

Who speaks for whom? Can nurses be patient advocates in renal settings?

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Abstract

Nursing texts laud the role of nurses as advocates for patients. With increased acknowledgement of patient-centred care, is it appropriate or desired for nurses to presume this as their role? An examination of concepts of advocacy and autonomy highlight potential conflicts between the nurses' adoption of the roles of advocate and surveyor in renal care. There is no clear and definitive answer to 'who can speak for whom' when considering advocacy for people involved in renal replacement therapies. It is evident that what is required is clearer articulation of how renal nurses can act as advocates for patients within the context of their multiple roles and with a goal of partnerships in care.

Keywords

Advocacy, autonomy, partnership, nurses' role.

Nursing texts laud the role of nurses as advocates for patients. There is a considerable body of literature endorsing the role of nurse as advocate for patients (for example, Vaartio *et al.*, 2006; Delany & Malloy, 2009; Craven *et al.*, 2013). In the specialty area of renal care, there are also many examples of specifying a role of renal nurses as advocate for patients (Thomas, 2013; Hörl *et al.*, 2004). Both the Australian (RSA, 1999) and New Zealand (RSA, 2012) documented statements of competency standards for nephrology nursing indicate advocacy as included in the specialty skills.

Nurse as advocate

While advocacy is clearly argued as a role, the definition and discussion about the scope of role in renal settings is scant. Nursing advocacy has been defined as "communicating with and informing patients, protecting patients, speaking out for patients, and building relationships with patients" (Hanks, 2010, p. 256). Spence (2011) highlighted a range of nursing definitions of advocacy, including acting or interceding in the best interest of the patient, protecting patients' rights, ensuring protection and comfort for patients who are unable to communicate. The goal of an advocate should be to assist people to access the services they need and support their decision making (Flynn, 2010).

The idea of advocacy within nursing practice is embedded in nursing traditions and reinforced in the educational preparation

of nurses. This view of nurses as advocates has not changed with the changing health care system (Blackmore, 2001; Bu & Jezewski, 2006; Spence, 2011). With increased acknowledgement of patient-centred care, the challenge emerges about the applicability or desirability for nurses to presume advocacy as their role.

Curren (2013) recently repeated the often argued position that renal nurses are best placed to assess a patient's capability to make and carry out autonomous decisions, because nurses often have the greatest contact with patients compared with other health care professionals. In contemporary health care settings intimate, physical and emotional care for patients is still provided continuously by nurses. Is the volume of contact a sufficient support for the assumption that nurses have a more privileged role as advocate?

In cases of vulnerability, advocacy may be necessary due to the power differentials between institutions, doctors, nurses and patients. Power distribution is unequal and nurses are arguably perceived as the stronger or more influential person speaking on behalf of the person in the weaker position, the patient (Jugessur & Iles, 2009). Whether the advocacy role of nurses remains valid in contemporary health care or contributes to unequal power distribution needs clarification. A leading factor in understanding the potential need for nurses' advocacy for patients is the perceived autonomy of patients.

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Autonomy

Advocacy is needed when a person is unable to exercise their autonomy. Definitions of autonomy in health care contexts commonly suggest the abilities of individuals to self-rule, self-govern, or self-determine (Beauchamp & Childress, 2001; Goering, 2009; Mackenzie *et al.*, 2007). This assumes that each individual is independent and not influenced by outside and competing factors. However, viewing autonomy from an individualist perspective (Christman, 2004) fails to recognise the variability and relationality of humans. We are social beings with complex sets of interpersonal relationships.

A counter view to understanding patients as individually self-determining is relational autonomy which describes the social relationships and social context of individuals that influence an individual's autonomous decision making (Christman, 2004; McLeod & Sherwin, 2000; MacDonald, 2002). Relational autonomy recognises the social values, relationships and power structures in which an individual is embedded, and how these values, relationships and structures inform an individual's decision making (Dodds, 2000; MacDonald, 2002). Therefore, people who are important within an individual's social context may influence decision making.

