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PATIENT ADVOCACY IN NURSING PRACTICE

- A systematic literature review



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PATIENT ADVOCACY IN NURSING PRACTICE

- A SYSTEMATIC LITERATURE REVIEW

Nursing advocacy is a relatively modern idea, its initial conception dating from the patient advocate movement of the 1970's. Its importance and prominence is reflected by its inclusion by various nursing bodies into their codes of ethics. Despite this, opinion is polarised as to the nature and extent of nursing advocacy. Nurses have reported "frustration" and "anger" as a result of them having to advocate on behalf of a patient (Hanks 2008, 470). Research involving British nurses in senior positions has revealed beliefs that the practice is subject to contradictions and paradoxes and can cause inter-professional conflict within the health care system (Mallik 1998, 1001).

The purpose of this research is to investigate and elucidate the practical difficulties, barriers and problems that nurses encounter when advocating for their patients. The aim is to publish the results of the research onto the Hoito Netti webpages in order to provide material which nurses may find useful when advocating for their patients. The research question shall be, "What obstacles do nurses face when advocating for their patients in general nursing? ". The research is commissioned by the Salo hospital district (Salon Alue Sairaala) and the results published on the Hoito Netti webpages for health care professionals.

A systematic literature review was used to collate all high quality research material pertinent to the research question. The PRISMA protocol for systematic reviews was followed and the CASP appraisal tool for assessing the research articles. The results were analysed using latent content analysis.

Obstacles to advocacy revealed by this research can be broadly characterised as antecedents and negative consequences or deterrents. The antecedents nurses require in order to be equipped to advocate include having empathy, confidence, theoretical and practical knowledge and personal knowledge of the patient. Deterrents include apathy, disagreement with the employing institution, conflict, medical dominance, negative consequences, harassment, confusion and ignorance of the concept.

KEYWORDS

Nurse, patient advocacy, nursing advocacy, experiences.

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List of Abbreviations

CASP	Critical Appraisal Skills Programme
CINAHL	Cumulative Index to Nursing and Allied Health Literature
NHS	National Health Service of the United Kingdom
PEO	Population Exposure Outcome
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis

1 INTRODUCTION

Nursing advocacy is a relatively modern idea, its inception being in the patient advocate movement of the 1970's (Hanks 2008, 469). Its importance and prominence are reflected by its inclusion by various nursing bodies into their codes of ethics (Hanks 2008, 468. Mallik 1998, 1002). Despite this, opinion is polarised as to the nature and extent of nursing advocacy. Nurses have reported "frustration" and "anger" as a result of them having to advocate on behalf of a patient (Hanks 2008, 470). Research involving British nurses in senior positions has revealed beliefs that the practice is subject to contradictions and paradoxes and can cause inter-professional conflict within the health care system (Mallik 1998, 1001).

The idea that patients require advocates does not seem to be in dispute. What is contentious is whether or not nurses are in the ideal position to undertake such work or whether the practice of advocating for the patient should be re-assigned to nursing's professional associations (Welchman et al. 2005, 296). Nursing advocacy activities have received less coverage in the research literature than the concept itself (Vaartio et al. 2006, 283). In 2002, a paper published by Hewitt in the *Journal of Advanced Nursing*, aimed to critically review the arguments debating the role of the nurse advocate. Hewitt noted an imbalance in the quantity of empirical research into the concept of nursing advocacy with the majority of research concentrating on theory and concept (Hewitt 2002, 439). By synthesising empirical research that provides concrete examples of the challenges nurses face in the field it is hoped to illuminate how the theory of nursing advocacy translates into practice. Nursing advocacy activities have received less coverage in the research literature than the concept itself (Vaartio et al. 2006, 283).

The purpose of this research is to investigate and elucidate the practical difficulties, barriers and problems that nurses encounter when advocating for their patients. The aim is to publish the results of the research onto the Hoito Netti webpages in order to provide material which nurses may find useful when

advocating for their patients. The research question shall be, "What obstacles do nurses face when advocating for their patients in general nursing? ". The research is commissioned by the Salo hospital district (Salon Alue Sairaala), see appendix attached, and the results will be published on the Hoito Netti webpages for health care professionals.

2 BACKGROUND TO NURSING ADVOCACY

2.1 The concept of advocacy

Mallik (1997, 131) observes that many nursing scholars use dictionaries as a starting point to define advocacy (Mallik 1997, 131). The Collins English Dictionary definition of the word advocacy is, “active support, esp. of a cause.” (Collins English Dictionary, 22). Woodrow (1997) recognises that the concept of advocacy arises in law, where the advocate consults a client before a case comes to court (see Hewitt 2002, 439). However Mallik claims that there is an assumption in the literature that patient advocacy by the nurses for the patients is distinctly different from other advocacy roles. Mallik (1997, 131) describes how the etymology of the word in the legal system refers to the concept of “counsel” with the result that “counselling” has been adopted by key theorists as an element of nursing advocacy. Mallik (1997, 131) further notes a difference in the structure of the advocacy relationship in law and in nursing. Whilst in law the etymology of the word advocacy relates to a “calling to” and the establishment of a contract between the parties, in nursing the action tends to reflect more a “giving of” of ones help to an individual. (Mallik 1997, 131.)

Vaartio and Kilpi (2004, 705) define the concept of advocacy as coming from the Latin “advocates”, meaning one who is summoned to give evidence. Vaartio et al (2004, 705) synthesised three definitions of advocacy derived from the empirical research of seventeen research articles. They were; advocacy as motivated by the patients’ right to information and self-determination; advocacy stemming from the patients’ right to personal safety and advocacy as a philosophical principle in nursing. Advocacy as a right to information and self-determination is described as “proactive” by the authors and involves but is not limited to; assisting the patient to define their wishes; informing them about their illness; rights and treatment options. Advocacy stemming from the patients’ right to personal safety is described as “reactive” and involves protecting a patient when their human rights are endangered. Vulnerable patients such as those with cognitive impairment or those under sedation may require an advocate.

Advocacy as a philosophical principle in nursing was reported as being embedded in nursing practice and involved interceding on behalf of a patient in ethical dilemmas.(Vaartio et al. 2004, 705-706.)

2.2 The history of Advocacy in nursing

Nelson (1998) describes how Florence Nightingale's concerns for patient safety constitute acts of advocacy (see Hewitt 2002, 440). This dedication to the patient has, however, sometimes lead to the nurse being in opposition to doctors. Snowball (1996) notes that it was not until 1973, that references to nurses maintaining loyalty and obedience to doctors was removed from the International Council of Nurses code (see Hewitt 2002, 440).

Cultural changes in the 1960's and 1970's lead to nurse theorists such as Henderson (1960) claiming that nursing was becoming patient rather than institution lead (see Hewitt 2002, 440). The upsurge in feminism and civil rights in the 70's in the USA spread to the United Kingdom and resulted in the birth of the debate regarding nurse-doctor-patient power relations (Snowball 1996, 68). Advocacy in nursing ethics has been discussed since first appearing in the literature in 1973 when it was added into the Professional Codes of the International Council of Nurses (Vaartio et al. 2004, 705). Patient advocacy as a central nursing role was identified in the Code of Professional Conduct of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in 1992 (Hewitt 2002, 439). According to Mallik (1997), the patient advocacy movement has its roots in the United States, arising from the strong emphasis on human rights (see Hewitt 2002, 440). A paucity in empirical literature from outside the United States was noted by Snowball in 1996 (Snowball 1996, 69). The nursing profession in the United States has dominated the influence of the acceptance of the role of nurses as patient advocates in the United Kingdom (Mallik 1997, 130).

2.3 The need for patient advocates

By acting as advocates nurses are able to empower weak and vulnerable patients releasing them from discomfort and unnecessary treatments. Patients also require protection from acts of incompetence by health care professionals. (Vaartio et al. 2004, 705.) Mallik (1997, 131) notes that whilst historically patients have always been deemed to become vulnerable as a result of their physical condition, it is only recently that cultural conditions have resulted in this vulnerability as being seen to impact upon the patient's autonomy thus instigating a requirement to advocate (Mallik 1997, 131). In the United States, Annas a lawyer, proposed a "Model Patients Bill of Rights" and the role of a "Patients Rights Advocate". The role of the Patients Rights Advocate was described as being independent of the institution. Annas believed nurses had an important role to play in "according" patients rights. (Mallik 1997, 131.)

However, it is not only weak and vulnerable patients that require advocates. Hewitt claims that patients are in danger of entering a process of "learned helplessness" as a result of an "omniscient and uninformative" doctor, resulting in the inability of the patient to speak for themselves (Hewitt 2002, 440). Tuxhill (1994) notes all healthcare professionals, despite their best intents, exercise a form of benevolent paternalism which restricts the self determination of the patient (see Hewitt 2002, 440).

Despite many research articles starting with a presumption that patients do indeed need advocates, there is little evidence to support this claim (Vaartio et al. 2004, 713). Authors have expressed different opinions as to whether this helplessness is the root cause of the need for patient advocates or whether indeed the opposite is true. The belief in the omniscience of medical science began to wane in the 1980's, with the patient becoming a knowledgeable consumer, bearing the right to question treatment (Hewitt 2002, 440). Many theorists describe the purpose of advocacy as defending and or promoting patients' rights. Willard describes how these rights may manifest as moral or legal (Willard 1996, 62).

