educational preparation and an increased ability to make sound, rational decisions, are in a better position to act as active client advocates. Nurses prepared at the associate degree level are doubly disadvantaged in assuming the client advocacy role since they have neither the close relationship with the physician, nor the broad educational preparation.

The survey conducted in the course of this study revealed that nurses with a higher education degree responded in larger numbers than are present in the general nursing population. This indicated an interest in, and a concern for the need for, the client advocacy role. The survey also demonstrated that graduates from diploma and associate degree programs most frequently defined client advocacy in a passive manner and nurses with a higher education degree responded more frequently in an active advocate role.

Summary

This chapter has examined a major contextual factor affecting the opinions of nurses about their role as client advocate. This major contextual factor is the nurse-physician relationship. The nurse-physician relationship is a major factor because as nurses assume a client advocate role, they move away from loyalty to the physician and give primary loyalty and accountability to the client.

As a major contextual factor, the nurse-physician relationship has several contributory factors. These include the history of the nurse-physician relationship and the male-female role conflict. The professionalization of nursing is also a contributory factor. The professional organization, and education for practice, are part of the professionalization process.

The masculine-feminine natures of medicine and nursing, respectively, have specific expected role behaviors in society. The assertive nature of the client advocate deviates from the compliant, accepting, dependent role of women traditionally expected by society. The paternalistic father figure of the physician does not encourage the nurse to be a decision maker as required by the client advocacy role. These nurse-physician relationship behaviors can be traced in this country to the Civil War, and in the world to the advent of the Nightingale system of nursing practice and education. Both of these

events demonstrate that as nursing increases its knowledge base, the desire to improve client care also increases.

The lack of consensus of nurses of their role as client advocate results from the manner in which these two professions have developed. Nurses have experienced role conflict in the need for the client advocate role while at the same time maintaining loyalty to the physician and a satisfying work situation. Nurses achieved this balance by responding to the need for the client advocate role in a passive manner.

A contributing factor to the nurse-physician relationship, and its affect on the lack of consensus of nurses toward their client advocacy role, is the increased professional status of nursing. During the early modern period, a professional organization and a professional journal served to increase communication of problems and needs among nurses. Primary in this was the discovery by nurses that blind obedience to the physician was not always warranted nor desirable. The organization and the journal also supported the desire to improve the educational preparation of the nurse. This led to an increase in knowledge in practice and, while at times having a positive effect on the nurse-physician relationship, also served to increase divisiveness. This divisiveness was also experienced among the nurses themselves.

Simultaneously with the above, nurses increased their knowledge base and professional status by educating newcomers in a university-based program leading to a baccalaureate degree. Proliferation of varieties of programs and levels of nursing personnel have confused the image of nursing with the physician and the general public as well. The present confused situation does not serve to increase the unity among nurses about the profession. A unified basic education will enable the nurse to function as a client advocate, and will unify the profession as well.

Client advocacy in nursing is based on the degree of autonomy experienced by the practitioner. Some believe that a substantial degree of autonomy will never be experienced by nurses. However, by uniting the profession through education and practice, it will be possible for nursing to achieve the degree of autonomy necessary to reach the profession's major goal of providing quality care for the client.

CHAPTER 6

GENERAL SUMMARY, RESEARCH PROBLEMS AND CONCLUSIONS

The problem addressed by this study is the lack of consensus of registered nurses in defining their role as client advocate. Winslow (1984), in an extensive review of the nursing literature, determined that nurses define their role as client advocate in a variety of ways.

The major purpose of this study was to confirm and/or modify Winslow's findings that nurses define their role as client advocate in a variety of ways. A questionnaire was submitted to a random sample of nurses registered to practice in the state of Virginia. The results of the survey confirmed substantially that nurses do define their role as client advocate in a variety of ways.

A second purpose of the study was to examine the historical development of the code of ethics for nurses. This was done to further explain the current lack of consensus among nurses about their role as client advocate. It was determined in reviewing the various versions of the code, that elements of client advocacy appear in all versions.

A third purpose of this study was to determine if there is an adequate explanation/interpretation of this diversity of opinions by nurses of their role as client advocate. A major contextual factor, contributing significantly to the lack of consensus of the part of the nurse, was identified. This major contextual factor is determined to be the nurse-physician relationship. Contributing contextual factors are found to be the masculine, paternal nature of the physician and the feminine, maternal nature of the nurse. Another factor associated with the nurse-physician relationship is the desire of the nursing profession to achieve full-fledged professional status.

