Advocacy is commonly understood as a core component of a nurse’s professional identity. In response to questions such as what is a nurse, and what do nurses do, it is not uncommon to hear nurses describe themselves as patients’ advocates. For many practicing nurses, advocacy has come to be understood as, and in some ways equated with, attention to patients’ safety and protecting patients from harm.

Although safety and protection certainly are important concerns of nurses, I want to highlight some of the problems with this view of advocacy and describe some of the difficulties that follow when nurses take up the role of advocate in a critical care setting where advocacy is seen as primarily concerned with protection. In contrast to this view of advocacy, I want to explore a stand on good practice that recognizes and engages in a more complete understanding of advocacy in a context in which agency is realized as part of a collaborative, multidisciplinary, team-oriented approach to care.

Advocating for, Safeguarding, and Protecting

Advocacy has become a central part of ethics in professional nursing practice. This link is evident in the literature of professional organizations such as the American Nurses Association (ANA) and the American Association of Critical-Care Nurses (AACN). ANA’s Code of Ethics for Nurses draws attention to the nurse’s role as patients’ advocate and encourages nurses to take a protective stance in relation to patients. The third provision of the ANA Code reads, “The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.”1 The interpretive statement associated with the third provision highlights safety and protection related to privacy, confidentiality, and participation in research, and it makes nurses responsible for acting on the questionable and/or impaired practice of professional colleagues.1

In a further explanation of the third provision of the ANA Code, Kline,2 speaking as a representative of the AACN Advanced Practice Work Group, connects advocacy with protection in the following statements:

Advocating [for] and protecting our patients include[s] questioning goals of care when there is a misalignment between patient-family and medical team goals.…

Incorporating safeguards in the form of standards of nursing practice into daily practice is another avenue to protect patients.…

Protecting patients also means identifying and reporting potential harm from a colleague, whether it is a nurse, physician or other healthcare professional.

In the statements of these 2 professional organizations, the nurse who takes up advocacy is encouraged to focus on protecting the patient from potential harms inflicted by the substandard practice of other nurses and/or members of the healthcare team. These statements from ANA and AACN can be interpreted as describing healthcare as a dangerous situation in which patients need a nurse-advocate to critically evaluate the practice of others in relation to the goals of the patient and the patient’s family and determine their safety and effectiveness. With this image of the healthcare situation as fraught with danger, advocacy taken up as primarily concerned with protection and attention to safety starts from a position of mistrust.

In nursing practice that starts from this position of strong advocacy-as-protection, it is easy to adopt
an “us against them” way of thinking in which nurses begin to see themselves as the only advocates for patients while cultivating suspicion of other members of the healthcare team. This situation has tended to become adversarial; it creates a tension in critical care practice by leaving little space for the trust, teamwork, and collaboration necessary for the best care of patients. Although situations occur in which questionable or impaired practice cannot reasonably be met with anything short of confrontation—from a stance of mistrust focused on protection of the patient—confrontation can become the standard response of the nurse-as-advocate.

Agency and Advocacy

The tension that the stance on advocacy based on this interpretation of the ANA Code creates for nursing practice has a significant effect on how nurses care for patients and on nurses’ sense of their own agency. Benner et al define clinical agency as “the experience and understanding of one’s impact on what happens with the patient and the growing social integration as a member and contributor of the healthcare team.” A nurse’s agency is embedded in a broader sense of human agency. In describing human agency, Taylor identifies certain choices and decisions that lead to specific actions as resulting from “strong evaluation.” Actions resulting from strong evaluation express and sustain the particular kind of life or way of being that a person values. Taking on the role of patients’ advocate is an act resulting from strong evaluation on the part of the nurse. The decision to take up advocacy in a particular way and respond as an advocate expresses the kind of practice that the nurse values. Thus nurses realize their agency both through taking up a position of advocacy and through the actions this position results in.