Bu et al (2006, 104) describe the kinds of events or incidents which instigate an advocacy intervention on both the macro and micro social level and describe these as “antecedents” as they pre-exist the occurrence of advocacy (Bu et al. 2006, 104). Tripp-Reimer (1999) describes the imbalance in health status and access to healthcare between whites and minorities in the USA over the past 40 years as a macro social antecedent (see Bu et al. 2006, 102). On the micro social level, patient vulnerability is the most commonly cited condition in the literature requiring an advocacy intervention (Bu et al. 2006 105). Vulnerable patients may be those who are illiterate or do not fluently speak the language of the health care system in which they are being treated. Patients may be deemed vulnerable through a learning disability. Patients may also be considered vulnerable as a result of their physical condition or the anxiety it causes, such as those patients suffering from cancer. The ability of patients who are suffering mental illness or who are unconscious as a result of procedural intervention or accident are considered vulnerable in this respect. It has been noted that some patients who are otherwise competent in normal circumstances become “tongue tied “, shy and scared in the presence of the doctor. Other antecedents include patients who have been treated unethically, negligently or incompetently. (Bu et al. 2006, 105.)

2.4 The meaning of advocacy in nursing

Advocacy in nursing has been described as an “ethical ideal” (Davis et al. 2003, 404). Advocacy in nursing has been described as participating with the patient in determining the meaning of health, illness, suffering and dying ; providing information and supporting patients in their decisions; pleading the cause of a patient; protecting the patient from unnecessary worry ; disclosing negligence and misconduct and valuing, appraising and interceding (Vaartio et al. 2006, 282). Advocacy has further been defined to include the acts of so called “whistle blowing” that is, making known public, institutions or practices that are deemed unethical or negligent (Davis et al 2007, 194). In short, interpretations of what nurses perceive to be acts of advocacy vary, to the extent that the term may appear a convenient “buzzword” to label a diverse range of activities (Snowball

1996, 67). Edelman (1967) described advocacy as a myth, “a set of ideas that is widely taught and believed without serious attempt at verification” (see Snowball 1996, 67). Vaartio et al (2006, 286) cite nurses who have described advocacy as an action that goes beyond providing good care (Vaartio et al. 2006, 286). Gosselin-Acomb reports on a case where the nurse believed advocating was something that went “extra and above routine care” (Gosselin-Acomb 2007, 1072).

According to Mallik (1997, 132) there exist three prominent nurse theorists whose writings have underpinned the academic debate on the nature of nursing advocacy. Those of Curtin (1979), Gadow (1980) and Kohnke (1980). Two different models of advocacy often feature together because their foundations are similar, those by Curtin and Gadow. (see Mallik 1997, 132). Gadow (1980) proposed a model of advocacy built on the “humanistic theory of nursing” where it is the patient and not the nurse who must define what is in the best interests of the patient (Hewitt 2002, 443). Central to this theory is the idea that the nurse and the patient share a common humanity; the closeness of the caring relationship being central to the translation into advocacy (Mallik 1997, 132). Curtin (1979) proposes that the nurse-patient relationship is “pivotal” around which other nursing interventions revolve. The advocates role is to support the patient in their choice. This model of advocacy involves minimal risk to the advocate as they are primarily helping patients to make sense of their situation but falling short of supporting them in the decisions they have made. This model is characterised as a philosophical model of nursing advocacy. Ten years after the publication of this model, Gadow recognised the limitations in that it could not apply to those patients who were unable to communicate with their nurses. (see Mallik 1997, 132.)

Kohnke’s theory is described as a functional model of advocacy by Mallik. Like Curtin and Gadow, Kohnke shares a view that patients have a right to self-determination. Kohnke’s model is described as informing the patient of their rights and supporting the decision the patient makes including the right to freely make decisions as they so wish. Kohnke’s model requires the nurse to make

decisions including whether to advocate or not and whether or not undisclosed information should be revealed. For Kohnke, advocacy is not believed to be a “natural” role of the nurse, and that the skills and knowledge must be acquired and it contrasts with the nature of advocacy in the model of Curtin and Gadow which may be viewed as more passive (Mallik 1997, 132). Kohnke elaborates that nurses can support patients’ decisions by both acting and not acting. By not acting Kohnke means that nurses should refrain from coercion especially in a situation where the nurse does not agree with the decision being made by the patient (Mallik 1997, 132). Gadow (1979) suggests that advocacy helps patients to find meaning in the personal experience of illness, suffering and dying (Snowball 1996, 69).

Attempts have been made within nursing science to clarify the concepts of nursing advocacy. In 2007 Bu et al (2007, 101-110) published a paper which aimed to “clarify and refine the concept of advocacy through synthesising the advocacy literature” because they believed the concept of patient advocacy lacked a consistent definition. Their study synthesised 217 articles and three dissertations published between 1966 and 2006. From this data it is claimed that three core attributes of the concepts of advocacy emerge. They are; safeguarding the patient’s autonomy, acting on behalf of patients, and championing social justice in the provision of health care. (Bu et al. 2007, 101-110.) These first two themes, it is suggested, are born from the theories of Curtin, Gadow and Kohnke. The last, the theory of social advocacy, was added by Fowler in 1989 (Bu et al. 2006, 103). The first core attribute of advocacy, safeguarding a patient’s autonomy, is concerned with actions which respect and promote a patient’s self determination. There are however two caveats, patients must first be competent and secondly they must want to be involved in their healthcare and to be fully informed. This concept of advocacy can be described as being concerned with patients’ legal rights. (Bu et al. 2006, 103.) The second core attribute of nursing advocacy as synthesised by Bu et al, is “acting on behalf of patients”. This involves acting for patients who are unable to represent themselves or who do not wish to represent themselves. Patients who are unconscious would belong to this group. The third concept is that of

“championing social justice in the provision of health care”. It is concerned with nurses actively striving to make changes to address inequalities and inconsistencies related to the provision of healthcare. Bu et al (2006, 104) also characterise the nature of advocacy as being on a micro social level or on a macro social level. By this they mean advocacy actions that either concern an individual and their treatment; a micro social advocacy intervention, or on a macro social level such as those interventions aimed at addressing social injustice in health care provision. (Bu et al. 2006. 104.)

Belief in personal autonomy is a common theme and is the basis for the advocacy models of Curtin, Gadow and Kohnke. Autonomy can be described in its broadest sense as meaning self determination. Yeo (1991) also describes four specific meanings of autonomy. Firstly, autonomy of “free action”, concerned with patients’ rights. Secondly, autonomy as effective deliberation, concerned with the patient’s ability to make a rational decision. Thirdly is autonomy as authenticity, concerned with the notion that the patient’s choices are consistent with their generally held beliefs and ,fourthly, autonomy as moral reflection, or being aware of the values expressed through the choices made.(see Mallik 1997, 133.) According to Mallik, the model of Curtin and Gadow is primarily concerned with the ideas of autonomy as authenticity and moral reflection, the model of Kohnke being more concerned with autonomy of free action and deliberation (Mallik 1997, 133).

2.5 Obligations and justification of nurses to advocate

Various professional nursing bodies require their members to advocate on behalf of their patients. The American Nurses Association Code of Ethics states its commitment to patient advocacy (Hanks 2008, 468). So too does the United Kingdom Central Council for Nursing Midwifery (Mallik 1998, 1002). The Canadian Nurses Association code of ethics for registered nurses 2002 describes the nurse’s obligation to advocate (MacDonald 2006, 121). Despite this, “meanings and models” of advocacy in nursing remain indeterminate and nurses are compelled to undertake potentially risky behaviour without adequate

support and authority required (Mallik 1998, 1001). Bu et al (2006) claim that neither the American Association of Nurses or the International Council of Nurses code of ethics contain a definition of patient advocacy despite their requirements for nurses to act as advocates (Bu et al. 2006, 102).

There are common themes that emerge in the literature with regard to justifying why nurses are in the best position to advocate for patients. Mallik (1997,134) synthesises “a traditional role in nursing” as the first of three justification arguments. Mallik (1997, 134) notes that although there are claims that nurses have always advocated at the level of their basic daily activities as a nurse, this notion is incommensurate with the vast body of knowledge that exists describing how, historically, the position of nurses within the healthcare system has been one of subordination. “Nurses being in the best position to advocate” is the second role Mallik synthesizes from the literature. Nurses are possibly in the best position to mediate in the healthcare system because they occupy the middle ground between the patient and the doctors. This proximity to the patient allows a unique relationship to develop at the emotional level which could be construed as a moral mandate to advocate on account of the nurse having intrinsically gained a unique knowledge of the patient.(Mallik 1997, 134.) “Nurses know how to advocate” is the third justification argument synthesised by Mallik from the literature with technical knowledge that nurses demonstrate being perceived as authority to advocate. There exist two facets to this concept of knowing how to advocate, that is, both the process of advocating and also the potential content of the encounter. The encounter itself may require the nurse to have experience of ethical decision making. There is difference in opinion as to whether knowledge of the healthcare system or personal qualities and professional experience are more important than education.(Mallik 1997, 135.) The fourth argument for justifying the nurse as the ideal advocate cites the nature of the nurse as an ideal partner of the patient in advocacy. This argument stems from observations that the position of being powerless and subordinate to the medical profession is common to both patients and nurses alike. Critics of this position argue that two powerless parties do not necessarily unit to form an empowered unit. (Mallik 1997, 135).

