DIMENSIONS OF THE PATIENT ADVOCATE ROLE
AS EXPERIENCED BY STUDENT NURSES

by

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CHAPTER I

INTRODUCTION

With the advancement of technology, medical care has moved away from the traditional physician-patient relationship toward areas of specialization. "As technology has increased the doctor's ability to deal effectively with more health threatening situations, it has also widened the gulf between the doctor and the patient" (Annas & Healy, 1974b, p. 252). With this specialization and fragmentation of care there is frequently no one person to look at the whole person, hence an ever increasing number of patients are being admitted to health care settings without a primary physician (Hawley, 1974; Kravitz, 1974).

Health care facilities have become more complex, and subsequently more confusing to the patient. Patient care has become fragmented with numerous departments concentrating on their specific aspects of patient care such as respiratory therapy, radiation therapy, physical therapy, occupational therapy and intravenous therapy. This trend has contributed to the impersonalization of patient care.

Recent surveys indicate that a patient treated with respect is likely to perceive his hospital care as good. Today's patient is "looking for personalized care given by skilled, compassionate professionals" (American Hospital Association, 1974, p. 57). Moreover, there is growing criticism of the depersonalization of care in hospitals (Brousseau, 1974; Her assignment, 1974; Lowe, 1974; Morgan, 1974; Ravich, 1975; Somers, 1971; Taylor, 1970). The hospital is accused of being "heartless and inadequately concerned with humane values" (Somers, 1971, p. 35).

> Even under the best circumstances, being in the hospital tends to make a patient unhappy. He is thrust into a strange world where even the smallest and most intimate details of his existence are dictated by strangers. His clothing is taken away and replaced by an awkward gown; he has no privacy or control over what is done to him....But every patient is an individual who is entitled to certain fundamental rights (Report of the Secretary's Commission, 1973, pp. 69 and 70).

What are the rights of the patient? What can nursing do to bring humane treatment and personalization back into patient care?

REVIEW OF THE LITERATURE

The literature reviewed for this study concerns the history of the patients' rights movement, the need for patient advocates, definitions and qualifications of patient advocacy, and patient advocacy as a function of nursing.

History of Patients' Rights Movement

The question of human rights came to the foreground in the United States in the 1960's with the rise of consumerism. At that time citizens began to demand accountability for the quality of goods and services rendered.

However, it is only in recent years that the public's attention has begun to center on the rights of the patients in the health care system. This attention to patient rights has been fostered by such developments as the rising cost of medical care, the United States Public Health Service disclosure that black men with syphilis went untreated so that the course of the disease might be studied, the publicized experiments on deformed newborns, and the recent focus on the patient's right to die with dignity (Annas & Healy, 1974b; Annas, 1975; Carnegie, 1974; Quinn & Somers, 1974).

With the rising consumerism, a patient's bill of rights was seen as a potential means of relieving the poor image of health care providers (Mills, 1974). The American Hospital Association's Committee on Health Care for the Disadvantaged developed over a period of one year a bill of rights for patients.

This committee consisted of hospital administrators, lawyers, physicians, consumers, hospital executives, and planning executives. Noticeable by their absence were nurses (Quinn & Somers, 1974).

The Board of Trustees of the American Hospital Association affirmed the Statement on a Patient's Bill of Rights on November 17, 1972. The American Hospital Association presented these rights as a means of attaining "more effective patient care and greater satisfaction for the patient, his physician and the hospital organization" (American Hospital Association, 1972).

The rights afforded to the patient by this statement are:

> 1) The patient has the right to considerate and respectful care.
> 2) The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be given to an appropriate person in his behalf. He has the right to know by name the physician responsible for coordinating his care.
> 3) The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent, should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation.

Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment.

4) The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.

5) The patient had the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in his case must have the permission of the patient to be present.

6) The patient has the right to expect that all communication and records pertaining to his care should be treated as confidential.

7) The patient has the right to expect that within its capacity a hospital must make reasonable responses to the request of a patient for services. The hospital must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

8) The patient has the right to obtain information to any relationship of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has

> the right to obtain information as to the existence of any professional relationships among individuals by name, who are treating him.
>
> 9) The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
>
> 10) The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of his physician of the patient's continuing health care requirements following discharge.
>
> 11) The patient has the right to examine and receive an explanation of his bill regardless of source of payment.
>
> 12) The patient has the right to know what hospital rules and regulations apply to his conduct as a patient (American Hospital Association, 1972, pp. 1 and 2).

When the American Hospital Association statement was adopted it was praised by the public and by many legislators and health care providers (Bihldorff, 1975; Curran, 1974; Quinn & Somers, 1974). The positive reactions to the statement led to development of many patient representative service programs (Snook, 1974).

However, some viewed the bill cautiously. Many hospitals felt that the Statement on a Patient's Bill of Rights was an outline of what was already being carried out (Quinn & Somers, 1974). Concern was expressed as to the ability to enforce these rights (Annas, 1974, 1975; Annas & Healy, 1974a, 1974b; Curran, 1974; Rozovsky, 1974) particularly those rights that involved physician-patient relationships (Mills, 1974; Monaghan, 1975).

Mills (1974) expressed concern over rights #2, 3 and 10 which have to do with the right to information, informed consent and the right to continuity of care. Mills questioned how hospitals would monitor physician-patient relationships. Adoption of the bill implies that the hospital will monitor physician-patient relationships and this would alienate administration and the medical staff (Monaghan, 1975).

One physician, Dr. W. Gaylin, commented that

> it perpetuates the very paternalism that precipitates the abuses.... It is the thief lecturing his victim on self-protections; i.e. the hospital instructs the patient to make sure the hospital treats him according to rules of decency and law to which he is entitled (Gaylin, 1973, p. 22).

The Report of the Secretary's Commission on Medical Malpractice (1973) recognized that "an important aspect of the human dimension of the patient provider relationship concerns the rights of the patients as human beings" (p. 71).

With this in mind the Commission recommended that hospitals and other health care facilities adopt and distribute statements on patients' rights.

Some hospitals fear that making a promise of rights increase the institution's vulnerability to increased lawsuits (Bill of Rights, 1975; Monaghan, 1975; Quinn & Somers, 1974). Annas and Healy (1974a) state that this ought not to deter institutions from endorsing the bill as the existence of the document is enough to allow it to be introduced as evidence in a court of law. American Hospital Association President McMahan stated that no institution has yet been sued because of the bill, and the American Hospital Association has no plans to revise of withdraw the statement (Bill of Rights, 1975).

The American Hospital Association's Bill of Rights is intended as a guideline for hospitals and the Secretary's Commission on Medical Malpractice is merely making recommendations to hospitals. Annas (1974; 1975), Annas and Healy (1974a; 1974b), and Rozovsky (1974) see rights that are not enforceable as no rights at all.

Some individual hospitals have adopted patients' bills of rights (Annas, 1975; Report of the Secretary's Commission, 1973; Snook, 1974). There are approximately 7000 member hospitals in the American Hospital Association. The Association estimates that only 1000 of their members have adopted some statement regarding the rights of their patients.

Generally these statements are weaker than the American Hospital Association statement. Only a small fraction of these 1000 hospitals make the statement public (Monaghan, 1975; Patient's rights, 1975).

Minnesota is the only state to date which has enacted a bill of rights for patients. According to the Minnesota law, which applies to patients and residents of health care facilities, the bill of rights must be posted in each health care facility and distributed to each patient. This law is much weaker than the American Hospital Association bill (Annas, 1975; Curran, 1974).

The rights considered in the Minnesota law are:

> 1) Every patient and resident shall have the right to considerate and respectful care.
> 2) Every patient can reasonably expect to obtain from his physician or the resident physician of the facility complete and current information concerning his diagnosis, treatment and prognosis in terms and language the patient can reasonably be expected to understand. In such cases that it is not medically advisable to give such information to the patient the information may be made available to the appropriate person in his behalf.
> 3) Every patient and resident shall have the right to know by name and specialty, if any, the physician responsible for coordination of his care.
> 4) Every patient and resident shall have the right to every consideration of his privacy and individuality as it relates to his social, religious and psychological well being.

> 5) Every patient and resident shall have the right to respectfulness and privacy as it relates to his medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
> 6) Every patient and resident shall have the right to expect the facility to make a reasonable response to the requests of the patient.
> 7) Every patient and resident shall have the right to obtain information as to any relationship of the facility to other health care and related institutions insofar as his care is concerned.
> 8) The patient and resident shall have the right to expect reasonable continuity of care which shall include but not be limited to what appointment times and physicians are available (Minnesota Laws, 1973, p. 1876).

The Minnesota law does not consider informed consent, refusal of treatment, or the controversial issue of experimental medicine. Also, there is no mention of the right to examine and receive an explanation of his bill or of the right to know what hospital rules and regulations apply to his conduct as a patient.

Pennsylvania Insurance Commissioner Denenberg released a Citizens' Bill of Rights in April 1973. It also is based on the American Hospital Association's statement. However, it applies to all citizens of Pennsylvania, not just to patients (Citizens' Bill, 1973).

The New York State Hospital and Review Planning Council amended the State Hospital Code to include a patients' rights chapter. Hospitals in New York are required by this amendment to establish written policies about the rights of patients.