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These data reveal that nurses do recognize the need for the client advocacy role, however, there is a lack of consensus of definition of the role. The code of ethics determines effort on the part of organized nursing to express the concern about the need for the role. The nurse-physician relationship, however, and the lack of full-fledged professional status do not provide ar environment for the effective enactment of the role.

Accuracy of Description of Client Advocacy Role by

Winslow's Typology of Definitions

Seventy percent of the sample population surveyed agreed with the definitions as described by Winslow. Thirty percent disagreed or had no opinion. The greatest support centered around the definitions doing the best for the client, obtaining needed care, and assuring quality care for the client. One definition, assisting the client to deal with fear, received the least confirmation from the respondents.

Respondents gave situations from clinical nursing practice that most frequently depicted defending the clients' rights' and assuring self-determination for the client. Two additional definitions and practice situations identified by approximately one percent of the respondents were attaining a high level of wellness and teaching the client.

Issues and Questions Raised

Thirty-four percent of the survey questionnaires were returned. While this is a satisfactory response it did not support the concern voiced by many nurses to the investigator of the need for the client advocate role. The low response raises the possibility that nurses are not familiar with the concept of client advocacy.

The survey tool initially asked the respondents to define client advocacy and then to give an example from clinical practice, describing the

implementation of the definition. This may have caused a significant number of respondents to lay the questionnaire aside in order to think about the answers. Some eventually may not have responded, however, because they were not familiar enough with the role to define or give an example of the behavior in practice.

Another issue is that the concept of the nurse as client advocate is found in the "Nurses Code" promulgated by the American Nurses Association. Approximately 30% of nurses belong to this organization, and yet it is recognized as the primary professional organization. Many nurses may be unaware of the existence or the meaning of a code of ethics for nurses. Therefore, in order to increase the effectiveness of the client advocate on health care, an effort is needed to familiarize nurses with the existence and purpose of the code.

Few respondents to the survey chose definitions or practice situations depicting client advocacy as defending the client's rights or assuring self-determination for the client. These definitions, by raising ethical concerns, depict client advocacy by its most active aspect. Such active definitions identify advocacy behavior differently from the more passive definitions such as doing the best for the client, obtaining needed care, and assuring quality care. Passive definitions probably do not enable nurses to contribute to quality of health care as would the more active definitions.

Demographic and professional data obtained did not affect substantially the respondents' answers to the survey questionnaire. Nurses who responded to the Virginia State Board of Nursing study, however, had different demographic and professional characteristics than the nurses who responded to the current study questionnaire. Among these differences were (a) a larger number of nurses with baccalaureate and advanced degrees, (b) a larger number of nurses

employed in critical care nursing, and (c) a smaller number of nurses practicing in medical-surgical nursing.

These data raise the question of whether or not a larger number of diploma and associate degree graduates from medical-surgical nursing practice did not respond to the questionnaire. Since these graduates, and the area in which they practice, represent a significant percentage of client care situations, their awareness of the role of the nurse as client advocate should be investigated. Further clarification of the role may come from research on the portion of the sample population who did not respond to the survey.

Finally, another issue is raised by the fact that a substantial number of nurses gave definitions and described practice situations of client advocacy behavior related to defending the clients' rights and assuring self-determination for the client. This same group, when choosing definitions and practice situations, selected the more passive descriptions, such as doing best for the client and assuring quality care. This may indicate that nurses recognize the need for an active advocacy approach but are deterred by use of the words defend and assure. These behaviors may not be recognized as being within their scope of control over practice.

Social and Historical Perspectives

The study examined social and historical factors that affected or contributed to the lack of consensus among nurses about their role as client advocate.

The versions of the code of ethics for nurses beginning with the Nightingale Pledge and continuing through the 1976 revision of the code were examined. All versions were found to have elements of client advocacy. Characteristics of advocacy role behaviors found in the nursing literature were

used as a guide to determine the existence of these behaviors in the various versions of the code.

The appearance of these elements changed when the nurse became an employee in the hospital. Nursing the client in the home portrays a more independent practice with a greater degree of accountability to the client. From the versions of the code it can be demonstrated that loyalty to the physician became less evident during an era when it become more acceptable to support clients' rights and when nurses, the majority of whom are women, were becoming more assured of equal rights.

