Legal Issues...Patient Advocacy and the Nursing Role

Issue Description
Patients, especially hospital patients, can be viewed as vulnerable in a strange environment even if they are competent to protect their own interests outside the healthcare milieu. This phenomenon has been described as the “powerless patient”. Therefore, patient advocacy developed over the decades as part of nursing as a profession. This is a natural progression since the professional nurse embraces advocacy as a higher quality of nursing as a calling and a profession, rather than a mere job. Despite some views, it is not a paternalistic process but preserves patient values and autonomy, allowing patients to make decisions in what they perceive to be their own best interests, even if their decisions are contrary to those of other health care professionals. In its broadest interpretation it is a “moral act of shared humanity” and is not confined merely to the patient’s legal rights but extends to moral and human rights as well, although advocacy is incorporated into legal standards of care. The extension to moral and human rights is important in a litigious atmosphere and shows that the nursing profession is not satisfied with merely adhering to the legal standard of care. Nursing advocacy has been compared to lawyer advocacy in that the lawyer represents her client regardless of the merits of the client’s case. The nurse and the lawyer embody similar adversarial roles on behalf of those for whom they advocate.

The following qualities for effective patient advocacy have been suggested by Swedish researchers: Ethical awareness, self-confidence, persistence, pride in the profession, and maturity. Another desirable attribute is cultural competency – an awareness of, and familiarity with, peoples’ customs and habits and a willingness to accommodate them. See: Quick Lesson About... Legal Issues...Communication Barriers: Language. Of course nurses require adequate support from their employers: Adequate lines of communication with management, support from management and colleagues, and institutional tolerance of challenges to hierarchical authority. Healthcare institutions should recognize that registered nurses use evidence to provide care and do not merely follow physicians’ task-based orders. Advocacy was introduced by the International Council of Nurses in its Professional Codes in 1973, after which journal articles on the topic began appearing. Despite being first discussed in the literature as far back as the 1970’s, the concept of nursing advocacy remains unclear, although it is centered around service of patients in the context of a personal relationship and has been described as a “vital part” of the work of RNs. It has been contended by two authors that nurses cannot be advocates because of obligations to other patients and time constraints. However, the same authors go on to say that advocacy “is an integral part of the role of professional health care practitioners in promoting patients’ well-being.” Nursing students are educated on the techniques of advocacy but the moral values required for advocacy are learned from their families, the community, and watching experienced nurses practice. However, young nurses soon learn that the status of the nurse as a hospital employee and as caregiver for other patients can conflict with personal advocacy. For example, errors are sometimes not reported due to loyalty to the hospital or professional colleagues.
A typical example of nursing advocacy is given in an “Ethical Problems” column where a nurse says she harbors doubts about the efficacy of the written informed consent to a blood transfusion given by her ill-educated patient. The expert columnist advises her to be more assertive in explaining the procedure in the presence of the physician before the patient signs the informed consent paper. This situation is typical of the dilemma some nurses face: Risk offending the physician or do nothing to advocate for the patient.\(^{(15)}\)

Five medical ethicists in Germany surveyed reports of patient advocates’ activity at a large university hospital in Erlangen, Germany. The ethicists discussed in detail the desirability of full-time patient advocates at hospitals to hear and resolve patients’ complaints. No mention is made of the nurses’ role as patient advocates in partnership with the appointed patient advocate.\(^{(49)}\)