Some individual resident homes are becoming concerned with patient rights as exemplified by the Texas Home for Jewish Aged where the residents composed a bill of rights based on the American Hospital Association's model. These rights included right to respect, right to privacy, right to know medications by name and effect, right to refuse treatment and right to die with dignity (Texas home, 1974).

The rights of patients in mental hospitals are also a topic of current discussion. New York revised its mental health law in 1965 to safeguard patient rights. Social workers and lawyers are now assigned to each mental patient and serve as that particular patient's advocates.

Chayet (1968) viewed the mentally ill as excluded from "legal rights and services" (p. 758). He stated that something must be done about the abuses of the mentally ill. Greenland (1969) concurred stating that all mental patients should be treated by qualified staff and also guaranteed the rights of legal counsel. Suchotliff, Steinfeld and Tolchin (1970) discussed patient rights in relation to the dehumanizing conditions in a Connecticut state hospital.

Ishiyama and McCulley (1969) were involved in an ombudsman program at Cleveland State Hospital. The objectives of the program were aimed at decreasing the feelings of depersonalization of nonprofessional workers and patients. Over a six month period there were 210 grievances with only five of these being from patients. They concluded that patients need allies who act solely in their behalf. These conclusions are supported by Jansen and Krause (1974) who studied the utilization of a patients' rights office at Willmar State Hospital in Minnesota during the first six months of 1973. During this time only three per cent of the total patients visited the patients' rights office.

The interest in patient rights in mental hospitals is at an all time high (Jansen & Krause, 1974) and the American Psychiatric Association Standards for psychiatric facilities have been recently revised regarding patient rights. Four specific areas now included are 1) the right to know hospital rules and regulations which apply to conduct as a patient, 2) the right to considerate and respectful care, 3) the right to every consideration of privacy, and 4) the right to be advised if the institution proposes to utilize experimentation which affects his care or treatment and the right to refuse to participate in such experimentation (Patients' rights, 1974).

Fergus Fall State Hospital in Minnesota established a patient advocate office in August 1972. The office is staffed by a full time advocate, a law intern, and a social worker. All new patients are contacted and informed of their legal rights and benefits (Johnson & Aanes, 1974).

The idea of patient rights is not new to nursing. The National League for Nursing issued a statement in 1959 entitled What People Can Expect of Modern Nursing Service.

Three assumptions are posed. First, nursing involves health promotion, care and prevention of disability, teaching, counseling and emotional support. Second, nursing is planned and carried out in combination with medical, educational and welfare services. Third, nursing personnel respect the individual dignity and rights of every person.

The publication goes on to identify seven patient rights. They are:

> 1) the right to nursing care necessary to regain maximum health possible;
> 2) the right to qualified nursing personnel;
> 3) the right to have personnel who will be sensitive to feelings and responsive to needs;
> 4) the right to be taught about illness within the limits determined by the physician;
> 5) the right for the patient and family to be involved with any plans for continued needs;
> 6) the right to have adequate records kept by nursing personnel and the right to have these treated with confidence, and
> 7) nursing personnel will strive to adjust the surroundings to help the patient maintain or recover his health (Carnegie, 1974; National League for Nursing, 1959).

Although the issue of patient rights has come into focus in the past few years, one can see that nursing has been a forerunner in this field.

Present Need for Patient Advocates

The idea that patients have rights is now quite firmly accepted. The means of ensuring these rights remain problematic. One proposed solution is the establishment of advocacy roles. In this section the rise of the advocacy proposal will be discussed.

Conditions in our health care system support a need for patient advocacy (Guy, 1971). Annas (1974, 1975) and Annas and Healy (1974a, 1974b) state that the present hospital system does not make provisions for the exercising of the patients' human rights. They propose that hospitals should support a patient rights advocate to guarantee the protection of patients' interests.

Curran (1974) views policy statements such as the various bills of patients' rights as steps in the proper direction. However, they must be combined with effective enforcement programs. He suggests that a complaint system be established along with the utilization of patients' representatives and advocates.

Lockerby (1973) states that a bill of rights might free the patient but the patient's "individuality emerges only as others relate directly to him as a person" (p. 52). Ishiyama and McCulley (1969) and Ravich and Rehr (1974) support the advocacy system. They believe there is a need for someone to respond to the patients, to their needs, requests and complaints, for someone to represent solely their interests.

Demands for consumer input and participation in health care are continuing to be advanced (Hepner & Hepner, 1973; Lee & Jacob, 1973; Milio, 1974; Report of the Secretary's Commission, 1973; Somers, 1971). Schein (1972) suggests that the involvement of the client is a practical necessity.

In the early 1970's the Association of Patient Service Representatives was formed as hospitals began to realize the need for a liaison service between the patients and the health care system. This association then petitioned the American Hospital Association to establish the Society of Patient Representatives. The Society of Patient Representatives was formed within the American Hospital Association in 1971 (Appendix A - Society of Patient Representatives).

The Report of the Secretary's Commission on Medical Malpractice (1973) found that 27 per cent of 1040 reporting institutions had some kind of formal patient grievance mechanism. However, most of these systems were designed only for handling petty complaints. The Commission recommended that all health institutions establish a patient grievance mechanism to deal with patient care problems. They further recommended that the establishment of such grievance mechanisms be a prerequisite to receiving Medicare and Medicaid payments.

> Many patients are moved to litigate because they are dissatisfied with the outcome of medical treatment and have been frustrated in their efforts to obtain either explanations, advice or even a sympathetic ear. It seems likely that many malpractice claims could be prevented if patients had some helpful person in a position of responsibility with whom to talk (Report of the Secretary's Commission on Medical Malpractice, 1973, p. 83).

Rozovsky (1974) listed three alternatives for the health care system: 1) incorporation of legal education into the educational program of all health professionals; 2) the creation of a spirit of human responsiveness in all hospital personnel; and, 3) the establishment of effective systems of auditing the standards of patient care.

Curran (1974) states that complaint systems and patient advocacy can work only if all medical personnel accept "the professional ethical values inherent in the concept of patients' rights" (p. 33).

Definitions and Qualifications of Patient Advocacy

A new group of workers is visible in the health care arena. Although their titles are varied, including patient representative, patient relations director, patient relations representative, patient service representative, ombudsman, social work advocate, citizen advocate, and patient advocate, they are all concerned to some degree with the individual patient and his rights.

Patient representatives make up the largest part of this emerging group. As of 1974 it was estimated that 600 patient representatives were employed in the health care system in the United States (Her assignment, 1974).

The Society of Patient Representatives defines the position of patient representative in the following manner. The patient representative must 1) have the patient representative position as a primary assignment; 2) provide a channel for patients to seek solutions to problems, concerns and needs; 3) be a patient advocate in helping obtain solutions from hospital administration, departments or services; and 4) be management's direct representative to patients (Her assignment, 1974).

Hospitals that are members of the Society of Patient Representatives set up their own objectives and job descriptions according to the philosophy of the individual institution. Most job descriptions for patient representatives describe them as "management's" representative. Many are restricted to "nonmedical housekeeping duties" (Report of the Secretary's Commission, 1973, p. 83).

Ravich, Rehr, and Goodrich (1969) reported on a patient service program which had been established in 1967. This program had been placed outside of administration under the jurisdiction of ambulatory care and social service so as to be a "gadfly" on administration. The purpose of the program was to respond to needs, requests and complaints of patients.

However, it was found that the program was limited to providing feedback to departments which were involved in problems (Ravich & Rehr, 1974). Ravich (1974) identified patient representatives as a rapidly growing component of the health care system. She sees these representatives as humane and as personalizing care, while safeguarding the patient's dignity and self-esteem.

Modesta (1970) viewed the patient relations representative as assisting the patient to meet his psychological, social and emotional needs. The representative is a member of the health team who functions as a liaison person between all segments of the hospital. The representative assists the patient in filling the communication gap. Enrich (1971) and Lockerby (1973) also see the representative as a liaison person.

Richan (1973), a social work advocate, stresses client involvement, with the client having the responsibility in decision making. Morgan (1974) states that public relation representatives treat the patient with respect, dignity, sympathy and understanding. Cavalier (1970a, 1970b) identifies the task of the ombudsman as one of human relations.

A patient advocacy program was initiated in 1973 at the McMaster University Medical Center in Ontario, Canada. The advocates functioned as companions to patients, as escorts for patients and families and as liaison agents between patients and staff (Bihldorff, 1975). Some institutions are utilizing volunteers as patient advocates in an attempt to humanize hospitalization (Frye & Miller, 1975; Schiff, 1975; Volunteer patient representative, 1975).

Shontz (1975) reported on Wright's proposal of 1971 which suggested that each patient be provided with his own advocate to serve as an ombudsman between the patient and the health care institution. The function of the advocate, who would be a staff person, would be 1) serving as a communication link between the patient and agency, 2) monitoring of decisions made by the health professionals, 3) role support through continuous consistent interpersonal relationship with the patient, and 4) preparing the patient for discharge.

Nurses, too, have defined advocacy. Guy (1971) states that "an advocate defends, intercedes, vindicates, supports, helps or pleads in favor of another person or cause" (p. 4). Kosik (1972) concurs with the definition of an advocate as an upholder, defender, intercessor. She goes on to define her philosophy of patient advocacy as humane and just treatment for all with the patient treated with respect and dignity. Advocacy includes seeing that the patient knows his rights and displaying the courage to see that the system does not get in the way of the patient's rights.