A major contextual factor, the nurse-physician relationship, was examined from an historical and a contemporary perspective. The concept of the nurse as the loyal assistant to the physician began in the United States prior to the time of Florence Nightingale. It began to decrease in the 1930's, but is evident today in a strong sense of loyalty to the physician. This probably is related to the traditional male-female role behaviors which are part of the general, as well as the professional, socialization process. Feminine role behaviors need to be modified if the nurse is to become an effective client advocate.

This role change is supported by the desire of nurses to be recognized as full-fledged professionals. Complete professional status will enable the nurse to gain the respect of the physician and all health care workers. Basic to this complete professional status is the question of professional autonomy. Autonomous practice is necessary for the nurse to function adequately as a client advocate. The greatest obstacle in this struggle for professional status and recognition is the lack of uniform educational preparation in an institution of higher learning.

Increased professionalism can have both a positive and a negative effect on the nurse-physican relationship. The nurse who has a broader and adequate general education can provide quality care to the client and professional assistance to the physician.

This study concludes that nurses do define their role as client advocate in a variety of ways. Age, basic educational preparation and area of clinical practice have little substantial relationship to these opinions. A greater number of nurses with advanced degrees, than in the general population, manifested interest in this issue. Elements of the concept of client advocacy are included in all versions of the code of ethics for nurses. The major contextual factor the nurse-physican relationship, probably plays a significant part in the lack of consensus among nurses of the client advocate role.

This study asked a speculative question concerning the definition of client advocacy that will influence the future of nursing practice. The question is based on the assumption that nurses would show substantial preference for one definition of client advocacy over the variety of definitions. This did not occur. Considering, however, the conclusions cited above, there may be significant meaning for the development of nursing theory within the framework of client advocacy as part of nursing practice.

Client Advocacy and the Development of Nursing Theory

During the 1950's, nursing began to recognize the need to define a body of knowledge subsequent to being recognized as a full-fledged profession. At the present time, nursing recognizes four areas in which theory was or is being developed: (a) the art and science of humanistic nursing, (b) interpersonal relations, (c) energy fields, and (d) systems. All proposed nursing theory involves one or more of the following concepts--man, society, health and nursing.

The role of the nurse as client advocate is such that it can have significant impact on the practice of nursing. To decide whether or not advocacy is a theory is not the purpose of this study. Client advocacy, however, can serve as a model for nursing practice and as such will bear examination through use of the four basic concepts involved in all nursing theory.

Man

Client advocacy in nursing accepts the fact that man has certain rights, paramount among them being the right to self-determination. Nursing is frequently depicted as the nurturing mother and is often criticized for encouraging dependence on the part of the client. In reality, nursing supports independence on the part of the client. A substantial number of respondents to this study described situations depicting assuring the right of self-determination as indication of client advocacy behavior.

Society

Society, or the environment in which the client interaction takes place, can be considered to be the situation in which the nurse practices as client advocate. This social interaction involves the nurse and the physician, the client, and the setting. The setting is usually within an institution in which care is being rendered. The institution frequently supports the rights of the client and yet in many instances acts from a paternalistic motivation. The environment, therefore, has physical, social and psychological characteristics. Not least of these are the role behaviors enacted by all persons involved in the environment, particularly by virtue of the position they hold in that environment. All of these factors must be considered for implementation of the client advocacy role.

Nurses

Nurses responding to the survey questionnaire chose assuring quality care most frequently as defining advocacy. Maintaining personal competency was seen by a substantial number of respondents as a clinical practice situation depicting assuring quality care for the patient. When client advocacy behavior is related to professional competency, the achievement of client advocacy role behaviors will be perceived as more realistic by nurses. Competency is felt to be achieveable by the nurse and thus the nurse can be in control of the clinical situation.

Health

The domain of nursing practice lies within the human response to health and illness. Health is a difficult concept to define. When the concept of client advocacy is related to health, however, it is possible to give relevant meaning to health. Nurses are committed to assist the client to maintain, regain health or have a peaceful death. The objective of the enactment of the client advocacy role is to enable the client to achieve a similar goal.