Much of a critical care nurse’s agency is expressed within the context of multidisciplinary team efforts to anticipate patient-related problems and address problems as they arise. Nurses act to influence the situation by understanding and giving voice to their own concerns as well as the concerns of the patient and the patient’s family, and by making these concerns heard in ways that result in action to address actual and potential problems. The fear and suspicion promoted when advocacy is primarily concerned with protecting the patient from harm encourages practice that focuses on discovering and pointing out the shortcomings of others, thereby undermining the collaboration necessary for best patient care. It also can distract the nurse from developing her or his ability to affect the situation directly and promotes a view of nurses’ agency as powerless to affect the patient’s situation independently. In addition, describing the advocate as a protector in many ways ignores the importance of collaboration with the patient and the patient’s family, who do not necessarily require or want protection.

A common example of this situation involves the relief of a patient’s suffering. When a nurse determines the need for an increase in a patient's dose of analgesia, she or he makes a case to the physician and requests a change in the order. If the order is not forthcoming, the nurse who takes a protective stand is often quick to conclude that the physician’s practice is not patient-focused and feels justified as the patient’s advocate in moving to a confrontational approach.

Advocacy and Collaboration

That strong evaluation prompts nurses to act as patients’ advocates speaks to the values embedded in the practice and points to how the needs of patients and their families are central to nurses’ agency. Given the equally central importance of collaboration in the critical care setting, critical care nurses must broaden their understanding of advocacy to include aspects that will promote optimal functioning of the healthcare team while keeping the patient and the patient’s family at the center. Along these lines, Benner has described advocacy as “the kind of power that removes obstacles or stands alongside and enables.”

The International Council of Nurses’ (ICN) Code of Ethics also includes a central role for advocacy. As with the definition offered by Benner, the role of collaboration with patients, other healthcare providers, and society is evident in these statements from the ICN Code of Ethics for Nurses:

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

These statements and others in the ICN Code describe the advocacy role of the nurse in broad terms that encompass direct action as well as collaboration;
the active role of the nurse in collaboration with the patient is evident. The nurse shares responsibility with society for promoting healthy environments and for acting to support the health of individuals and communities. In the ICN Code, the nurse is more than a watchdog who vigilantly evaluates the practice of others. The nurse as advocate in this view takes up protection as an outgrowth of an active caring practice: “The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.”

Benner’s definition and the statements of the ICN Code capture the essential role of collaboration as part of advocacy and open advocacy up as an active part of nursing practice that includes but goes beyond protection. Removing obstacles to enable the realization of the goals of patients and their families can take many forms. A nurse-advocate with this broader understanding of the role might also make a case to the physician for increasing a patient’s dose of analgesic.

But the nurse here meets the physician as one strong evaluator to another; making the case from this stance requires the nurse and physician to engage in open and honest communication that results in mutual appreciation for the concerns of each others’ practice. If the outcome of the conversation is not an immediate increase in the analgesic dose, it is important that the nurse and physician come away with a true understanding of the source of one another’s concerns related to the patient’s situation. This understanding can then open up other possible strategies for the nurse to independently affect the patient’s suffering.

Communication and Trust
As Aspects of Advocacy

In a discussion of trust and communication, Logstrup’s[7] points to the fundamental connections between interlocutors:

By our very attitude to one another we help to shape one another’s world. By our attitude to the other person we help to determine the scope and hue of his world; we make it large or small, bright or drab, rich or dull, threatening or secure. We help to shape his world not by theories and views but by our very attitude toward him. Herein lies the unarticulated and one might say anonymous demand that we take care of the life which trust has placed in our hands.

In this description of the power of attitudes, Logstrup captures the essential nature of the relationship between and among members of the healthcare team. Engaging in the best patient care means placing our lives in the hands of our colleagues and accepting their lives into our hands. An attitude of confrontation and judgment disrespects this relationship and closes down the possibility of meeting each other as strong evaluators.

Blaming instead of making an effort to solve the source of breakdown is what Logstrup has referred to as moralism. In adopting a position of advocacy as only or primarily concerned with protection, it is easy to slide from moral agency to moralism and blame others for perceived shortcomings in their practice without fully understanding or appreciating that practice. Solving a source of breakdown in any patient care situation requires that nurses and all healthcare providers look hard at their own practice as well as at the practice of others and engage in clear and honest communication that seeks understanding. In seeking to understand the other, whether another healthcare provider or patient, an attitude of respect and trustworthiness can move us from a threatening world of accusation and blame to one that is larger, richer, and safer for everyone.

REFERENCES