Nations (1973), a nurse-lawyer patient advocate, sees the advocate as responding in an active way to patients' complaints, requests and grievances.

Cote' (1973), a nurse functioning as an advocate at New York Hospital, defines an advocate as a listener, interpreter, coordinator, and expeditor. She states that with the passage of the patients' bill of right the role of advocate will assume the dimensions of informing patients of their rights and assisting the patients in asserting those rights.

Proctor (1975) reports on two nurses who function in an advocacy manner for their patients. They assist the patients in making their own decisions regarding their medical care. They defend the patients against the medical establishment.

Annas, a lawyer with degrees in economics and public health, has written much about patient rights and advocacy. He states that "the patient advocate, regardless of title, ... must actually represent the patient since the goal is to enhance the patient's position in making decisions concerning his health care" (1975, p. 209).

Annas states that public relations programs are not advocacy programs. These public relations programs are subservient to the administration and are not fully for the patient. A patient advocacy program is an "enforcement mechanism" for the protection of patients' interests (Annas & Healy, 1974b, p. 244). The advocate exists for the purpose of assisting the patient in exercising his rights.

Annas (1975) and Annas and Healy (1974b) identify four goals for a patient advocacy system. These goals are:

> 1. to protect patients, especially those at a disadvantage within the health care system;
> 2. to make available to those who seek it the opportunity to participate actively as a partner with their doctor in a personal health care program;
> 3. to restore medical technology and pharmaceutical advance to proper perspective by confronting the exaggerated expectations of the modern American consumers, and
> 4. to reflect in the doctor-patient relationship the reality of the health-sickness continuum and the humanness of death as a natural and inevitable reality (Annas, 1975, p. 210-211; Annas & Healy 1974b, p. 257-258).

Annas and Healy (1974b) suggest that hospitals adopt a patient advocacy system, not only for its public relations value, but for resolution of doctor-patient difficulties at the hospital level rather than in court. Annas (1975) states that the advocate must have knowledge of medicine and law. The advocate must be hired outside of the hospital so that his first responsibility will be to the patient, not to administration.

> While certainly no panacea, the advocate could help not only the individual patient but also society and the medical profession in working toward what must be a common goal: ensuring that human rights do not become victims of medical progress (Annas & Healy, 1974b, p. 269).

Nursing and Patient Advocacy

The Report of the Secretary's Commission on Medical Malpractice (1973) recommended that "all ... nursing schools develop and require participation in programs which integrate training in the psychological and psychosocial aspects of patient care along with the physical and biological sciences" (p. 69). They also recommended that clinical courses which include human relations be required in all nursing curricula.

> Serious consideration should be given to the use of specially trained nurses as patient advocates....Nursing schools owe it to their students to train them in the art of advocacy. Nurses so trained can act not only as independent practitioners, but also can move into the direct care of the patients as partners of doctors....in promoting these (patient) rights, the nurse as patient advocate has the potential of playing the key role (Annas, 1974, p. 25).

Hesterly (1973), an operating room nurse, states that nurses have to assume the advocacy role: to nurse is to care. The nurse has been identified as the first to hear complaints and to receive questions from patients (Annas, 1974; Patients' privacy, 1975). This places the nurse in an unique position in regards to advocacy. Taylor (1970) also views the nurse as in a prime position. She states that the nurse because of "nursing's continuous responsible presence ... is in a superior position to see to it that the patient's environment is therapeutic at all times" (p. 59).

Levin (1972) encourages nurses to work hand in hand with the patients by supporting consumer involvement. Schaefer (1974) identifies the nursing process as a dynamic process with the client as the connecting link between the decision making process and the nursing process.

> In the past decade or so, nurses have slowly been claiming that their area of responsibility includes the reactions (human responses) of persons to problems relating to health.... Many are now saying that these reaction phenomena are the focus of nursing for which nursing interventions are being developed. This, of course, is to stake the claim that interventions for these phenomena are the particular responsibility for nursing personnel (Peplau, 1971, p. 6).

Just as nursing was a forerunner in declaring patient rights (National League for Nursing, 1959), now nursing must incorporate advocacy as an integral function of nursing. Unfortunately, the nurse has long been viewed as working for the administration and as the handmaiden of the physician. This raises some questions. Can nurses truly act for the patient? Can nurses be trusted in this role by patients (Annas, 1974)?

Purpose of the Study

This descriptive study examines the patient advocacy role as performed by student nurses. Abdellah and Levine (1965) state that descriptive research "provides a factual, descriptive picture of the situation" (p. 425).

With this in mind, the purpose of this study was twofold: 1) to explore the dimensions of the patient advocate role as implemented by student nurses in a private hospital diploma school of nursing; and 2) to describe the activities of the nursing students who functioned as patient advocates.

CHAPTER II

METHODOLOGY

This descriptive study aims at giving an accurate view of patient advocacy as performed by student nurses.

Subjects and Setting

The subjects were twelve third year student nurses from Good Samaritan Hospital & Medical Center School of Nursing in Portland, Oregon. These students functioned as patient advocates for one month of their psychiatric experience. The remainder of the psychiatric experience consisted of one month in community experiences and one month at Dammasch State Hospital.

At the beginning of the school year, rotation patterns were determined according to student requests on a first-come basis. Thirty students began the psychiatric experience in January 1976. These thirty students were randomly assigned among three subgroups; twelve to the patient advocacy group, eight to the state hospital group and ten to the community group.

The students in the patient advocacy group were all female. Mean age was 21.9 years. All but one were Caucasian. Three had education beyond the high school level. One had completed two years of basic science at a state college, the second had one year of basic science, and the third was a licensed practical nurse before entering the present diploma program.

The mental health coordinator for the school, along with the other psychiatric instructors, initiated the patient advocacy experience in September 1975 on the conviction that mental health principles need to be carried over into general hospital practice. The patient advocacy role was designed to provide the student nurse with an opportunity to look at the "whole person". The emphasis during this experience was on advocacy with the hope that the students would subsequently be able to incorporate the concept into all aspects of their nursing.

The objectives for the experience as given to the students follow:

> Overall objective: To isolate and amplify the patient advocate aspect of nursing with the goal of reintegrating this facet into the total role in a meaningful way.
> Specific objectives: The student will be able orally and/or in writing to express:
> -the factual observation that the health care system exists <u>because of</u> and <u>for</u> the client.
> -that all clients have dignity and worth.
> -that the nurse has a responsibility to cooperate with the physician in his medical plan to cure the patient.
> -that the nurse has a special responsibility to <u>care for</u> and <u>care about</u> all of the client's needs and problems and the client as a unique, whole person.
> -that it is the responsibility of the nurse to work in close cooperation with the physician in helping to meet the client's needs and in helping to solve the client's problems.
> -that it is the responsibility of the nurse to help the client identify his needs and problems.

-that it is the nurse's responsibility to be aware of the many health related resources and facilities available for meeting the needs and solving the problems of the client.
-that it is the nurse's responsibility to work with the client and the physician in utilizing the many appropriate resources and facilities available.
-that it is important to enter, work within and leave a system without being unduly disruptive.
-that the above objectives combine to assure comprehensive quality nursing care.

The student will demonstrate his/her ability to utilize the above concepts by:
-following a patient through the admission procedure to his bed;
-working with the head nurse and team leader to set up a nursing care plan;
-talking with the patient each day to help identify needs and problems;
-doing health teaching with counseling and support as a primary goal;
-assisting the patient/family to improve his/their coping skills rather than encouraging dependence on the nurse;
-working with the physician and other health team members in meeting needs of patients and helping patients to solve problems;
-contacting appropriate resource persons to help patients meet their needs and solve problems.

To document the achievement of these objectives each student was required to keep a log of ongoing experiences.

The students selected the areas throughout the hospital in which they wished to work. These areas included seven general medical-surgical units, the isolation unit, the gynecological unit and two intensive care waiting areas. These areas served as base stations for the students.

The twelve student patient advocates spent sixteeen hours each week functioning as patient advocates. The specific hours were established independently by each student. The students and the advocate instructor met twice a week for one hour in a seminar to share the meaning of their advocacy experience. Advocacy students also attended five hours of class along with the other psychiatric students to learn theoretical bases for practice. Finally, two hours per week were spent in group sessions. Each group consisted of ten students and one psychiatric instructor. This afforded the students an opportunity to share the overall psychiatric experience since each group had students from the patient advocacy, community and state hospital groups.

Although each advocacy student had a base station for her activities, she was encouraged to seek other experiences throughout the hospital. The chaplain, public relations director, visiting nurse and social worker all came to the classroom at various times to share their view of advocacy. This gave the students some insight into ancillary roles and how they advocated for patients. It also served to encourage the students to spend additional time with these various personnel. It was up to the individual student to arrange these experiences for herself.

Procedure

In preparation for this study, the investigator observed psychiatric classes and advocacy seminars during the winter term 1975-76. This gave the investigator knowledge concerning the introduction of advocacy to the student nurses.

The investigator then met with the subjects for this study during the first class period of their rotation and explained the purpose of the study. The students were asked to read and sign a consent form if they were willing to participate in the study (See Appendix B - Consent for Research Project).