It is claimed that despite being difficult to describe, advocacy has none the less become embedded in nursing practice (Thacker 2008, 175). Whilst advocacy is seen as being central to nursing practice, a clear definition of what it is, is difficult to find (Zomorodi et al. 2009, 1748). Some authors claim that the simple act of caring is, in itself, a form of advocacy (Hewitt 2002, 442).

2.6 Nursing advocacy; a divisive issue

Opinion is polarised as to the validity of the practice of patient advocacy as related to nurses. There are examples of nurses holding self contradictory opinions about advocacy and disagreement about how it should be implemented. Mallik (1998, 1001) conducted a study which sought to reveal the views and positions of nurses who held senior position within the British nursing establishment. Mallik found that although these so called elite believed advocacy to be integral to the moral value system of nursing as applied to the nurse patient relationship they objected to the role being professionalised. The objection was based on the grounds that exclusive claims from nurses on the right to advocate for patients might intensify inter-professional conflicts within the health care system. (Mallik 1998, 1001.) British nurses in senior positions have expressed the belief that whilst advocating for patients was good professional practice, nurses' sole claims to be in the best position to act for patients amounted to a professionalisation strategy for nursing. The nursing elite interviewed for Mallik's research rejected the sole claim to advocacy on the same basis that they reject the nurses' sole claim to be the "carers" rather than "curers" arguing that it is offensive to suggest that other health care providers are not providing care. These nurses also believe it entirely possible for other healthcare providers to provide advocacy and point out the doctor should be doing this as part of their natural role. Paradoxically, despite these critical observations these nurse remained committed to the idea that sometimes patients need advocates and nurses could in theory be in the position to undertake the role.(Mallik 1998, 1004). Generally the respondents of Mallik's study were in agreement with the centrally held hypothesis that the nurse patient relationship provides nurses with the ideal information required to

advocate. One participant expressed the opposite idea, that claims to know everything there was to know about someone from a brief nursing acquaintance amounted to impertinence. (Mallik 1998, 1005).

Woodrow (1997) notes that most arguments calling for nursing advocacy derive from the nursing profession itself (see Hewitt 2002, 443). These attempts to professionalise the act of caring could be seen to serve the interests of “nursing” rather than those of the patients (Hewitt 2002, 444). Mallik states that the main source of conflict which often arises when nurses practice advocacy is between themselves and the medical profession and that this encounter may sometimes be implicitly more concerned with tempering medical dominance rather than addressing the concerns of the patient. Patients are also sometimes sceptical that nurses have the power to intervene on their behalf. Respondents in Mallik’s study indicated they believed that advocacy was something a nurse should be charged with by the patient. When conflict does arise because the patient’s choice cannot be sincerely argued or represented by the nurse then an argument exists for appointing an independent advocate. (Mallik 1998, 1006.)

Handy (1985) has argued that it is impossible for nurses to act as patient advocates because they “internalise” the views of the dominant power, either those of doctors or the employing institution. Witts (1992) maintained that nurses education does not prepare nurses for the advocacy role. (see Hewitt 2002, 441.) Allmark and Klarzynski (1992) allude to the fact that as part of the health care system, nurses do not have the impartiality to act as patient advocates; they draw an analogy of the nurse as patient advocate with a policeman advocating for a person in their custody (see Hewitt 2002, 442). Woodrow (1997) cites different demands from different patients as a possible cause of ethical conflict for the nurse (see Hewitt 2002, 442). Willard claims that the act of advocacy is confused in the literature with the act of beneficence, that is, the act of doing good, or kindness. Further, Willard notes that promoting patients’ moral and legal rights requires nurses to give open, correct and honest information to safeguard the patients autonomy. (Willard 1996, 60-62).

According to Vaartio and Kilpi, nursing advocacy cannot be equated with the legal advocates role but must be seen in terms of “furthering health and nursing care”. It includes ensuring that patients are aware of their rights and are in the position to make informed decisions. It also includes protecting patients against incompetence. (Vaartio and Kilpi 2004, 705.) However, nursing advocacy has generally not been accepted by other health care professionals. In particular, the medical profession has displayed hostility due to what it perceives as encroachment upon its territory (Hewitt 2002, 441). The legal position is unclear. Whilst doctors in the United Kingdom are entitled by law to withhold information under the “therapeutic privilege”, if it is deemed in the best interests of the patient, the nurses ability and right to question this privilege is undetermined. (Hewitt 2002, 444)

2.7 Benefits and consequences of advocacy

The consequences of advocacy for the patients have only been reported as beneficial in contrast with those reported for nurses. For patients, positive benefits manifest as positive health outcomes. Vaartio et al (2004, 710) report very specific patient outcomes such as increased patient survival in care of the elderly and increased birth weight of babies of low income mothers as positive effects of advocacy interventions (Vaartio et al, 2004. 710-711). On a general level, positive consequences include preserving and protecting patients rights, values and autonomy and empowering the patient (Bu et al. 2006, 105). With regards to social justice advocacy, participating in policy making and changing inappropriate rules are anticipated positive outcomes (Bu et al. 2006, 105). Positive consequences for nurses include professional autonomy and proficiency (Vaartio et al, 2004. 710-711). Bernal (1992) reports positive consequences including enhancing and improving the public image and professional status of nurses (see Bu et al. 2006, 105).

Risks to nurses from patient advocacy are often reported and discussed. They stem largely from the conflict of loyalties and accountabilities of the nurse within the healthcare system. (Mallik 1997, 136). Nurses acting as advocates have

been labelled as trouble makers by colleagues, accused of insubordination and have suffered the loss of reputation, friends and self esteem. Patient advocates may experience moral distress due to moral dilemma resulting in a feeling of powerlessness. Whistle blowing has been reported to result in ostracism and disruption extending to nurses personal lives. (Bu et al. 2006, 105.) Negative consequences for nurses include loss of job, status or professional role or direct conflict with the organisation (Vaartio et al, 2004. 710-711).

Despite the fact that nurses are obliged by their professional associations to advocate, there remains little practical support and protection leaving the nurses potentially exposed to conflict (Hewitt 2002, 442). Salvage (1985) has written on the medical hostility attracted by nurse advocacy (see Hewitt 2002, 440). Independent advocates have been suggested by Mallik (1997) and Holmes (1991) and have become a reality in the United States of America and the United Kingdom (see Hewitt 2002, 443).

2.8 The situation today

Today in the United Kingdom there exist volunteers who are independent of the health care institutions working in an advocacy role to protect the interests of the mentally ill and handicapped, the elderly and the otherwise disenfranchised. In the National Health Service of the United Kingdom, in recent years, the role of Patient representative has been introduced. This role is not specifically defined as being concerned with advocacy and there is some evidence of boundary disputes arising between nurses and Patient Representatives. (Mallik 1997, 131). Pullen (1995) has suggested that the role of patient advocate in the United Kingdom would be best fulfilled by specialist nurse practitioners (see Mallik 1997, 131). In the United States professional patient advocates appeared in hospitals in the 1970's (Mallik 1997, 131).

In Finland the act on the "Status and Rights of Patients" came into force on the 1st May 1993. Finland was the first country in Europe to implement such an act to protect patients rights. In the context of patient advocacy, the act ensures the right of the patient to "self determination". The word "autonomy" is not used in

the Finnish health care legislation, “self determination” being used in its place. Self determination is taken to mean that medical care must be planned and implemented in mutual understanding with the patient. There is no clear definition in the health care acts of Finland regarding which kinds of situations require informed consent. A patient’s right to self determination is limited under the Finnish health care acts in certain situations. Self determination is limited in certain circumstances covered by the Mental Health Act, the Act on Social Work with Intoxicant Abusers, The Communicable Diseases Act and in the Act on Special Care for the Retarded. Section 11 of the Act on Status and Rights of Patients demands the provision of a patient ombudsman to advise on the provision of the act, to help patients with complaints, inform patients of their rights and act for the promotion and implementation of patients rights. (Leino-Kilpi et al. 2000, 10).

A patient’s right to privacy is protected under section 3 of the Act on Status and Rights of Patients. Exceptional circumstances by where health care personnel are allowed to divulge information regarding a patient include when a patient is unconscious and there is no reason to believe the patient would otherwise object. Informed consent concerns the patient’s right to have access to information regarding their condition, the proposed treatment plan, alternative treatments available and the likely outcome of such treatments. Exceptions include when the patient has expressed a wish not to be kept informed and also if giving the information would cause serious hazard to the life or health of the patient. Sections 7 and 9 of the Act on Status and Rights of Patients deals with a child’s right to self determination. If a minor is deemed capable of deciding on the treatment option available to them then it is their right to do so. Section 8 prescribes that a patient who has steadfastly and competently expressed their will regarding their courses of treatment, emergency care shall not be provided to the contrary when that person becomes incompetent through unconsciousness or other reason.(Leino-Kilpi et al. 2000, 13-14.)

3 Aim and Question

The purpose of this research is to investigate and elucidate the practical difficulties, barriers and problems that nurses encounter when advocating for their patients. The aim is to publish the results of the research onto the Hoito Netti web pages in order to provide material which nurses may find useful when advocating for their patients. The research question shall be, "What obstacles do nurses face when advocating for their patients in general nursing? ".