Tensions 'best interest' versus empowerment

A relational definition of autonomy introduces a broader view that challenges the conventional view of advocacy in nursing practice. Humans are social in nature; therefore, it is unimaginable that social contexts have no influence on a person's autonomy. Feminist perspectives of relational autonomy argue that the social context of the individual is accepted as part of their ability to be autonomous and to make autonomous decisions. Therefore, if we base our understanding of autonomy on a relational view, then the potential role of an advocate changes (Cole *et al.*, 2014).

Using a relational conception of autonomy, individuals rely on their social experiences and relationships to influence the health care decisions they make. Understanding patients as relationally autonomous situates the advocacy role of nurses as more complex and intricate than previously suggested. The focus shifts from assessing if patients have compromised autonomy, to inclusion of people who form part of the social context of patients. The challenge now becomes supporting patient engagement in their decision making, confidentiality, and assisting them to manage tensions that may arise between caregivers and patients. Drawing on the work of Flynn (2014) in disability studies, the challenge is about moving from a traditional of what is in the 'best interest' of the patient, to an approach that views empowerment to be the goal of advocacy. Empowerment requires that an advocate does not make 'substituted decisions' in someone's best interest.

Supporting patient engagement in decisions with the inclusion of their key social networks demands new ways of thinking and acting in practice. Public health policy has created a demand for new approaches that are consistent with a relational view of autonomy.

Patient-centred care

Health service delivery has changed in the past 30 years towards more patient-centred and partnership approaches to care. The Australian Commission on Safety and Quality in Health Care (ACSQHC) (2010) recommended that patient-centred approaches to care become a measure of quality in health service delivery. Patient-centred care has been argued as a cornerstone of health care practice, and identified as a shared value among health professionals where practice is guided by principles of what is 'good' for patients and their families (McGrath *et al.*, 2006). Patient-centred care infers that care focuses on the person as a whole, not only their disease and symptoms, and, therefore, requires partnerships between health care professionals, patients and their family and caregivers. Partnerships arguably lead to improved health outcomes and increased levels of satisfaction for all stakeholders. However, there is increasing recognition that involving people in partnership for care is highly desired, but difficult to deliver (Penney & Wellard, 2007; Wellard *et al.*, 2003). Barriers to engaging in partnerships for care with consumers are diverse and reflect the often experienced gap between espoused ideals and practical realities of health service delivery in a constantly evolving system where innovation frequently outstrips the resources to support it.

While recognising the shift towards consumerism, the structures of health care services continue to position users of services as patients who rely on professional expertise, frequently reconstructing paternalism as a silent foundation for professional practice. Renal care is caught in this tension between a desire for partnerships in care but hampered by limited resources and structures that result in more paternalistic responses.

Can nurses be patient advocates in renal settings?

Reconceptualising advocacy in the context of relational autonomy and patient-centred care challenges the common view of nurses as advocates. Aspects of the work of renal nurses involve forms of surveillance; for example, where analysis of interdialytic weight gains and biochemical levels provide the basis of determining patient compliance or adherence to treatment. Maximising patient adherence to treatment plans is important to avoid longer term complications and promote best quality of life and clearly informs the parameters of managing individual treatment sessions. Nurses are well placed to assess and monitor patients in these aspects of care.

But is the role of surveyor of compliance compatible with the role of advocate? Can an advocate also police and monitor

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behaviour? There is a considerable body of literature suggesting that surveillance of compliance creates tensions between patients and health professionals (for example, Kammerer *et al.*, 2007; Bissonnette, 2008). Allen and colleagues (2011) found that patients often viewed relationships involving compliance as adversarial and lacked trust in these health professionals' ability to view them holistically.

There is no clear and definitive answer to 'who can speak for whom' when considering advocacy for people involved in renal replacement therapies. However, it is evident that what is needed is clearer articulation of how renal nurses can act as advocates and avoid the inherent tensions in these dichotomous activities. How do we assess the need for advocacy rather than presume it as our role is needed? How does understanding relational autonomy inform the ways we interact and work with patients and their family members? What skills are needed to support patients to be empowered to manage their own decision making?

Developing considered responses to these questions and building consensus amongst renal nurses is important. Professional nurses have a responsibility to ensure they build skills in developing partnerships with patients to lead to decisions that benefit patients in achieving their desired outcomes.

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