Logs concerning advocacy experiences/activities were required (See Appendix C - Patient Advocacy Logs) and an interview was conducted with each of the twelve advocacy students at the end of the fourth (final) week of the advocacy experience. This interview had been pre-tested with three students who had completed the advocacy experience during the fall quarter of 1975.

The instructions given to each student before the interviews were:

> I am going to give you a series of questions relating to patient advocacy. There are no right or wrong answers. I am interested in your feelings and attitudes and experiences as a student nurse patient advocate. I would like

> you to be as specific as possible and to give examples where you feel they would be pertinent. I am going to tape record the interview so that I will not need to take notes and can give my full attention to what you are saying.

Data-Gathering Instruments

The major data-gathering instrument was an open-ended interview. It consisted of a series of question which were individually administered to each subject. The questions were selected after reviewing the literature and monitoring classes and advocacy seminars.

1. What does patient advocacy mean to you?
2. How does functioning as a patient advocate differ from your previous experiences as a student nurse?
3. Did you have any problems or difficulties with your own feelings regarding the role?

   Did you encounter any problems or difficulties with the staff while you were a patient advocate?

   Did you encounter any problems or difficulties with your peers; i.e. other student nurses while you were functioning as a patient advocate?

   Did you encounter any problems or difficulties with patients while you were functioning as a patient advocate?

   Did you encounter any problems or difficulties with anyone else that we have not already mentioned?

4. What kinds of patient problems or needs did you become aware of while functioning as an advocate? Did you become aware of any problems or needs of the patients' families while functioning as a patient advocate?
5. Are there any patient problems with which you feel the patient advocate should not be involved?
6. Did you ever discuss the issue of patient rights with your patients?
7. What was your one most rewarding experience as a patient advocate?
8. What was your least rewarding experience as a patient advocate?
9. What are your overall feelings about your patient advocacy experience?
10. If you were conducting this interview what question might you ask that has not already been asked?
11. Is there anything additional you would like to add?

Additional data were derived from entries into the logs kept on a routine basis by the students. These data included:

a) patient's response to patient advocate - (See Appendix C - log item 3);

b) patient problems - (log item 4);

c) patient advocate problems - (log item 5); and

d) positive and negative experiences for the day - (log item 6).

Analysis of Data

The interview and logs were analyzed by reviewing their content according to the following categories:

1) definitions of advocacy - derived from interview question 1;

2) functions of the patient advocate - covered in interview questions 2, 5 and 6 and in log items 1 and 6;

3) problems encountered by the student nurse while functioning as a patient advocate - obtained from interview question 3 and from log items 3, 5 and 6;

4) patient/family problems identified by the advocate - covered in interview question 4 and log item 4; and

5) subjective reactions of the students to the patient advocacy experience - derived from interview questions 7, 8 and 9.

Definitions of advocacy were sought since the review of the literature indicates a broad range of meanings to the term from listener to defender of patient rights.

No empirical studies of the enactment of the patient advocacy role have been conducted to date. Therefore, it was important to identify the functions developed by the student nurse patient advocates of this study. Nurses who have written about patient advocacy view themselves as defenders, intercessors, (Guy, 1971; Kosik, 1972), as listeners, interpreters, coordinators, expeditors, and defenders of patient rights (Cote', 1973; Nations, 1973).

These questions may then be posed: Would student nurse patient advocates function in these ways? Would the ways the student nurse patient advocates function be congruent with their definitions of the role?

It was the supposition of this study that the problems described by the student nurse patient advocates while in the advocacy role might give some insight into how nursing could function in relation to patient advocacy. Areas might be identified which need to be resolved before nursing can truly be "for the patient".

The kinds of patient and family problems uncovered by the student nurse patient advocates could help increase nurses' awareness of common areas of concerns for patients. It is only in recognizing problems that one can begin to resolve them.

CHAPTER III

RESULTS AND DISCUSSION

As mentioned in the preceding chapter, the purpose of this study was to explore the dimensions of the patient advocate role as defined by the student nurse patient advocates and to describe their activities as they implemented the role. This study was limited in its scope in that it dealt only with advocacy as viewed by the student nurses who were performing the role. It did not attempt to study the milieu of the hospital in which the advocacy role was implemented, nor did it attempt to identify the attitudes of the administration or the staff toward the role of advocacy.

The findings obtained from the interviews and the student logs may be summarized under the following broad headings: 1) definitions of patient advocacy; 2) functions of the student nurse patient advocate; 3) problems encountered in the role; and 4) problems of patients and families identified by the student nurse patient advocates. Additional information was obtained regarding whether the student nurse patient advocates believed there were any problems with which the advocates should not be involved, as well as what were the students' most rewarding and least rewarding experiences. Finally, statements were elicited from the students regarding their "feelings" about the advocacy experience as a totality.

Definitions of Advocacy

At least six elements were mentioned in the definitions of patient advocacy as given by the student nurse patient advocates. These six elements, in order of frequency of their mention, are acting as a liaison agent, problem solving, serving as the patient's representative, caring about patients and talking to patients, and performing in a public relations capacity.

Six students referred in some manner to being a liaison agent or buffer between the patient and/or his relatives and the staff and/or hospital system.

> It is a liaison between the nursing staff and the other departments of the hospital and relatives and patients. Sometimes people are really too busy to listen and maybe they forget to do something for the patients, and relatives can get frustrated with this (Student 1).
>
> ...Also getting hold of doctors, social service and business office to come up if the patient is concerned... (Student 4).
>
> ...to be a buffer between the patient and the hospital... (Student 6).
>
> A person who plays the medium between the patient and the hospital to smooth things over and to make the stay for the patient better (Student 7).
>
> Relating to the patient and finding out problems that might exist between the patient and the hospital and administration (Student 8).

> A channel between the staff and the patient. Aiding the patient in his emotional, mental and physical needs - besides regular physical needs (Student 10).

The function of problem solving was included in the definition by six students.

> To me that's helping the patients with their problems. It is not just giving physical care. But I feel I do better when I am giving physical care too (Student 3).
>
> I felt my role as a student nurse patient advocate was to find out if the patient was having any stress and to alleviate it - because stress aids in creating illness and it prevents getting better (Student 5).
>
> ...to help him work out any hassles that he has (Student 6).
>
> Relating to the patient and finding out problems that he might have with the hospital and the administration (Student 8).
>
> Talking to patients, seeing if they have problems. Helping patients to solve their problems with them making the decisions on what to do about the problem (Student 9).
>
> It is talking to patients to help them have a better hospital stay and helping them solve their problems (Student 12).

Talking to patients was mentioned in the definitions given by four students.

> To me it means getting in and talking to the patient... (Student 4).

> ...to be there if he needs somebody to talk with (Student 6).
>
> Talking to patients, seeing if they have problems....to talk to patients if they are lonely (Student 9).
>
> It is talking to patients to help them have a better hospital stay and helping them solve their problems (Student 12).

Three students suggested that advocacy involves representing the patient.

> When we first got started, I didn't know. Now I believe it is a patient representative. It doesn't necessarily need to be a special person with a title. I think the nurse can do it - where you are aware of the patient's feelings, that the patients do have feelings (Student 2).
>
> Being the patient's representative (Student 5).
>
> Being a representative of the patient to help him get his thoughts together about his care (Student 6).

A caring quality was evident in some of the students' definitions.

> ...I think the nurse can do it - where you are aware of the patient's feelings, that the patients do have feelings (Student 2).
>
> To me it means getting in and talking to the patient and letting him know that he is an individual and what is important to him is important to me. If he doesn't have a toothbrush or whatever and he needs that, than that's part of my extending my role to help him get what he can't get by himself while he is here....It is just being tuned in to people and letting them know that you care (Student 4).

> I think it is treating somebody in the hospital the way I would want to be treated if I was a patient. To me it is just making sure that the patient is as happy as he can be with his hospital stay because nobody likes to be in the hospital (Student 11).

A public relations element was noted in one definition.

> ...it is not letting patients go home with bad feelings about either the hospital or the staff or the medical field in general (Student 12).

None of the students defined advocacy in terms of patient rights.

The concept of patient advocacy is relatively new to the health care profession and no one concise definition can be found in the literature. In a like manner, the definitions given by the student nurse patient advocates also encompass many elements. All of the concepts brought out by the students' definitions, that is, representing the patient, buffer or liaison agent, assisting the patient with problem solving, caring, talking to patients and public relations are mentioned in the literature (Cote', 1973; Guy, 1971; Lowe, 1974; Nations, 1973). However, none of the students' definitions included patient rights while some of the definitions advanced in the literature do include defense of patient rights as a part of advocacy (Annas, 1974; 1975; Annas & Healy, 1974a, 1974b; Cote', 1973; Kosik, 1972; Nations, 1973; Proctor, 1975).

It appears that the student nurse patient advocates more easily identified with the roles of patient representative, liaison agent, assisting patients with problem solving, caring and talking to patients and public relations than with the role of defender of patient rights. The former activities are compatible with nursing, that is, the nurse may perform any of these activities as part of nursing, while the latter activity of defender of patient rights is not readily recognized as an area of nursing.