This brief review of the four concepts deemed essential to the development of nursing theory demonstrates the relevance of client advocacy to these concepts. It presents a challenge to the possible development of such a theory.

Promising Interpretation of Client Advocacy

In his study, Winslow (1984) finds that as nursing moves toward client advocacy, it takes a major step toward full-fledged professional status. Nursing is establishing a sound educational basis for newcomers, founded on a more adequately defined body of knowledge. This sound educational basis will enable the nurse to assume accountability to the client. As this process takes place,

state nursing practice acts will be modified to provide legal support for this full-fledged professional role. The public image of nursing will eventually change as evidence of this role change emerges more clearly. As the nurse gains respect for practice ability and is more autonomous, the degree of controversy associated with client advocacy will decrease. The end result will be improved quality of care for the client.

APPENDIX A

FLORENCE NIGHTINGALE PLEDGE AND

VERSIONS OF THE CODE OF ETHICS

FOR NURSES

FLORENCE NIGHTINGALE PLEDGE

I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully. I will abstrain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.

Brief Analysis of Various Editions of Code of Ethics

Year	Major Areas	Comments
1926	The relationship of the nurse 1. to the patient 2. to the medical profession 3. to allied professions 4. to nurse 5. to the profession	Discussed at biennial convention. Never adopted.
1940	A. General responsibilities of the profession B. Relation to the patient C. Relation to medical profession D. Relation of nurse to nurse E. Relation to employer F. Relation to public G. Relation of the nurse to others	Suggested for use by the profession until principles are formulated and approved for publication.
1950	17 statements: 1-5 Relationship with patient 6-8 Relationship with physician 9,10 Financial remuneration 11 Golden rule 12 Don't lend name to advertisements 13-15 Personal and professional behavior 16,17 Obligations as a citizen	Accepted by delegates at biennial convention.
1960	17 statements: 1-4 Responsibilities to patient 5 Responsibilities as a citizen 6, 7 Responsibilities to profession 8 Maintain professional competence 9 Responsible for own actions 10 Establish standards of employment 11 Participate in legislative matters 12 Personal behavior 13 Support commercial research but do not advertise products	Revisions needed because of development of standards of practice.

Year	Major Areas	Comments
1960	(Continued) 14 May advertise professional services 15 Delegate only to adequately prepared persons 16 Work with physician and others 17 Refuse to participate in unethical practices. Expose incompetence or unethical conduct "in others."	
1968	10 statements 1, 2 Dignity of man; maintain 4 confidentiality; protect from incompetent, unethical, illegal acts of others 3, Nurse maintains competence, 10 no advertising 5, 8 Responsibilities for assistants, 9 employment, public 6, 7 Professional responsibilities	Refined to eliminate non-ethical statements
1976	11 statements: 1, 2 Relationship to patient 3 4, 5 Assumes responsibility for 6 care given 7-10 Relationship to profession 11 Relationship to public	Directed toward present day practice. Stresses accountability to client and, as such, is identified as a change "to an ethical code."

APPENDIX B

COVER LETTER, SURVEY QUESTIONNAIRE

AND FOLLOW-UP POSTCARD

January 16, 1987

Dear Colleague in Nursing:

Since 1976, the Nurses Code of Ethics has recommended nurses act in the role of client advocate. As a doctoral candidate at the College of William and Mary, I am interested in determining how nurses interpret the role of the nurse as a client advocate. I would appreciate your taking a few minutes to answer the enclosed survey and return it to me in the enclosed, stamped, self-addressed envelope.

Please answer the questions on page 1 before responding to those on page 2. I would prefer that your responses to questions 1 and 2 not be influenced by the questions on the second page.

All information obtained through this survey is confidential and will be treated as such. If you are interested in learning about the outcomes of the study, please so indicate on the survey and I will be glad to share the results with you.

Thank you for your time and interest.

Sincerely,

Ms. Lynn Bell, R.N., M.S.
10520 Claybar Trail
Richmond, Virginia 23236

Enc.