4 Methods

4.1 Research rationale and design

In 2002, a paper published by Hewitt in the *Journal of Advanced Nursing*, aimed to critically review the arguments debating the role of the nurse advocate. Hewitt noted an imbalance in the quantity of empirical research into the concept of nursing advocacy with the majority of research concentrating on theory and concept (Hewitt 2002, 439). By synthesising empirical research that provides concrete examples of the challenges nurses face in the field it is hoped to illuminate how the theory of nursing advocacy translates into practice. Investigating the barriers or obstacles that nurses face in general nursing is pertinent to health care in Finland because a patient's right to self-determination is protected by law and this right is generally agreed to be a central tenet of nursing advocacy. Nursing advocacy activities have received less coverage in the research literature than the concept itself (Vaartio et al. 2006, 283). The aim is to publish the results of the research onto the Hoito Netti webpages in order to provide material which nurses may find useful when advocating for their patients. The research is commissioned by the Salo Hospital District (Salon Alue Sairaala), see appendix 1 attached, and the results will be published on the Hoito Netti web pages for health care professionals.

A systematic review to find qualitative and quantitative peer reviewed articles was conducted. A systematic review is pertinent in the context of this study because it aims to synthesize all high quality peer reviewed evidence on the subject and aims to synthesize the results in an unbiased way, presenting the results objectively and independently (Bettany-Saltikov 2010, 47). This is critical to this subject matter given the emotive extremes of position that characterise the research literature.

Literature was searched through the Turku University of Applied Sciences online databases of CINAHL and Medline Ovid. Key words were based on the PEO anagram for qualitative research, where P stands for population, E for

exposure and O for outcome (Bettany-Saltikov 2010, 51). Keywords were nurse, nursing advocacy or patient advocacy, and experiences.

The Preferred Reporting Items for Systematic Reviews and Met-Analysis or PRISMA was adopted as the methodological framework. The PRISMA protocol was adopted as a template for the study as it is sanctioned by the Cochrane library, which is itself, widely regarded to be the benchmark of quality for conducting literature reviews. The process of screening was based on the PRISMA flow diagram. (Moher 2009)

4.2 Search Terms

A search was carried out in the CINAHL and Medline databases through the portal of the University of applied Science, Turku on the 26th and 27th January 2012 respectively using the open ended search term nurs*, nursing advocacy, patient advocacy and experience*. Search dates were restricted from 1988 in CINAHL and 1946 in Medline. Both databases were searched to the present day. Preliminary searches of complete texts revealed a quantity of literature far beyond the scope of this researcher to review. According to Aveyard (2010, 78), when a researcher is overwhelmed by the literature it is permissible practice to confine the search terms to abstract only (Aveyard 2010, 78). This was the method used in this case. Table 1 below shows the search stream.

Table 1. Search stream

Population	Exposure	Outcome
1 nurs*	2 nursing advocacy	5 experience*
	3 patient advocacy	
	4 combine 2+3 using OR	
6 combine 1, 4 and 5 using AND		

The terms of the strategy were formulated using the PEO anagram for qualitative research outlined by Bettany-Saltikov (Bettany –Saltikov, 2010).

Step 1 identified all texts using the open ended search term “nurs*” as the target population of the research. Step 2 searched the term “nursing advocacy” as an exposure pertinent to the study. Step 3 searched the term “patient advocacy” as an alternative exposure because experience dealing with the literature revealed that academics from different sides of the Atlantic refer to the same practice by different names. Step 4 combined steps 2 and 3 with the integer OR. Step 5 used the open ended word “experience*” to signify the outcome. The final step combined steps 1, 4 and 6 with the integer AND. Results are outlined in table 2, Data base search results.

Table 2. Data base search results

Database with dates	Search date	Number of hits	Number of duplicates	Number of articles eligible by primary inclusion criteria.	Number of eligible articles retained by secondary criteria.	Number of full content articles available
CINAHL (1988-2011)	26/01/2012	66	0	44	19	12
MEDLINE (1946-2012)	27/01/2012	63	42	9	3	3

4.3 Inclusion and exclusion criteria.

CINAHL returned 66 results after being limited to peer reviewed articles. Medline returned 63 articles. The Medline articles were unable to be screened for peer review. Of the Medline articles, 42 were duplicates from CINAHL. The titles and abstracts were then screened in a two stage process outlined in figure 1. the PRISMA flow chart, illustrated below.

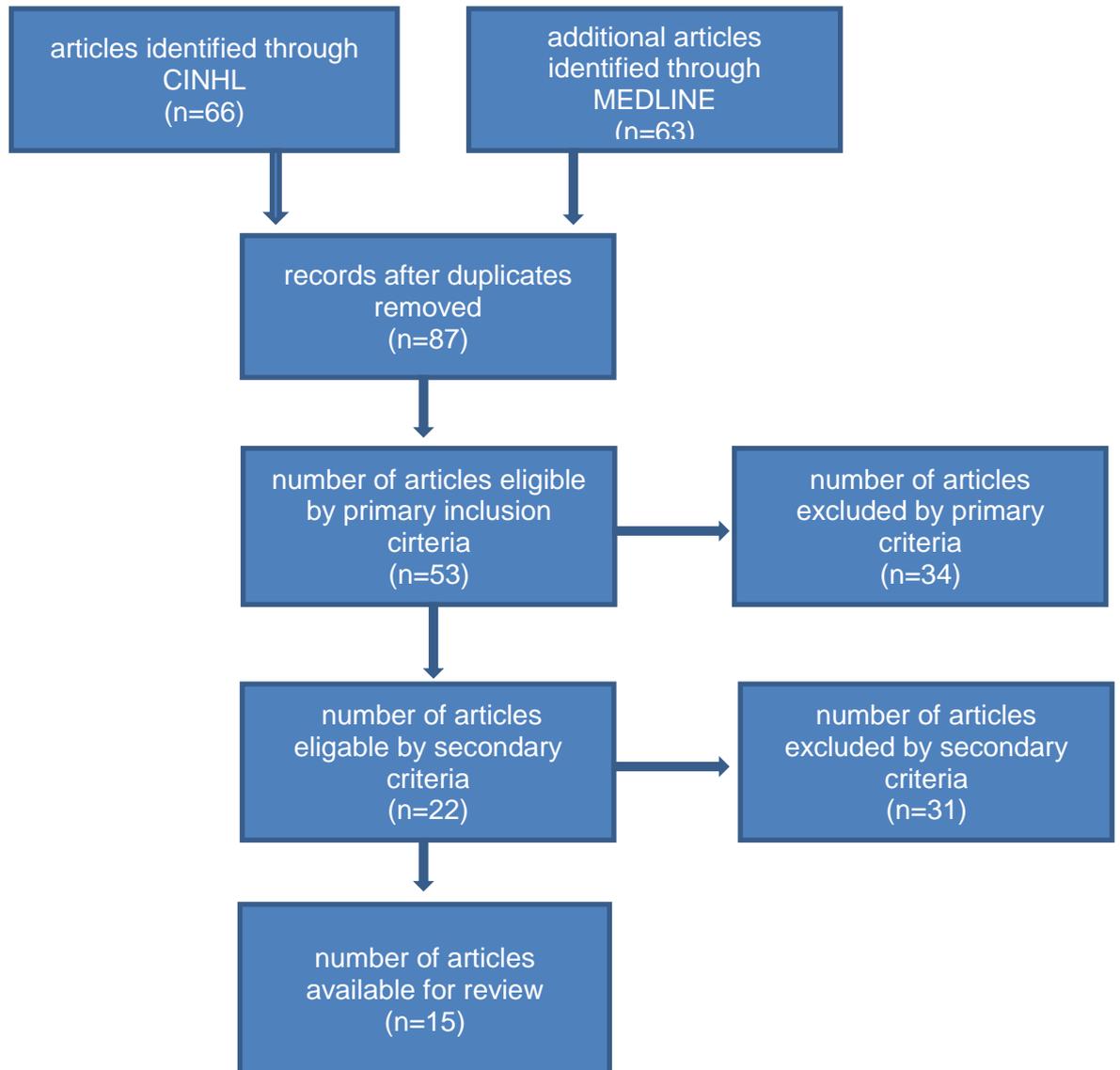


Figure 1. PRISMA flow chart (Moher 2009).

The first round of screening determined whether the article was eligible under criteria designed to determine the suitability of the methodology to answer the research question. Primary inclusion eligibility criteria included that the research be empirical and peer reviewed. Primary exclusion criteria included articles that were theoretical or position papers, papers not published in English and systematic literature reviews. Systematic literature reviews were excluded because it was deemed important to access primary, raw data that was unsynthesised in order to adequately answer the research question.

The first round of screening reduced the CINAHL pool of articles to 44 and the Medline pool of articles to 9. The second screening criteria concerned the content of the research and whether it was likely to contain information pertinent to the research question. Eligibility inclusion criteria were based on the PEO search anagram that the research was likely to report the exposure reported by the population of nurses concerning the exposure of advocacy. Secondary exclusion criteria included those articles concerning mental health patients, since the autonomy of this population is already limited by their legal status. Mallik (1997, 133) notes in her article of 1997 that Gadow had previously excluded mental patients as being able to benefit from nursing advocacy because they are, as she describes, “silent”, they are unable to impart their wishes to the nurse or any third party. Advocating for these individuals will therefore involve, in part, an act of paternalism (Mallik 1997, 133).