These students have not yet been fully socialized into the role of nurse. Therefore, one might argue that the students should be less molded in their nursing role and be able to identify more easily with roles that might be foreign to nursing. Conversely, it might be more difficult for the students to relate to the role of defender of patient rights since the students have few powers themselves. They are in a marginal position within the hospital system. How could such powerless persons ensure another's rights?

These student nurse patient advocates might be viewed as in a complex social situation. They are striving to take on the role of nurse and have expectations as to what this entails. At the same time they are striving as advocates to take on the advocacy role and the ensuing result is role ambiguity and/or conflict.

Functions of the Patient Advocate

The students' activities as patient advocates were many and varied. All of the students appeared to spend the bulk of their time talking with patients and families. Communication and emotional support played a large part in the role of the advocate. This role was seen as caring for the "total patient" and for his family as an extension of the patient.

In response to the question, "How does functioning as a patient advocate differ from your previous experience as a student nurse?", two major themes were evident. First, emphasis on communication was noted and second, emotional support versus physical care was mentioned. Role ambiguity and concern for the family were also evoked.

The emphasis on communication was mentioned in the following ways:

> It differed quite a bit in that it was mostly communication. There were a couple of times that I helped with some dressings but other than that it consisted of talking to the patient and the family and not doing physical care (Student 4).

> ...I had this one lady who was upset because her doctor didn't seem to be telling her things. I talked to her about it. Then read her chart. She was to have surgery the next day. I did some research on the surgery and was able to explain to her what was going to happen and it seemed to help her alot (Student 5).

> It gave me time to just talk to my patient....It gave me a better chance to communicate with them (Student 6).

> We got more time to do just that (advocacy) instead of the physical care. I spent more time sitting down and talking with the patients without having to hurry or rush to do this or that (Student 9).

> We had more time to talk with the patients, but I didn't like it as much as I liked doing total care (Student 11).

> ...I really think it helped the patient just having somebody come in and talk and not be rushed for time (Student 12).

The attention to emotional support as opposed to physical care is evident in the following answers:

> Well, it was really different because I didn't give the physical care. I am not used to just going in there and talking with someone. I think it is neat in that by not giving the physical care the patient is more apt to say that this was not okay or that this didn't happen...(Student 5).

> ...It gave me time to think about what was going on in their (the patients) heads and deal with that (Student 6).

> We were more involved with the patients' emotions and making their stay more comfortable even though we didn't do the actual care (Student 7).

> I didn't focus so much on the patients' emotional needs before - it was mostly physical - and this was mostly emotional (Student 8).

> We got more time to do just that (advocacy) instead of the physical care...(Student 9).

> I am standing back looking over what is being done, kind of an overview. I am looking closer to all the needs of the patient, rather than just his physical needs (Student 10).

> I really enjoyed not having to do the physical work and being able to just sit down and talk with the patients without having to worry about baths and medications...(Student 12).

Role ambiguity or conflict is also noted.

> It was highly unstructured. All of a sudden there was no right or wrong. There were no rules; it was just kinda do your own thing and it took awhile to adjust (Student 2).

> I felt we were supposed to be a part of the team, but I didn't feel that. I felt like I could help better when I was actually taking care of the patient. Then I could get at their problems better. But I don't think there should be just one person doing that (advocacy) but it should be incorporated into the role of the nurse (Student 3).

> We had more time to talk with the patients but I didn't like it as much as I liked doing total care (Student 11).

Concern with the family was brought out in one student's response to the question.

> I never really interacted deeply with relatives before. I would say "Hi" or "Can I help you?" or give them a chair or a cup of coffee or say "It's a nice day", but I never really looked at them as poeple who might have troubles and might need help. I got more involved with the family - definitely - as a patient advocate (Student 1).

The documentation of activities in the logs was incomplete in some instances. However, all of the logs noted instances of talking with and supporting patients while ten of the logs mentioned reassuring or supporting families of patients. Eight logs made specific reference to liaison activity between the staff and the patients and six contained references to patient teaching regarding diet, medications or pre-operative instructions.

It was important to determine if the activities of the student nurse patient advocates were congruent with their definitions of patient advocacy. The definitions considered the areas of patient representative, liaison agent, assisting in the identification and resolution of patient problems, public relations and caring and talking with patients. All of these areas were identified as appropriate for action by the student nurse patient advocate. In addition, some of the students were involved in patient teaching, discharge planning, and in performing extra comfort measures for the patients. In a way they performed a peer audit of the nursing care in their specific areas of the hospital. They compared the care that their patients were receiving to the care that most students would expect to receive themselves.

Only one student (Student 1) mentioned the family in her definition of advocacy. However, ten of the logs indicated that family support was a major activity for the student nurse patient advocate. Nursing claims to include the family in its holistic approach to patient care. One can only question if this has really been accomplished to date. It is as if the advocacy experience has opened the students' eyes to the existence and importance of the family.

Of the four functions of advocacy mentioned by Wright (Shontz, 1975) all were touched upon by the student nurse patient advocates. They performed heavily in the areas of communication and role support while monitoring of decisions made by the health professionals and preparing of patients for discharge were less evident.

The students had been primarily task oriented while in the traditional student nurse role. However, as advocates they were concerned more with communication and emotional support. This was mentioned in some way by ten students. Two students (Student 5 and Student 12) were favorable toward this orientation while two students (Student 3 and Student 11) stated they preferred doing total patient care. The remaining eight students mentioned this change but did not state any preference.

A dichotomy is evident here. Some students were comfortable in dealing solely with the social and psychological aspects of patient care while others preferred to combine these aspects with physical care.

One might ask if the physical or task orientation is particularly strong with this group of students in a three year diploma school. Perhaps this orientation would be less evident with baccalaureate nursing students. On the other hand, perhaps our cultural orientation positively sanctions the performance of physical care by professional nurses but discourages involvement with the psyche. One must question whether nursing as presently practiced does identify and aid in the resolution of emotional concerns of patients. If this were so, would being exposed to psychosocial problems of patients be such a concern for these students?

As the advocacy role is implemented by nurses, it seems apparent that there will be conflicts. Some nurses will be more comfortable incorporating advocacy into total nursing care, while others will want to be freed from the physical aspects of patient care while functioning as an advocate.

None of the student nurse patient advocates mentioned patient rights in their definitions of patient advocacy. Furthermore, only one student felt comfortable enough to discuss patient rights with a patient. Eleven of the twelve student advocates stated that they did not discuss the issue of patient rights with any of their patients. One student stated "No, because I was afraid to get into that, to say that you have the right to do this or you have the right to do that." Another said, "No,...I worried about getting into hot water with the hospital, and that was kind of a chicken way out not to tell them (patients). Nobody asked though." Another student said, "No. I was thinking about their rights while they were telling me what they had been through and if I had thought any of their rights had been violated, I would have said something." The twelfth student stated that she had touched upon the issue of patient rights with her patient who had lost her false teeth and glasses.

Although one must take care in making generalities, the one student who did discuss patient rights did so in regards to lost personal property. The element of humane treatment or personal rights was not discussed by any student.

The student advocate log entries indicated that the student appeared more comfortable bringing out rights to good physical care or in one instance to lost property. However, they were not comfortable in the area of psychological rights. In other words they seemed on shaky ground in the area of interpersonal interactions but were somewhat more secure when the right involved something tangible or a routine task. In this respect the way the students functioned might be compared to most existing grievance mechanisms in hospitals which tend to handle petty complaints (Report of the Secretary's Commission, 1973).

Role conflict is again evident here with the students being hesitant to point out deficiencies in care, being concerned over getting into trouble with the hospital. One student replied that "as a student, I think I am kind of a guest in the hospital. In a way, I walk a fine line." Could this student realistically be a defender of patient rights?

In the literature the question is posed whether or not there is an inherent conflict for nurses in being patient advocates (Annas, 1974, 1975). Guy (1971, p. 4) questions "Is our foremost commitment to the patients or to employers?..." The nurse when employed by the hospital owes her allegiance to the institution and the physicians, consequently can she represent or defend the patient? This role conflict may be even greater for student nurses. Students serve many masters. They are subservient not only to administration and to physicians, but also to the staff and instructors.

One student stated that she responded in the following manner to a complaint by a patient.

> My first reaction was well that's kind of a piddly problem. Then I thought, well, take it from the patient's point of view. It is a very important problem to him and to his wife. Then I thought about it from the staff's side because I've been on that side before. And I got to thinking that maybe they (staff) are super busy (Student 2).

Another student described her feelings when discussing how she handled a patient problem as "like being in the middle - really hard" (Student 3). These students are depicting a role conflict that must be resolved if nurses are going to function as advocates for the patient.

As stated earlier, in addition to functioning as an advocate on a specific unit, the students could elect to spend time with the chaplain, visiting nurse, social worker, or public relations director. They could also advocate in the emergency, admitting and/or day care departments.

Nine students chose to accompany the chaplain on his rounds. Seven students made rounds with the social worker and visiting nurse. Seven students worked as patient advocates in the emergency department, four students in the admitting department and three in the day care unit. None of the students chose to spend time with the public relations director.

All of the students reported that the time spent with the ancillary personnel was profitable and gave them more insight into the resources of the hospital. Since no direct feedback was obtained on the reason behind the lack of utilization of the public relations department, one could speculate that the students did not view public relations as a primary aspect of advocacy. This seems in accord with Annas (1975) and Annas and Healy (1974b) who state that public relations programs are not performing patient advocacy.