SURVEY ON CLIENT ADVOCACY IN NURSING

Please complete the following:

Date of birth: _____

Level of Nursing Preparation:

1. Basic (initial) nursing preparation (answer one):

	Date completed
Diploma	_____
Associate Degree	_____
B.S. in Nursing	_____

2. Advanced education (indicate highest level)

	Date completed	Area of concentration
B.S. in Nursing	_____	_____
B.S. in other field	_____	_____
M.S. in Nursing	_____	_____
M.S. in other field	_____	_____
Doctorate	_____	_____

Primary area(s) of nursing practice during the past five years:

_____

_____

1. How would you define the role of the nurse as client advocate?

2. Please give an example of the role of the nurse as client advocate in a nursing practice situation.

3. In your opinion how much do the situations described below agree with your understanding of the role of the nurse as client advocate?

Circle one response for each of the following items:

SA=strongly agree N=no opinion D=disagree
 A=agree   SD=strongly disagree

Rate*
(see below)

The nurse:

a.	sets priority on listening to an anxious client.	SA	A	N	D	SD	_____
b.	maintains own competence	SA	A	N	D	SD	_____
c.	encourages client to seek additional information about proposed surgery.	SA	A	N	D	SD	_____
d.	helps the client to express fears about impending surgery	SA	A	N	D	SD	_____
e.	contacts the social worker because the client has financial problems.	SA	A	N	D	SD	_____
f.	investigates the possibility of rural home health care for the client.	SA	A	N	D	SD	_____
g.	advises the client of other forms of therapeutic intervention that have not been made known by other health care professionals.	SA	A	N	D	SD	_____

*If you rate more than one item SA (strongly agree), please indicate which item you feel BEST describes the role of the nurse as client advocate. Rate each other item that you strongly agreed with in descending order according to how well each describes the role of the nurse as client advocate. (1=best description, 2=second best, to #7 if necessary.)

4. Using the same directions under #3, indicate your agreement with the following definitions of the role of the nurse as client advocate.

Rate*
(see below)

Client advocacy can be defined as the nurse:

a.	doing what is best for the client.	SA	A	N	D	SD	_____
b.	helping the client to obtain needed health care.	SA	A	N	D	SD	_____
c.	assuring quality client care.	SA	A	N	D	SD	_____
d.	serving as liaison between between the client and the health care system.	SA	A	N	D	SD	_____

e. defending the client's rights   **SA   A   N   D   SD**   _____

f. assuring exercise of self-   **SA   A   N   D   SD**   _____
    determination for the client.

g. assisting the client to deal   **SA   A   N   D   SD**   _____
    with fears.

*If you rate more than one item SA (strongly agree), please indicate which item you feel BEST defines the role of the nurse as client advocate. Rate each other item that you STRONGLY AGREED with in descending order according to how well each defines the role of the nurse as client advocate. (1=best description, 2=second best, to #7 if necessary.)

Thank you

Follow-up Postcard

Dear Colleague:

I recently mailed you a survey questionnaire on client advocacy in professional nursing. With all the bad weather, perhaps you overlooked it.

I would appreciate your taking a few minutes to complete the survey and return it. If you are uncertain about answers please tell me this when you return it.

Thank you,

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Abstract

CLIENT ADVOCACY IN NURSING: A CONTEMPORARY PERSPECTIVE

Bertha Roslyn Bell, Ed.D.

The College of William and Mary in Virginia, December 1987

Chairman: Professor William F. Losito

The purpose of this study was to determine whether or not Winslow's typology of definitions of client advocacy in nursing accurately and comprehensively represented the manner in which registered nurses defined the role. The author also hoped to explore contextual factors influencing the lack of consensus among nurses of the client advocacy role.

A survey questionnaire was developed and submitted to a random sample of nurses registered to practice in the state of Virginia. The sample population was asked for a definition of and a clinical situation describing client advocacy. A Likert scale was used to determine the degree of agreement of the sample population with Winslow's typology as well as clinical practice situations developed by the author.

Survey data revealed Winslow's typology of definitions represent the manner in which a substantial number of respondents defined client advocacy. Demographic and professional data of the sample population was obtained and analyzed. There was no substantial relationship between these variables and the opinions of client advocacy definitions.

The relationship to two factors, the development of the code of ethics and the nurse-physician relationship, were examined. All versions of the code of ethics contain elements of client advocacy behaviors. The lack of consensus among nurses of the client advocate role is related to male-female role conflicts and the desire of the nursing profession to attain full-fledged professional status.

Further investigation is indicated to determine if the current lack of consensus among nurses of the client advocate role, is an indication of the process of role change the profession must experience to realize the acceptance of any one definition of the client advocate role.