5 Results

15 papers were available for the research and they were subject to a preliminary analysis the results of which are summarized in the table below.

Table 3. Characteristics of included studies

Author	Year	Title	Method	Sample	Results	Strengths & Weaknesses
Snowball, J	1996	Asking nurses about advocating for patients.	Qualitative-Interpretive. "Hermeneutic" Semistructured interviews. Purposive pool. Sample was volunteer group.	n=15	Implied barriers. The need to be a friend. Risk.	Ethical approval obtained. Study sample were "enlightened nurses". Included.
Jackson, D. Raftos, M.	1997	Confronting the culture of silence in residential care institution.	Qualitative. Interviews. Purposive sample.	n=3	Barrier. "Conflict with attitude of management.	Participants actively sought. Participants edited content. Included.
Hart, G. et al	1998	Mediating conflict and control:palliative care.	Qualitative. Reflective framework. Analysis by iterative approach.	n=15	Barriers. "organizational policy can limit care" "direct conflict with doctor"	Included.
Snellgrove, S. et al	2000	Interprofessional relations between doctors and nurses.	Qualitative. Semi structured interviews. Inductive content analysis.	n=39	Implied barriers. Need for experience. Doctors will not take inexperienced nurses advice.	Included.
Breeding, J.	2002	Registered nurses' lived experience of advocacy.	Qualitative. Phenomenological. Audiotaped interviews. Purposive sample.	n=5	Barriers. "suffering snide comment from colleague,public humiliation, ongoing	Included.

					conflict.”	
Ahern, K. et al	2002	The beliefs of nurses involved in a whistleblowing event.	Qualitative. Descriptive survey. Forced answers	n=95	Risk as a deterrent to advocate.	x Excluded: forced answers. Includes data from mental health nurses.
Boyle, H.	2005	Patient advocacy in the perioperative setting.	Qualitative. Phenomonological. Purposive sample. Interviews with three open ended questions.	n=33	Barriers not reported.	x Barriers not reported.
Vartio, H. et al	2006	Nursing advocacy: how is it defined.	Qualitative. Inductive content analysis. Convenience sample.	n=21	Experience.	Included.
McGrath, P.	2006	Nursing advocacy in an Australian multidisciplinary context.	Iterative, qualitative, phenomenological. Open ended interviews.	n=18	Barriers. “medici-centrism prevents nurse advocacy.” “lack of understanding at hospital sub culture of what nursing advocacy is.” Implied Barrier. Doctors unaware of what nursing advocacy is.	Included.
Gosselin- Acomb, T.	2007	Nursing advocacy in	Qualitative. Semi structured questionnaire. Some forced	n=141	Barriers. “lack of time”.	x Excluded unable to

et al		North Carolina.	answers.		Implied barrier. Need ongoing education.	distinguish forced answers.
Davis, A.	2007	Whistleblowing in japan.	Qualitative questionnaire. Forced choice and open ended questions.	n=24	Barriers unclear.	x Excluded. No data on barriers. Forced answers.
Hanks, R	2008	The lived experience of nursing advocacy	Qualitative study. Phenomenological . semi structured interview	n=3	Barriers unclear.	x Unable to extract data
Thacker, K	2008	Nurses' advocacy behaviours in end of life care	Qualitative/quantitative. Comparative descriptive study.	n=317	Barriers. "Physician" "patients family" "fear" "Lack of communication" "lack of knowledge" "lack of time" "lack of support"	x Was it a leading question? Was the method objective?
Black, L	2011	Tragedy into policy.	Quantitative. Questionnaire. Forced choice answers.	n=564	Implied barrier. Fear of retaliation.	x Excluded.
Jowers Ware , L	2011	Factors that influence patient advocacy by pain management	Quantitative. Descriptive correlational study. Fixed answers.	n=188	Barriers. "lack of employer support" "lack of professional clinical experience"	x Excluded.

		nurses.			<p>“professional obligations” “power struggles” “lack of assertiveness” “concern over disapproval from admin” “family obligations” “no mentor/role model” “time” “cost” “distance”</p>	
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The information in Table 3 was used to further appraise the research articles in order to identify which papers were likely to answer the research question and which were to be excluded, if any, for other reasons. The articles of Thacker (2008), Black (2011) and Jowers-ware (2001) were either described as mixed qualitative or quantitative research and were of very large samples compared with the other qualitative studies. The studies of Black (2011) and Jowers-Ware (2011) offered fixed answers to the question “What barriers do nurses face when advocating for their patients?”. They were excluded for this reason. By the same argument the study by Thacker (2008) was excluded not because the answers were fixed but because the question of “What barriers do nurses face when advocating?” could, in itself, be consider leading or polarising.

The qualitative study by Ahern (2002) was excluded because it only offered fixed answers to questions. Studies by Davis (2007) and Hanks (2008) were excluded because it was not possible to extract the relevant data. The study by Boyle (2005) was excluded because barriers or obstacles were not reported. The study by Gosselin-Acomb (2007) was excluded because it was not possible to determine which answers were from fixed lists. These exclusions are potential limitations of this research and are discussed later. Seven articles were left.

5.1 Appraisal process.

Seven articles were left for review, all of which were qualitative and contained an element of interview. These articles were subject to appraisal under the Critical Appraisal Skills Programme (CASP) generated by the Centre for Evidence-Based Medicine in The United Kingdom (Polit 2012, 669). Table 4 below shows the results of the appraisal. Aveyard (2007, 91) councils that for the purpose of systematic reviews as part of a bachelors thesis it is unwise and unnecessary to exclude research due to the appraisal process, but rather include research and site particular weaknesses where relevant (Aveyard 2007, 91). For this reason this element of appraisal was left to last to avoid unnecessarily appraising articles that would not qualify for other reasons. The

ten questions for appraisal are listed in Table 4 below. Each article was awarded a value score out of ten to signify its adherence to the criteria.

Table 4. CASP appraisal questions and results.

Question	Snowball 1996	Jackson 1997	Hart 1998	Snellgrove 2000	Breedin g 2002	McGrath 2006	Vartio et al 2006
Was there a clear statement of the aims of the research?	*	*	*	*	*	*	*
Is a qualitative methodology appropriate?	*	*	*	*	*	*	*
Was the research design appropriate to address the aims of the research?	*	X	*	*	*	*	*
Was the recruitment strategy appropriate to the aims of the research?	*	*	Not reported	*	*	*	*
Were the data collected in a way that addressed the research issue?	*	X	*	*	*	*	*
Has the relationship between	*	X	X	X	*	*	X

researcher and participants been adequately considered?							
Have ethical issues been taken into consideration?	*	*	Not reported	Not reported	*	*	*
Was the data analysis sufficiently rigorous?	*	*	S	S	S	S	*
Is there a clear statement of findings?	*	*	*	*	*	*	*
How valuable is the research?	*	*	*	*	*	*	*
Appraisal score	10/10	7/10	6/10	7/10	9/10	9/10	9/10

Key: *=yes X=no S = Subjective

5.2 Synthesis and analysis

Articles were subject to latent content analysis in order to extract the data from the text. Articles were read, codes highlighted and sub themes and themes formed from the data. Data concentrated on the manifest content of the article or that which was being reported. According to Graneheim et al, researchers need to identify what it is that is the object of study and have called this item the unit of analysis. (Graneheim et al 2004, 105-107.) For this research, the unit of analysis was any object, event, person or idea that prevented or deterred a nurse from deciding to advocate on the patient's behalf. It should be noted here that the unit of analysis was not preconceived at this point and could manifest in any way. Also, it was not presumed that the action the nurse was taking was a

real advocacy event because there is no consensus to define it. Rather, it is understood that the nurse believed they were advocating for their patient. The meaning unit refers to the sentence or group of words that convey an idea and is referred to here as a content unit or coding unit. Where necessary, shortening of the text or condensation has been undertaken, that is, shortening the text but preserving the underlying meaning. (Graneheim et al. 2004, 106.)

The seven remaining articles were coded according to the recommendations of Graneheim and Lundman (Graneheim et al 2004, 107-108). As has been discussed in the background to this study there are various descriptions of advocacy. For the purpose of identifying these from the articles they are identified as acts defined as advocacy by the nurses themselves or any action taken by a nurse in order to influence the direction of the patients care plan because the nurse felt it was in the best interests of the patient. It is intended that this definition is more structural and does not limit the definition of advocacy to its content. In this way it is able to cover simple acts of caring in the same scope as complex acts interceding in hospital policy and ethics. In dealing with the text it became very clear that antecedents or pre-conditions or rather the lack of them was a significant factor in preventing a nurse from advocating. The unit of analysis came to also mean qualities or attributes in the environment or human agents that were a pre-requisite to advocacy. In this way the absence of these qualities is considered an obstacle to nursing advocacy. The results appear below in Table 5, Article coding.