Problems in the Role

For purpose of analysis, the problems which were encountered in the advocacy role were divided into 1) problems with students' own feelings regarding the role of patient advocate; 2) problems with staff; 3) problems with peers; 4) problems with patients; and 5) any other problems.

Problems with own feelings

Ten of the twelve students admitted to having problems with their own feelings regarding the role. They made such statements as: "uncertain at times about what I was doing"; "felt anxious most of the time"; "I was really uptight with the role"; "I think every nurse should do it (advocate), but to go in and do it separately, I had negative feelings at times"; "hard to talk to people at first." Six of the students stated that they were not comfortable going in "to just talk."

Six students stated that they became more comfortable with the role as time progressed. One made the comment "just when you get the hang of something, it is time to move on to something else."

This anxiety as expressed by the student nurse patient advocates was related to uncertainty in the role and discomfort at least initially in "just" talking. Nurses are seen as task oriented and the isolation of the patient advocacy role placed the emphasis on emotional support as opposed to physical care. Since the physical aspect of care had taken priority with these students over the previous months of socialization into the role of nursing, one might anticipate that the students as a group would feel uncomfortable in their new role. Some students suggested that they were more comfortable in the advocacy role while physically caring for the patients. Then, too, the lack of structure in this self-directed experience caused uneasiness in students who were accustomed to clear cut directions and established written procedures.

Problems with staff

Nine of the twelve students stated that they encountered no problems with staff. Statements included: "No, never any problems"; "No, they were really helpful"; "Really cooperative"; "No, always really nice."

Another of the nine said "they accepted me once they knew what I was doing. I just said that I represented the patient - that I was mostly there to talk and that I wouldn't cause any trouble." She continued that "one of the residents was kind of suspicious at first, but after awhile she (the resident) was okay."

In reviewing the logs it was noted that two of these nine students wrote about patient difficulties with staff in which the student nurse patient advocate chose not to get involved. One stated "I kind of got negative feelings and steered clear" (Student 5). The other wrote about three individual patients who were having problems with staff. The student advocate listened but took no apparent action. One incident involved a patient who called for a bedpan. The student wrote in her log

> Mrs. P. told me about an experience that she had with a nurse who got very angry with her because she called out for a nurse after she had her light on and no one came.

> She had to go to the bathroom and fast; she was afraid that she would wet the bed. So she felt justified in calling for the nurse so they would not have extra work. She felt very bad about the nurse yelling at her. I didn't feel it was right for the nurse to yell at her, but I didn't want to tell Mrs. P. this (Student 3).

The conflict of roles is again brought out. The student felt that the patient was not being treated properly; however, the student advocate did not feel comfortable in stating this to the patient or in bringing about any change. One must be reminded that these were students and this situation might be faced more easily by a professional nurse who possesses more status and is more comfortable in her role.

The remaining three students mentioned incidents that occurred with staff, always over the concern of a patient. The first incident involved a nurse's ignoring a family who was waiting for over an hour to see their loved one in the intensive care unit. The student nurse patient advocate persisted until the family was finally allowed in the unit. The student reported that she was the one who became frustrated while the family accepted the wait patiently. This same student reported an incident about a minister waiting to see a member of his congregation. The minister was told at three o'clock that it was the change of shifts and that he could come it at 3:30 p.m. The minister was waiting patiently at four o'clock. The student said, "I told him I would check.

He had faith in the nurse that she did not forget him. I went in to check and found that the patient that he wanted to see wasn't even in the intensive care unit. She had been transferred to another floor." Once again the student was upset while the minister accepted it. Although it is recognized that the public is becoming increasingly concerned with the dehumanizing treatment given by hospitals (Lowe, 1974; Morgan, 1974; Ravich, 1975; Somers, 1971; Taylor, 1970), many continue to accept whatever the health care system says or does (Annas, 1975).

The second student reported about a patient who had not had a bath or his bed changed when she arrived in the afternoon. The patient's wife was attempting to give her husband a bath. The student nurse patient advocate reported this to the head nurse who apologized to the family and found someone to administer the bath. However, the student advocate reportedly felt "hostile vibes" from the head nurse. She stated that the nurse "apologized to the family but did not thank me or anything for bringing it to her attention." The student felt unappreciated by the head nurse. In this instance the student is not viewed as a member of the team who is attempting to ensure quality patient care, but rather is seen as an outsider, a troublemaker. The system does not build in rewards for the advocate.

The third student said "there was only one minor incident - a patient from Dammasch State Hospital wanted a pain med and

I asked the nurse for it. She got angry stating that he just had it." The student advocate was concerned that the problem was that the patient was from a mental hospital, not that he had just had the pain medication. Other than that she stated that the staff "would make suggestions and were glad that I was going around and helping the patients."

Verbally the students reported that they had few problems with staff. The logs support this. However, the logs also indicate that the students had minimal interaction with nursing and medical staffs. This may account in part for the small number of advocate-staff encounters. Some of the student advocate logs do indicate that the student advocates were aware of some patient dissatisfactions. These students listened and were supportive to the patient, but usually took no direct action to resolve the difficulty.

Once again we must visualize the student nurse patient advocate's position within the hospital system. As a student she is lowest in the hierarchy of power. The student nurse patient advocate had no real power. There was no established chain of communication for the student to follow when she encountered a problem. This lack of real or imagined power and the uncertainty in communicating problems contributed to the students' lack of assertiveness as advocates.

Problems with peers

None of the students encountered any problems with peers. Three of the students commented that the other students were helpful, making suggestions about which patients had problems, who might need their assistance. One student nurse patient advocate reported that she went to other floors - "other than my own and I'd ask them (the student nurses on the floor) 'Do you mind if I see your patient?' and they would say 'Sure, go ahead.'"

Problems with patients

Ten of the students reported that they encountered no problems with patients while in the advocacy role. Comments included: "No problems"; "No, they always accepted me"; "One patient said that it was really nice that someone was coming in to see how he was doing. He said that he didn't know that they had that kind of service here in the hospital"; "I had no difficulties with patients, some weren't really receptive but most of them really liked to have someone to talk to." One of the ten students reported that there were not enough patients available to her in the gynecological area.

The other two students reported instances of being rejected by patients. Annas (1974) questioned if nurses in the advocacy role could be accepted by patients because of the nurse's image as the helpmate of the doctor. In this study the patients as a whole accepted the student nurse patient advocates. In the two cases of rejection the patients appeared distraught and did not want to talk with anyone. The rejection was not related specifically to the student advocate. Rejection by patients and distrust were not evident problems for this group.

The patients and their families appreciated the availability of the student nurse patient advocates. However, they did not appear to utilize the advocates as effectively as one might hope. Perhaps the patients did not have a clear concept of the advocacy role. Perhaps the student advocates did not follow through on patient requests. This is an area that needs clarification.

Problems with others

Only one of the twelve students reported problems with anyone else. This student reported a difficulty with the wife of a cardiac patient. The wife, according to the student nurse patient advocate, refused to believe that her husband needed surgery. Based on his wife's lack of acceptance the patient was refusing surgery. This was frustrating to the student. One could question if this student was considering the patient's right to refuse treatment.

Summing to this point, the student nurses while acting in the capacity of patient advocates identified problems of role conflict, anxiety with the role, lack of reward from the organization and rejection by patients. No discussion of anxiety in the role, or of lack of rewards from the organization is found in the literature. However, Annas (1974) does discuss rejection by patients.

Anxiety with the role may be peculiar to students since it can be assumed that most advocates would have selected the role voluntarily and hence tend to be comfortable in that position. These students had no choice in the matter; performing as student patient advocates was expected of them in their psychiatric experience.

Lack of reward and occasional rejection by patients might be problems of some magnitude for all advocates. Advocates would seem to need to build in their own rewards in order to feel that their accomplishments were worthwhile.

Patient Problems Identified by the Advocates

Loneliness or just needing someone to talk with was mentioned by ten of the twelve students. One of the comments was that there is a "need for someone to listen, someone who seems like they care."

Hospitalization does separate one from his usual environment and loneliness would be an expected outcome of this separation. Hospital systems frequently ignore the patients' need for companionship.

Seven of the students mentioned fear or worry as an identified problem for patients. The fear was related to such concerns as lack of knowledge regarding procedures to be done, or fear of impending surgery. One patient was fearful of "going crazy." The student nurse patient advocate discovered that this was related to the sleeping medication and was able to relieve the concerns of the patient.

Other problems identified included concern with diet; upset with nursing care; confusion; frustration; lack of knowldege concerning medications, diet and treatment; gaps in communication between patients and staff; need for discharge planning; lost personal articles; and physical needs not being met.

None of the students identified any areas or problems with which they felt that the patient advocate should not be involved.

Family Problems Identified by the Advocates

Every one of the twelve student nurse patient advocates mentioned worry or concern over the illness of the loved one as a problem for the family. They identified a real need fof emotional support and reassurance of the family, as well as the need for the family to be better informed. Not knowing what was happening was identified as a source of anxiety for the family.

The student advocate in the intensive care unit saw a need for a liaison person between the staff and the family. This person could report on the condition of the loved one in the unit. Frequently, the staff was seen as too busy to talk with the family and reassurance about the loved one was deemed necessary.

Another identified problem was lack of places for families to spend the night. Some relatives were sleeping in the waiting area of the intensive care unit. The student nurse patient advocate procured a list of nearby homes which rent rooms at a reasonable rate and gave these to families. Finally, families often were not familiar with the physical plant. They needed directions to restrooms, telephones and cafeteria.

These student nurse patient advocates attempted to work hand in hand with the patient and the families as Levin (1972) suggests that it is time for the nurse to do. "The nurse is in a unique position to insist that the ... environment available to each patient should be as therapeutic as possible" (Taylor, 1970, p. 59).

Just as the student advocates' activities focused more on emotional support than physical care, so do the patient and family problems identified by the students depict the same emotional versus physical dichotomy. Loneliness and fear were the predominate concerns of the patients while physical needs seemed to be secondary. In a like manner, worry and concern occupied the minds of the families.

The patient and family needs are not being met today in our health care system. The present public relations programs deal mainly with housekeeping problems while the patient is primarily concerned with his health (Annas, 1974).

This study indicates that the patients' concerns regarding their health care were manifested in loneliness and fear. Effective communication skills would be helpful in identifying these concerns and in aiding the patient in the resolution of the same.

Most Rewarding Experiences

Seven of the twelve student nurse patient advocates reported that their most rewarding experiences were concerned with getting involved or giving support to family members.

Although the most rewarding experiences of the remaining five students varied, they, also, had to do with feelings of accomplishing something worthwhile. These experiences included developing a meaningful relationship with a cancer patient; referring patients to someone who could help them such as the social worker or visiting nurse; explaining to a patient that she was not going crazy; filling a need, especially for one lady, who needed someone to talk with; and "having the patient tell me 'You are the first person I met up with in this stay who has come back when they said they would.'"

All of these "rewards" came not from the organizational system but from inner feelings of having done something that benefitted the patient. In this respect the student advocates were building in their own reward system as the hospital system did not provide these rewards.

Least Rewarding Experiences

The least rewarding experiences as described by the student nurse patient advocates included: lack of feelings of accomplishment which was reported by five students; patient rejection of advocate reported by two students; patient inaccessibility reported by two students; and superficiality of experience reported by two students. One student advocate stated that she had no least rewarding experience.

In each of these reported least rewarding experiences the student advocates appeared to lack feelings of accomplishment or worth in their role. One must consider the possibility that ineffective communication skills were the major contributor to these feelings.

Overall Feelings Regarding Advocacy Experiences

Although many of the students were uncomfortable in the role or were glad that the experience was over or actually hated the experience, the group consensus was that it had been a profitable exposure. Each of the students in summing up her overall feelings made some positive statement or stated some way in which she had personally grown because of the experience.

The responses given by the student advocates are listed from most favorable to least favorable according to the impressions of the investigator. It is important to note both positive and negative aspects of the statements.

> I've really enjoyed patient advocacy. It was a great experience and I am going to miss it (Student 4).

> It was really good in that it made us more in tune with the resources available in the hospital, like the visiting nurse and the social worker, and more aware of the patients' feelings so that we can do something (Student 7).

> I thought it was really neat. It gave me a chance to sit down and work on skills with being with patients. As far as patient advocacy, I think the nurse should do it - not someone else (Student 6).

> I really got alot out of it. I hated doing it but I got alot out of it. It's hard to just sit down and talk. It got better after awhile. What I got out of if was that I considered other's anxieties and how they coped. I could pick up more things than I did before (Student 8).

> I kind of enjoyed it. It is a different aspect from what I am used to doing. It really gave me an insight into what other aspects there are, besides patient care. It really made me become more aware of the patient rather than just his physical needs (Student 10).

> Well, I have some good feelings, but it is hard for me in dealing with patients without taking (physical) care of them. For me that is hard. But going around with the chaplain and the visiting nurse was really interesting. I think four weeks is a bit much. If I was taking care of these patients too that would have been different (Student 3).

> Well, I think it is nice that it is pointed out to us but I think it should have started in the freshman year - with that being part of the role all the way through and not setting it aside as a special thing. I am all for the patients and am like that all the time. It was not that it was a waste of time, but I think it should be started freshman year (Student 11).

> It was kind of a good experience. It helped me be more comfortable with people, but it was hard for me to do, going in to talk with people. I wasn't really defined in what I was doing. It you are a nurse, you've got that purpose and you go in and do it. If you're a social worker, you've got that purpose. If you're a priest, you go in and you talk about that. And I don't know exactly where I fit in all that (Student 9).

> Well, I think it could have been better. I, myself, try to work as a patient advocate when I am working and I don't think you really need a separate area to do it. I'm glad I did have the chance to just go out and talk with patients and not have to worry about their physical care. I think I got more out of going around with people like the chaplain and the visiting nurse and seeing how they function (Student 12).

> I am really glad it is over with. I really was upset with the instructor because she presented it in a way that led to confusion. A lot of things that I had questions about and other students had questions about, she would say 'Well, I really don't know' and that was upsetting. I liked going in and talking with some of the patients especially when I felt like I was doing something.

> The first couple of weeks I didn't know what I was supposed to be doing and I'd get out of the room and I'd say 'Now, what did I do?' After the first couple of times I realized that I can't solve all their problems, so the only thing I could do would be to help them see some options for themselves. But it was a different insight, being strictly a patient advocate. I think it should be part of the nurse's functions and I don't think you are a good nurse unless you are a patient advocate and aware of the patients' needs. I learned alot of things about people and I think my communication skills have improved a great deal. It's made me more aware of the total patient (Student 5).

> Well, my first reaction was that it was a total waste of time. And I am not exactly sure why I felt that way. I don't think I set my expectations really too high. Everybody was saying that the instructor kept knocking us - telling us don't do this and don't do that. Except for one patient, I don't think I've been that beneficial to those people. I talked to them, so they had someone to talk to cause they're lonely; so it was beneficial in that way. I guess I did have expectations that were kind of high. I wanted to solve drastic problems. I wasn't too pleased with the four weeks. I think the medical profession gets off on a tangent and develops all these mini areas and I think it has gotten out of hand. It (advocacy) should be kept in line with the nurse and what she does. I get the feeling that they are trying to create a special person - over here is the patient advocate person, here's a nurse and over there is a doctor, and none of them is together. I don't think that is right. It confuses the patient. He has five or six persons coming in and he never knows who is who (Student 2).

> I am very ambivalent toward myself. Not toward what I am doing because I feel it helps. Sometimes I am overanxious. Sometimes I am comfortable and sometimes I am not. Sometimes I feel like 'What am I supposed to do?' or 'Can I do it better?' or 'Should I have said something?' All of these things were running through my mind because I really didn't feel comfortable in what I was doing. I really felt anxious most of the time. The time I spent with the chaplain and the visiting nurse was very positive (Student 1).

The anxieties and concerns expressed by these students indicate a need for more indepth preparation for the role of advocacy and what it entails. The students need to have immediately available to them a sounding board, so that concerns do not need to be "saved" until the next advocacy seminar. Despite the negative aspects brought out by the student advocates, the positiveness of the experience is evident.

CHAPTER IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this descriptive study was to explore the dimensions of the patient advocate role as implemented in a private hospital diploma school of nursing and to describe the activities of the nursing students who functioned as patient advocates. Twelve student nurse patient advocates participated in this study. Data were collected by means of a series of questions administered through an open ended interview and from student logs. A content analysis of the interview and logs permitted identification of definitions of advocacy, functions of the student nurse patient advocates, problems encountered by the student advocates while in the role and patient/family problems. Information was also obtained on subjective reactions of the student nurses to the advocacy experience.

There was no one concise definition of advocacy. Included in the definitions were liaison agent, patient representative, problem solving, caring, talking to patients and public relations. Patient rights were not mentioned in any of the definitions. Only one of the twelve students ever discussed patient rights with a patient and this was not in relation to human rights but rather to personal property.

Communication and emotional support of the patient and/or his family were of major importance in the activities of the student nurse patient advocates.

Problems in the role included: 1) anxiety in the role related to uncertainty, "just" talking, and difficulty working with problems of a psychosocial nature; 2) role conflicts involving commitment to hospital versus commitment to patient, advocacy versus nursing, and physical care versus emotional support; and 3) lack of rewards from the system.

Loneliness of patients and fear or worry of patients and/or families were identified as major areas of concern for patients and/or families.

On the basis of this study no widespread generalizations can be made. It is suggested that functioning as a patient advocate does create an area of role conflict for the student nurse who is still being socialized into the role of nurse. She is uncomfortable in the area of patient rights where one must be assertive to be effective. The student nurse patient advocate is powerless in the present hospital system and is unsure of herself in the defense of patient rights.

Responses of this group of student nurses to the patient advocate role highlight the conflict of task orientation to communication and emotional support. There was evidence of much difficulty in dealing with their own feelings regarding the role of patient advocate. Anxiety was noted in ten of the twelve students.

Although this study is limited in its scope, this investigator believes that advocacy can be incorporated into the role of nurse. It is suggested that advocacy be introduced to student nurses so that they can integrate it into all aspects of nursing.

Implications for further practice include that advocacy continue to be a part of the psychiatric experience, communication skills be enhanced by utilizing role play via videotape, and a chain of communication be developed and implemented which will aid in facilitating the development of student advocates feelings of certainty and power.