Table 5. Article coding

Author & Year	Code
Snowball (1996) (1)	<p>Advocacy requires a therapeutic/friendly relationship between the patient and the nurse.</p> <p>Nurse must show they share a common humanity with patient in order to develop therapeutic relationship.</p> <p>Risk to nurse professionally by antagonising nurse-doctor relationship.</p> <p>Challenge to medicine.(Some view this conflict as necessary and positive)</p> <p>Need for a culture where nursing input valued in health care decision making.</p> <p>Higher education of other healthcare workers to achieve equivalence.</p> <p>Being suffocated by management culture and bureaucracy.</p> <p>Nurse requires confidence.</p> <p>Good communication between doctors and nurses required.</p>
Jackson (1997). (2)	<p>Disagreement with managerial policy over prioritise: clinical or clerical.</p> <p>Marginalisation by other staff.</p> <p>Fear of ruination of career.</p>
Hart (1998) (3)	<p>Organisational constraints or conflict with organisational policy. Patient wanted more autonomy(weekend pass) not allowed by policy.</p> <p>Distress from becoming emotionally close to patient and family.</p> <p>Co-existent contradictory ideology, advocate of patients' wishes, advocate of good nursing practice.</p> <p>Confrontation with doctor because of difference in opinion.</p> <p>Balancing wishes of family and patients in palliative care.</p>
Snellgrove (2000) (4)	<p>Majority of doctors unaware of concept of patient advocacy.</p> <p>Difference in opinion about what qualifies a nurse to enter into decision making collaboration with doctors. Nurses say education/training.</p> <p>Doctors respect clinical experience.</p> <p>Working in general medical/surgical nursing or in a specialized area.</p> <p>Nurses in specialisms are treated more equitably.</p>
Breeding (2002) (5)	<p>Suffering a snide comments or public humiliation by doctor as a result of advocating for patient.</p> <p>Disagreement with different members of patients' family over most appropriate course of treatment for patient. Pleasing family members with different wishes.</p> <p>Conflict of interest in by following patients' wishes causing distress to patients' family.</p> <p>Needing supportive relationships with colleagues to follow difficult course of action.</p>
McGrath (2006) (6)	<p>Advocacy requires a professional attitude.</p> <p>Advocacy requires multi disciplinary acceptance of need for patient centered advocacy.</p> <p>Advocacy requires time spent and familiarity with patient.</p> <p>Medico-centrism potential obstacle in patient advocacy.</p> <p>Advocacy requires the nurse to have confidence.</p> <p>High level of practical knowledge required.</p> <p>Doctors interviewed did not have a language for advocacy.</p>
Vartio et al (2006) (7)	<p>Being in dialogue with patient about wants and needs.</p> <p>Theoretical and practical competence of the nurse.</p> <p>Being sensitive or aware of the needs of a patient who cannot express them for themselves.</p> <p>Being aware of patients right to act autonomously (not being paternalistic).</p> <p>Ability of nurse to act autonomously.</p> <p>Negative feedback from patient or doctor to nurse.</p>

	Negative impact on career prospects.
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The codes extracted from the text were then placed into groupings with similar characteristics. These groups have then been given a theme or category. This theming and categorisation is illustrated in Table 6, Themes and Sub-Themes illustrated below.

Table 6. Themes and Sub-Themes

Unit of analysis	Sub-categories	Categories
1) Advocacy requires a therapeutic/friendly relationship between the patient and the nurse. 1) Nurse must show they share a common humanity with patient.	Relationship with patient	Pre-conditions
1) Nurse requires confidence. 6) Advocacy requires professional attitude. 6) Advocacy requires the nurse to have confidence. 7) Ability of nurse to act autonomously.	Human attributes	
1) Need environment conducive to nurse advocacy role. 5) Need supportive attitude from colleagues. 6) Multi disciplinary acceptance of concept of advocacy.	Conducive environment	
2) Disagreement with managerial policy over prioritise: clinical or clerical. 3) Organisational constraints or conflict with organisational policy.	Disagreement with employing institution	Confrontation
1) Risk from antagonism/confrontation with medicine. 3) Confrontation with doctor.	Conflict	
4) Difference in opinion about what qualifies a nurse to enter into decision making collaboration with doctors. Nurses say education/training. Doctors respect experience. 6) Medico-centrism potential obstacle in patient advocacy.	Medical dominance	
1) Higher education to equate with other healthcare workers to achieve equivalence.	Higher education	
6) High level of practical knowledge required. 7) Theoretical and practical competence of the nurse.	Learning by doing	Knowledge
2) Fear of ruination of career. 4) Distress from closeness to patient/relative. 7) Negative feedback from patient or doctor to nurse. 7) Negative impact on career prospects.	Negative consequences	
2) Marginalisation by other staff. 5) Suffering a snide comments	Harassment	Fear

or public humiliation by doctor as a result of advocating for patient.		
3) Co-existent contradictory ideology. 5) Pleasing family members with different wishes. 5) Following patients wishes which differ to families.	Conflict of interest	Dilemma
3) Unclear beliefs about role of advocate. 4) Doctors unaware of concept of patient advocacy. 6) Doctors interviewed did not have a language for advocacy.	Unawareness of advocacy.	Ignorance
6) Advocacy requires time spent and familiarity with patient. 7) Being in dialogue with patient about wants and needs. 7) Being sensitive or aware of the needs of a patient who cannot express them for themselves. 7) Being aware of patients right to act autonomously(not being paternalistic).	Knowing the patients needs and wants.	Knowing (the patient).

From the table we can see that there are seven emergent themes: pre-conditions, confrontation, knowledge, fear, confusion, ignorance, and knowing the patient.

5.3 Subthemes and themes

The results are discussed in the context of reviews into nursing advocacy that have been conducted over the last twenty years as well as with the results of the other articles excluded from this study. The three reviews conducted have been by Mallik, "Advocacy in nursing – a review of the literature" (1997), MacDonald , "Relational ethics and advocacy in nursing: literature review" (2006) and "Nursing advocacy – a review of the empirical research 1990-2003", (2004) by Vaartio and Kilpi 2004.

Table 7 below shows the purpose and nature of each of the seven studies, the subjects of the study and describes how the data was reported.

Table 7. Nature of the studies

Study	Purpose of study	How obstacles are reported
Snowball 1996 United Kingdom	To explore perceptions, understanding and experience of patient advocacy of 15 nurses working in general nursing.	Audiotaped semi structured interviews used to elicit narrative accounts.
Jackson 1997 Australia	To explicate experiences of some Australian nurses involved in a whistleblowing event. Events concerned were of neglect of elderly in a nursing home.	Field notes from a string of interviews. Method may be regarded as unscientific.
Hart 1998 Australia	To generate knowledge to improve palliative care nursing practice.	15 practice incidents are commented on by nurses. Nurses believed they were advocating.
Snelgrove 2000 United Kingdom	To examine accounts of doctors and nurses about differences and overlaps of their roles. (Their perceptions of their roles and interprofessional their relations).	Nurses report advocacy as a way to challenge doctors. Doctors do not mention advocacy voluntarily (what are we to read into this omission). Doctors report expecting input from nurses when they are experienced. Nurses report thinking training important.
Breeding 2002 Australia	To reveal the essential nature of the lived experiences of advocacy of nurses in a critical care unit.	Nurses reported barriers during interviews.
McGrath 2006 Australia	To report on the effectiveness of nurse to advocate in a culture of medico centralism.	Doctors, nurses and allied health professionals reporting in interviews.
Vaartio 2006 Finland	To describe the nursing advocacy is defined, the activities it involves and the way it is experienced by nurses and patients.	Nurses report from three open ended questions.

From the information in Table 7 we are able to make some general observations about the character and scope of the research. The articles span sixteen years and come from three countries, two of which are English speaking. Four of the seven articles (Jackson 1997, Hart 1998, Breeding 2002, McGrath 2006) were authored by Australian researchers. Three of the articles (Snowball 1996, Breeding 2002, Vaartio et al 2006) purported to report on some aspect of nurses' experiences of advocacy and as such the aim of the research closely matched the nature of the PEO anagram used in the search strategy. The article by Jackson (1997) explicitly aimed to elucidate the experiences of nurses aimed in a whistle blowing event; that is, making public institutional abuse and neglect of vulnerable patients. The studies by Snellgrove (2000) and McGrath (2006) aimed to look at advocacy in the context of nurse/doctor relations. The last article by Hart (1998) aimed to look at advocacy in the context of palliative care. It should be noted that it was not anticipated that relevant barriers or obstacles would be uncovered by other stake holders in the planning of the methodology. Doctors in particular revealed pertinent information that represents significant obstacles for nurses to advocate and therefore this unexpected data is included and synthesised alongside that of the nurses in this study.

Pre-conditions

The results in this category could be described as either pre-conditions or antecedents. They are either qualities that a nurse must possess in order to be equipped to advocate or favourable conditions in the environment. They are considered for the purposes of this research to be obstacles because their lack of presence inhibits the ability of the nurse to advocate. Sub-categories in this group were; relationship with the patient, human attributes and conducive environment.

In the sub-category, "relationship with the patient", nurses were articulate in communicating what they thought was important in empowering a nurse to advocate. Nurses in the article by Snowball (1996) reported both that it was important to have a friendly attitude with the patient and also to show a common

humanity with them. This reflects the theories of Gadow and Curzin who claim being emotionally involved with the patient was important in enabling advocacy.