More interaction is needed with medical and nursing staffs. The team approach can be emphasized with the student advocates attending report, making rounds with medical and nursing staffs and visiting new patients daily. Each student should be afforded the opportunity to make rounds with the ancillary personnel. An effort to involve the patient relations director more actively in the program should be made.

The patients need to be more fully educated to the role of the student nurse patient advocate. The student advocate in each assigned area could make daily rounds to meet new patients and to explain the functions of the advocate.

Recommendations for further study include a comparative study of different levels of student nurse patient advocates, a study of utilization of graduate nurses as patient advocates and/or as role models for student nurse patient advocates, and determination of satisfaction of patients who are cared for by student nurse patient advocates. In addition, subsequent studies might seek 1) to study the milieu of the hospital in which the advocacy role is implemented so as to ascertain the impact of hospital policies on recognition of patient rights, and 2) to study the attitudes of professional staff toward the student nurse patient advocate role.

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APPENDICES

APPENDIX A

SOCIETY OF PATIENT REPRESENTATIVES

SOCIETY OF PATIENT REPRESENTATIVES

Early in the 1970's it was recognized that a number of hospitals and other health care facilities were feeling the need for a service which could provide a liaison between patients and the complex health care system which was serving them.

In March 1971 a meeting was held at the Thomas Jefferson University Hospital in Philadelphia, Pa., to determine how many hospitals on the east coast were utilizing the patient representative concept and how many others would be interested in creating the position. Approximately 140 people attended this meeting, representing 55 institutions in 9 states. Those states represented were New York, New Jersey, Pennsylvania, Connecticut, Massachusetts, Ohio, Illinois, North Carolina and West Virginia. As a result of that meeting a new organization was formed called "The Association of Patient Service Representatives."

On July 28, 1971 the Association of Patient Service Representatives petitioned the American Hospital Association to establish an affiliated Society of Patient Representatives. A statement of the goals, objectives and functions of this health career was presented. On September 23, 1971 members of American Hospital Association staff met in New York City with the executive committee of the new Association of Patient Service Representatives so that all aspects of affiliation could be discussed together in depth. Following that meeting a recommendation was made and approved for the creation of a Society of Patient Representatives within AHA.

An advisory panel was appointed and scheduled to meet in January 1972 to organize the new affiliated society, develop bylaws and prepare a slate of candidates for election to the first Board of Directors. The advisory panel which accomplished this important organizational effort and got the society launched as a national organization was as follows:

Doris Glasser
Long Island Jewish Hospital
New Hyde Park, New York

Anne Alexis Cote'
New York Hospital
New York, New York

Treuman Katz
Cedars Sinai Medical Center
Mt. Sinai Division
Los Angeles, California

Elizabeth Stone Miller
Thomas Jefferson University Hospital
Philadelphia, Pennsylvania

Mahon Washington
Michael Reese Hospital & Medical Center
Chicago, Illinois

An Education Committee was appointed and planned two workshops during the year. The first on Effective Communications was held in April in Miami Beach, Florida. The objectives were to develop an understanding of the importance of effective communications in the work of a patient representative and to provide the tools to enable patient representatives to improve and increase their skills in communication with patients, families and hospital staff.

In October 1973 a workshop was presented on Techniques for Increasing Effectiveness in Established Patient Representative Programs. This workshop offered a different method for learning, allowing for participant involvement through the case study method.

An Ad Hoc Committee on Career Definition was appointed to develop guidelines for the definition and development of patient representation as a health career. This committee prepared material which is now being distributed to hospitals around the country in response to the many requests for information about the concept of patient representation and for help in establishing programs.

The hardworking creative people who served on these original committees were:

Committee on Education

Irene Rosenfeld, Chairman
North Carolina Memorial Hospital
Chapel Hill, North Carolina

Elizabeth Miller
Thomas Jefferson University Hospital
Philadelphia, Pennsylvania

Carol Koranda
Good Samaritan Hospital & Medical Center
Portland, Oregon

Florence Hill
Department of Health and Hospitals
St. Louis, Missouri

Committee on Career Definition

Norma J. Shaw, Chairman
Queens Hospital Center
Jamaica, New York

Jenrose M. Martin
Norton-Children's Hospitals
Louisville, Kentucky

Geraldine W. Roberts
Cincinnati General Hospital
Cincinnati, Ohio

Delores Royal
University Hospital
Augusta, Georgia

Beatrice Sandvik
Virginia Mason Hospital
Seattle, Washington

Membership in the society increased steadily. This summary is written 1½ years after the emergency of the Society of Patient Representatives as a national organization affliated with the American Hospital Association. At this writing, the society has approximated 305 members from 43 states, including Hawaii, the Panama Canal Zone and Canada.

January, 1974

APPENDIX B

CONSENT FOR RESEARCH PROJECT FORM

Consent for Research Project

I, ______________________________, agree to serve as a subject in the investigation, Dimensions of the Patient Advocate Role as Experienced by Student Nurses, under the supervision of Arlene Jurgens. This investigation aims at 1) exploring the dimensions of the patient advocate role as implemented at Good Samaritan Hospital & Medical Center School of Nursing and 2) describing the activities of the nursing students who function as patient advocates.

I will be required to respond to some questions relating to patient advocacy during the final (fourth) week of my advocacy experience. The time required for this will be about thirty minutes. Also, I understand that the investigator will read my daily log and any information obtained from the log or interview may become part of the study. All information that I give will be handled confidentially.

Arlene Jurgens will be available to answer any questions that I might have regarding the tasks required of me in this study. I understand that I am free to withdraw from participation in this study at any time without affecting my grade or student status.

I have read the above information and agree to participate as a student nurse patient advocate in this study.

Signature ______________________

Date ________________ Witness ______________________

APPENDIX C

PATIENT ADVOCATE LOG FORM

PATIENT ADVOCATE LOGS

Purpose of the logs: to identify the need for patient advocacy in the nursing role and to identify the behaviors and activities of the student nurse patient advocates.

The following information is to be kept on each patient you are following:

1) Why are you seeing this particular patient?
   Did you select him? If so, why?
   Was he referred to you? If so, why?

2) Background information on patient - include age, diagnosis, mental status, any other information considered pertinent.

3) Patient's response to patient advocate - positive, negative, neutral.

4) Any patient problems which are identified - such as lonely, lack of information regarding medications, diagnosis, treatment, etc.
   How are these problems handled?

5) Any patient advocate problems which occur - such as rejected by patient, poor communication with staff, etc.
   How are these problems handled?

6) Positive and negative experiences for each day - include own feelings and reactions.

7) Amount of time spent daily with patient and/or family.

8) Disposition of patient if no longer being followed by patient advocate.

January 1976.

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF
ARLENE FITZGERALD JURGENS
IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF NURSING

Title: DIMENSIONS OF THE PATIENT ADVOCATE ROLE AS EXPERIENCED BY STUDENT NURSES

The purpose of this descriptive study was to explore the dimensions of the patient advocate role as implemented in a private hospital diploma school of nursing and to describe the activities of the nursing students who functioned as patient advocates. Twelve student nurse patient advocates participated in this study. Data were collected by means of a series of questions administered through an open ended interview and through student logs. A content analysis of the interviews and logs permitted identification of definitions of advocacy, functions of the student nurse patient advocates, problems encountered by the student advocates while in the role and patient/family problems. Information was also obtained on subjective reactions of the student nurses to the advocacy experience.

There was no one concise definition of advocacy. Included in the definitions were liaison agent, patient representative, problem solving, caring, talking to patients and public relations. Patient rights was not mentioned.

Only one of the twelve students ever discussed patient rights with a patient and this was not in relation to human rights but rather to personal property.

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Loneliness of patients and fear or worry of patients and/or families were identified as major areas of concern for patients and/or families.

On the basis of this study no widespread generalizations can be made. It is suggested that functioning as a patient advocate does create an area of role conflict for the student nurse who is still being socialized into the role of nurse. The student nurse patient advocate is powerless in the present hospital system and is uncomfortable in the area of patient rights where one must be assertive to be effective.

Responses of this group of student nurses to the patient advocate role highlight the conflicts of task orientation to communication and emotional support.

There was evidence of much difficulty in dealing with their own feelings regarding the role of patient advocate. Anxiety was noted by ten of the twelve students.

Implications for further practice in this diploma school of nursing include that advocacy continue to be a part of the psychiatric experience, that communication skills be enhanced by the utilization of role play via videotape, and that a chain of communication be established so as to facilitate the student advocates in feelings of certainty and power.

More interaction is needed with medical and nursing staffs. The team approach might be emphasized with the student advocates attending report and making rounds with the medical and nursing teams. Each student should be afforded the opportunity to make rounds with ancillary personnel.

The patients need to be more fully educated to the role of the student nurse patient advocate. The student advocate in each assigned area could make daily rounds to new patients to explain the functions of the advocate.

Recommendations for further study include a study of the milieu of the hospital in which the advocacy role was implemented in order to ascertain the impact of hospital policies on such a program, a comparative study of different levels of student nurse patient advocates, a study of utilization of graduate nurses as patient advocates and/or as role models for student nurse patient advocates, and determination of satisfaction of patients who are cared for by student nurse patient advocates.