The second sub-category was “human attributes”. In both the articles by Snowball (1996) and McGrath (2006) nurses reported the need for confidence as a pre-requisite to advocacy. The article by McGrath (2006) also reported the nurses needing a professional attitude. The article by Vaartio et al (2006) reported the ability of nurses to act autonomously as a precondition. These results reflect the observations of Mallik (1997, 135), that experience and personal qualities are both necessary to advocate (Mallik 1997, 135).

The third sub-category in this group is “conducive environment” and alludes not only to positive attitudes in other members of the multidisciplinary team but also to the nature of the health care institution. Snowball (1996) reports the need for a conducive environment to support the role of the nurse as advocate. Breeding (2002) reports the need for a supportive attitude from colleagues. McGrath (2006) reports on the necessity of multi-disciplinary acceptance of the concept of advocacy.

Confrontation

Confrontation features widely through the articles studied for this research. The nature of the confrontation is reflected in the three sub-categories; “disagreement with the employing institution”, “conflict” and “medical dominance”.

Conflict in this research seems to be clearly delineated between the physician and the nurse, or the employing institution and the nurse. Being in “conflict with the employing institution” was the first sub-category and presented itself in the research of Jackson (1997) and Hart (1998). “Conflict” was the second sub-category and was evident as an antagonistic confrontation with a member of the medical profession in the research of Snowball (1996) and as a confrontation with a doctor in the research of Hart (1998). The third sub-category was medical dominance and is manifest in situations where doctors believed decision making was the sole preserve of the medical profession. The article by McGrath

(2006) reports the predominance of the medical profession in decision making or in other words medico-centrism, as a source of potential conflict. The article by Snellgrove (2000) cited the fact that doctors and nurses had different ideas about what qualified the nurses to be able to question or participate in discourse related to a patient's treatment. Nurses were of the opinion that they needed continued education and training in order to be qualified to advocate, whereas doctors valued experience. It may imply that doctors may take the age of the nurse into consideration when making judgements about their ability to offer valid input.

The reporting of conflict supports the claims by Mallik (1997, 130) that advocacy can lead to conflict with the interdisciplinary team (Mallik 1997, 130-138). The results of conflict and negative consequences echo results by Vaartio and Kilpi (Vaartio et al, 2004) in their review of the empirical research from 1990 to 2003 (Vaartio et al 2004).

Conflict is not always reported in a negative way. Some nurses openly recognise and expect it to be a normal part of the advocacy process. Snellgrove (2000, 666) cites an example where the nurse claims they are "not afraid to challenge" a consultant about appropriate pain relief levels and will "openly challenge especially if I have an alternative suggestion" (Snellgrove 2000, 666).

Knowledge

The category of knowledge is subdivided into two types, "higher education" and "learning by doing". A need for higher education was mentioned in the studies by Snowball (1996). It is interesting to note that this need was perceived by nurses and does not necessarily correlate with what doctors believe to be valuable attributes in nurses. This reflects the sentiments of the doctors reporting conflict in the previous theme. Lack of education or experience can be seen as both the cause of conflict and as a basis for misunderstanding and is related to the following themes that were generated. Mallik (1997, 135) reports that nurses are generally unprepared for advocacy unless they are educated and trained to do so (Mallik 1997, 135). The sub-category of learning by doing was synthesised from the articles by McGrath (2006), referring to high levels of

practical knowledge and Vaartio et al (2006) referring to the theoretical and practical competence of the nurse.

Fear

The category of fear is subdivided into two sub-categories, “anticipated negative consequences” and “harassment”. In the sub-category of anticipated negative consequences, fear of ruination of career appears in the article by Jackson (1997), distress being caused by the closeness to the patient in Snelgrove (2000), negative feedback from patient or doctor by Vaartio et al (2006) and negative impact on career also by Vaartio et al (2006). The sub-category of harassment was synthesised from Jackson (1997) as marginalisation by other members of staff and from Breeding (2002) as suffering a snide comment or public humiliation by a doctor.

Loss of job and or status is reported by Mallik as a possible end result of having advocated (Mallik 1997, 136). In 2006, Japan introduced a whistle blowing act in an attempt to combat the threat of loss of employment by those employees who reported negligence (Davis 2007, 195). As of 2011, twenty one US states had legislated to introduce some kind of protection for whistleblowers (Black 2011, 29).

Nurses have been shown to deal with threats or intimidation in different ways. The nurses in the article by Jackson (1997) studied for this review felt trapped and powerless without recourse to improve their situation. In similar cases where nurses have been introduced into environments where they believed the standard of care to be poor across the institution have left after the first day (Black 2011, 27).

Dilemma

The category of dilemma is a direct result of the nurse experiencing a conflict of interests. Conflict of interest was reported in the study by Hart (1998) in the context that nurses were sometimes aware of two co-existent ideologies within themselves. Conflict of interest may arise where a nurse finds they are unable to fulfil the wishes of family members with different ideas and requests, as

reported by Hart (1998). Hart (1998) also cites an example where nurses may find themselves in a conflict of interests when they follow patient's wishes which may differ from those of family members. These examples are manifestations of the ways in which advocacy may be characterised as a paradox. The nurse being pulled in two directions simultaneously.

Ignorance

Ignorance as a category is further defined as a lack of awareness of the concept or content of advocacy. It is present in both doctors and nurses. Hart (1998) notes that nurses have reported being unclear about the role of the nurse as patient advocate. Vaartio et al (2006) report the need for nurses to be aware of the right of patients to act autonomously. Snowball (1996) and McGrath (2006) report separate instances where doctors were unaware or did not have a language to express nursing advocacy. This in itself could conceivably lead to conflict as a result of misunderstanding. It is noticeable by its omission in all of the research reviewed that the doctor's right to withhold information is not mentioned. This may imply that nurses are unaware of this right. This right, which has been tested under British law, could lead to direct conflict with the nurse in instances where he or she believes the patient should be fully informed. It is possible that nurses are unaware of this legal precedent. It maybe that nurses are ignorant of some of a doctor's roles and responsibilities as doctors maybe ignorant about those of nurses. Kohnke describes advocacy as being founded in ensuring patient self determination over decision making (MacDonald 2006, 120). However defending this self determination may bring the nurse into direct conflict with the physician practising the therapeutic privilege.

Knowing the patient

The concept of the category "knowing the patient" is defined by the sub-category, "knowing the patients needs and wants. Vaartio et al (2006) record both knowing the wants and needs of patients not only through dialogue but also being aware of the wants and needs of those patients who cannot express

their desires for themselves. Spending time with the patient to become familiar with their wishes is noted by McGrath (2006).

The results partially support the findings from the quantitative studies of Thacker (2008), Black (2011) and Jowers-Ware (2011) that were excluded from the research. Together they reported the physician, fear, lack of communication, lack of knowledge and lack of support which fit within the conceptual framework of the codes formed from this research. Lack of time as an obstacle, which was reported by Gosselin-Acomb (2007), Thacker (2008) and Jowers-Ware (2011) was not substantiated by the review of articles for this research.

It could be argued that for some of the obstacles encountered, effective or increased communication could help in some way to resolve contentious issues. Curtis et al (2011, 13) state that poor communication between health care professionals and communication overload are shown to a negative impact of patient well being and staff (Curtis et al. 2011, 13). Interpreted broadly the results can be characterised as either, antecedents or deterrents.

6 LIMITATIONS

Systematic literature reviews as a methodology are not themselves beyond criticism. One primary concern is that so called grey literature, that is, unpublished work, is often omitted (Aveyard 2007, 73). The depth of critical appraisal of the research articles was limited by the skills and ability of the researcher. The recommendations by Aveyard (2007) that undergraduate students only take into account the ten main headings of the CASP institute recommendations are difficult to implement in practice (Aveyard 2007, 98). This is because the questions themselves cannot always be answered simply, and each may require in depth analysis and further knowledge in order to be able to answer them in full.

Some articles were excluded because they did not report on barriers to advocacy. This in itself may be pertinent. The strength of the evidence may be weak as the size of the samples was small. The quality of the articles as indicated by the CASP appraisal was not uniform. Seven articles were unavailable despite being eligible. From the information in the abstracts, it was assumed that they contained information pertinent to this study. The search stream could have been modified and been longer. In particular the search term “exposure” could possibly have been expanded. The raw data was extracted, analysed and coded into categories by one researcher despite recommendations in the literature that two researches be utilised. This may affect the credibility of the findings. (Granheim et al. 2004, 110.) The small sample sizes and relatively small number of articles synthesised may affect the credibility of the review.

Trustworthiness & Transferability

The articles were all from English speaking countries. There is some evidence in the literature that cultural conditions affect the nurses’ willingness to advocate, such as cultural conditions in Japan which value group harmony, loyalty and saving face (Davis 2007, 194). This may affect the transferability of the results (Polit et al. 2012, 525).

7 DISCUSSION

A possible limitation of both the articles synthesised for this study and this study itself is the phenomenological nature of the methodologies used. Phenomenology is concerned with the lived experience of people. Phenomenological research aims to determine the essence of the phenomena and seeks to determine the meaning to those who experience it (Polit et al. 2012, 56). The last several decades have seen phenomenology become a dominant means of acquiring nursing knowledge. One reason for this is that it appears to be a credible alternative to empirical science in attempting to understand nursing in relation to lived experience (Earle 2010, 291). Whilst phenomenology aims to make clear experiences of real events the undetermined nature of the term “nursing advocacy” may mean it is essentially impossible to treat the results with any consistency. By taking a phenomenological approach and asking nurses what their experiences are we are able to determine that some nurses who believe they are advocating face certain obstacles, but we are unable to critically determine what that action was and evaluate whether or not it was indeed an advocacy action. This is a limitation of a phenomenological methodology. This is particularly pertinent given that preceding research upon which nurses base their knowledge and assumptions about what advocacy might be is based on phenomenologically determined data which in itself may be unproven. For example, this research has discovered that nurses believe a friendly demeanour is important in advocacy. This supports the accepted theories that Gadow and Curtzin make about the nature of advocacy. However, their theories are opinions, and have not been critically challenged although they appear to be widely accepted. It is not possible to ascertain whether the opinions of the nurses are their own, or whether they are reflections of the widely held beliefs on the subject. Breeding et al noted that it remains “difficult to meaningfully explore advocacy because of the lack of agreement on what it is” (Breeding et al. 2002, 110).

Regardless of the above, the results of this research indicate with some certainty than many nurses who believe they are advocating for their patients

face real, tangible obstacles in the process of doing so. These obstacles are diverse and widespread. The nature of the nurse-doctor relationship is prominent in many of the obstacles reported including direct conflict with the doctor and doctors being unaware of the concept of nursing advocacy. Hewitt mentions the hostility of doctors toward the idea of nursing advocacy in her paper, "A critical review of the arguments debating the role of the nurse advocate" from 2002 (Hewitt 2002, 441). Curtiss and Tzannes (2011) have researched and elucidated on the idea of effective communication with doctors (Curtiss et al. 2011, 13-20). Certainly the results of this study indicate that improved communication with medical colleagues would go a long way towards removing the obstacles of confrontation with a doctor, harassment, and ignorance of the concept of nursing advocacy.

The previously mentioned article by Hewitt (2002) reports an example of nurses having lost their employment because of their perceived duty to advocate conflicting with hospital policy (Hewitt 2002). Willard (1996) reports of hierarchical structures within the British NHS which restrict the ability of nurses to advocate (Willard 1996). These observations are supported by the results of this study which reported disagreement with an employing institution and fear of ruination of a career.

How conflict is perceived by nurses is not uniformly negative. Mallik reports that Kohnke (1982), Curtin (1979) and Winslow (1984) all claim that education is essential in that it prepares the nurse for the conflict that will follow if they advocate (Mallik 1997, 130-138). What is not made clear is whether this anticipated conflict is undesirable or whether it constitutes constructive conflict or an argument conducted in antagonistic harmony. That is, where two opposing sides posit differing arguments in an attempt to resolve a difficult issue in an environment of mutual respect. Some nurses have recognised the nature of conflict as positive, integral and an expected part of advocacy rather than an obstacle. This difference in attitudes is reflected in a study by Ahern et al (2002) into the beliefs of nurses who were involved in a whistle blowing event which revealed that nurses tended to fall into two categories,: those who saw nursing

as a traditional role and were less likely to challenge the rigid hierarchical militaristic structure of the hospital setting and those who believed they had a moral duty to advocate on behalf of a patient regardless (Ahern 2002, 308).

Both Mallik (1996) and Snowball (1996) observed in separate studies, that the academic arguments for nursing advocacy at the time were based on the theories of a small group of academic nurses whose opinions had not been critically challenged. The ideas of Kohnke's being that which emphasized self-determination which may conflict with the doctors therapeutic privilege, and those ideas of Curtin and Gadow , by where the nurse needs to be emotionally close to the patient maybe outdated today .(see MacDonald 2006. 120).

Mallik (1996) claimed that many of the theory articles at that time focused on justification arguments for claiming the role of advocacy. Mallik further notes that although many theorists start with a description of advocacy by the dictionary, further comparisons are not carried through. It is suggested here that future research should concentrate on how well individual advocacy activities fit the structure of advocacy as prescribed by law. The argument as to why a comparison should be made with advocacy in law is a logical and linguistic one based on the etiology of the meaning of the words. According to Saussure (Wicks, 2003), determinate thought is only possible because of a pre-existing language (Wicks 2003, 100). Words, or rather the "sound images" of words are arbitrary and are given meaning by their historical use. This is relevant because the concept of advocacy in law significantly precedes that of advocacy in nursing. Language precedes us as human beings and, in the same way actions and meanings of advocacy in law precede the use of the word in the context of nursing. It would therefore be fair to test the appropriateness of the action of nursing advocacy to the actions of advocates in law. Effectively this means a comparison between advocacy in nursing against the metaphor of advocacy in law. Wurzbach (1999, 94) describes the essence of metaphor as understanding and experiencing one thing in terms of another. Wurzbachs claim that the content of nursing advocacy does not correlate with that of advocacy in law

should naturally lead nurse theorists to ask the question “why?”. (Wurzbach 1999, 94-97.)

It should further be pertinent to note that such a comparison should concentrate on the form that judicial advocacy takes as well as the content, in other words the structure of the advocacy relationship between the stakeholders. In law, advocacy exists as a mutual understanding between two professionals of equal standing whose purpose is to present an argument to be decided by an impartial third party. The evidence presented by this review suggests that such a dynamic does not readily exist in the relations between doctors and nurses. In contrast, some authors have suggested that such powerlessness on the part of nurses makes them a perfect partner for patients in advocacy. Nurses are aware of themselves being viewed as less than equal in the eyes of the medical profession and some have argued that advocacy is a useful strategy for addressing that imbalance, when it is not challenging authority but rather expressing a concern (Snelgrove 2000, 666). Nurses joining patients in a position of subservience to doctors does not correlate with the judicial model of advocacy where advocates are considered equal before an impartial third party.

It is important to measure the actions of advocacy against the metaphor of legal advocacy so that those actions that do not fit can be reconceptualised as something else which may prove more useful, less confusing and dispel the myths about what nursing advocacy is. The meaning of advocacy appears different for different nursing professionals. Certainly the evidence uncovered by this study identifies different actions which are all conceptualised under the umbrella term of advocacy. It may be useful in future to reconceptualise these actions. For example, protecting patients from illegal and unethical actions is for example widely cited as a manifestation of advocacy (Jowers Ware et al 2011, 26). This is required by the American Nurses Association whose code of ethics state that nurses “must be alert to and take appropriate action regarding instances of incompetence, unethical, illegal, or impaired practice by any member of the health care team or system or any act on the part of others that places the rights or best interests of a patient in jeopardy” (Boyle 2005, 250).

Many events which would fall into this category are however clearly unlawful and as such it is the duty of every health care provider to report them regardless of whether or not they have a mandate to advocate. This act of monitoring and reporting would be more usefully described as “good governance” or “best practice”, that is to say, that the nurse is ensuring that rules are followed and standards kept high. These actions are confused by adding the term “advocacy” to the equation.

Whilst many advocacy actions may not qualify as such if compared to the structural metaphorical model of advocacy in law, some clearly do. That is, those actions where the physician is willing to enter into a dialogue and where an antagonistic opinion is taken into account. There is anecdotal evidence both in Finland and the United Kingdom and in the research articles reviewed for this paper where doctors have welcomed critical input into the debate about how to treat a patient. The term advocacy could be reserved for where its meaning most closely resembles that of the structure of law. Other activities could be reconceptualised in a way, such as good governance, that would prove useful to the nursing profession. Allmark and Klarzynski (1992) remark that broad definitions devalue the concept of advocacy (see Breeding 2002, 110).

Nurses have the potential to fulfil the role of partnering doctors in ensuring the best interests of their patients are realised, when the nurse is no longer expected to be obedient or subservient to the doctor, but rather, when the nurse’s autonomous role is valued and is seen as being complementary to that of the doctor.

8 CONCLUSIONS

Broadly characterised, the results show a lack of support on an institutional level and a lack of awareness in the medical profession on the concept of nurses acting as patients' advocates. Obstacles to advocacy revealed by this research are complex, widespread and multifaceted. They can be broadly characterised as pre-conditions or antecedents and negative consequences or deterrents. The antecedents nurses require in order to be equipped to advocate include having confidence as well as theoretical and practical knowledge and personal knowledge of the patient. Deterrents include disagreement with the employing institution, conflict, medical dominance, negative consequences, harassment, dilemma and ignorance of the concept. These results substantiate many of the results of previous research into the barriers faced by nurses who advocate for patients. This research does not substantiate the claim that time is a factor or obstacle in advocating on behalf of patients.

Suggestions for future research

This research has determined that real, tangible problems and issues manifest themselves as a result of nurses practicing what they believe to be advocacy. Attempts to overcome the obstacles of patient advocacy in nursing practice cannot hope to be successful without addressing the confusion and lack of consensus that surrounds the concept of nursing advocacy. The cause of many of the obstacles reported is lack of institutional support and lack of awareness. The paradox here is that real, tangible and clearly defined problems are arising from something, i.e. advocacy, which is ill-defined and with multiple meanings and contexts. The root cause of this theoretical confusion being lack of consensus in definition. The nature of the complexity of determining the meaning of advocacy highlights the difficulties faced by nursing in researching this subject. It is suggested here that any thorough investigation into the nature of advocacy could not hope to be successful unless it was multidisciplinary. Mallik (1997, 134) refers to authors of philosophy and anthropology in her review of 1997 (Mallik 1997,134).

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