Another view of nursing advocacy examines the “root causes of injustices or inequities” and seeks to change systemic flaws in the health care system. This is known as “policy advocacy,” which is still in its infancy. “Advocacy upholds health as a human right through just action.”\(^{(53)}\) In public health nursing practice, advocacy possesses a political element, extending to the marginalized who suffer from disparities in healthcare, and working towards change.\(^{(16)}\) Nurses’ training, including an “acculturation to silence,” does not equip nurses to advocate for patients on a general level although advanced graduate education has been developed for this purpose.\(^{(17)}\) However, early development of nursing as a profession by Florence Nightingale in the mid 19\(^{th}\) century promoted advocating for patients in general rather than on an individual level.\(^{(18)}\) In this sense policy advocacy in nursing could be said to have an early history. Nurses can advocate successfully in the community for patients due to the trust and respect they enjoy among the public. For the same reason they are also able to lobby elected officials (including members of state and federal legislatures) on behalf of patients. Examples of the issues they can cover in community lobbying activities are inadequate funding for health care, high prescription drug costs, and inadequate provision of school nurses. In the legislative arena it is essential to be familiar with how laws are made if one is to be an effective advocate.\(^{(19)}\) An example of present-day policy advocacy is the lobbying by the California Nurses Association for legislation to require minimum nurse staffing levels in California acute care hospitals, see Units Potentially Involved, below. The California Association for Nurse Practitioners (CANP) has long lobbied for expansion of the Nurse Practice Act in California in accordance with the IOM’s recommendations.

It has been suggested that activities of nurses’ labor unions cause tension between the nurse’s role as patient advocate and advocate for professional rights.\(^{(50)}\) A troublesome aspect of nurses’ labor strikes is that they are perceived to be contrary to the interests of patients. However, nurses’ unions have included patient advocacy as an important component in their platforms. Moreover, adequate nurse-patient ratios are both an important goal of the unions and in the interests of patients (see also Units Potentially Involved, below). Another view is that strikes are as much a part of the healthcare system as hospitals reducing the nurse-to-patient ratio – “strikes are the systemic check on unjust or medically inappropriate executive decision-making.”\(^{(50)}\)

An argument in favor of nurses’ unions is found among the employees of huge hospital chains. One chain issued orders that clinicians reach specified admission quotas without regard to medical necessity. Executives who issue these orders are neither prosecuted nor jailed. Wrongful termination lawsuits arising out of refusal to strive for these quotas are ineffective. Therefore, a united front in the form of nurses’ unions is essential to protect the interests of patients and, more important, to protect those who should not become hospital patients.\(^{(52)}\)

**Definitions**

**Nurse as Advocate:** “Clients are perceived as vulnerable…, factors are in play that are perceived as detrimental to the client or the client’s goals, and the nurse advances client interests or protects client rights by interceding on behalf of the client in the context of the health care team.”\(^{(20)}\)

**Advocacy:** “[T]he act of pleading or supporting”; “[S]peaking out and speaking for patients”;\(^{(21)}\) “Informing patients and then supporting their decision” even if they disapprove of it.\(^{(22)}\)

**Policy Advocacy:** “Knowledge-based action intended to improve health by influencing system-level decisions.”\(^{(23)}\)

**Risks**

As of the year 2000 a physician in the UK could obtain a patient’s consent to treatment without giving all relevant information concerning the treatment. This placed a greater burden on the nurse as patient advocate. The nurse ran the risk of malpractice litigation if the interests of the patient were not promoted by supplementing information the patient received, to enable the
patient to give a properly informed consent. In addition, the nurse could help the patient formulate and ask questions of the physician. However, the risk factor in patient advocacy results in nurses limiting advocacy to low-risk situations.

**Units Potentially Involved**

**Intensive Care Unit:** The advocacy role of nurses was challenged when three nurses in Canada refused to provide nursing care to a cardiac patient newly admitted to the ICU. They contended that they had too many patients to attend to and an extra patient would endanger existing patients. They were suspended without pay for three days and physicians provided nursing care. The board of arbitration upheld the discipline on the grounds that the nurses were insubordinate. A comment on the case noted firstly that the nurses violated the terms of their employment and they provided no evidence that they would compromise their professional standards or incur civil liability by admitting the extra patient. Secondly, the board compromised the nurse’s role as patient advocate by stating that physicians are in a better position to assess the needs of the patients in the ICU. This is true for patients’ biological needs but nurses “are in a good position to determine the needs of patients as physical, social, emotional and spiritual human beings.”

**Cancer Units:** The lower survival rates for Black women diagnosed with breast cancer as compared with White women led Harlem Hospital in New York City to start the first patient navigator program in 1990. The program assisted patients in obtaining treatment in the bureaucratic maze of various programs and treatments available. Although navigators had to be members of the community served by them, nurses could participate in the program by coordinating the navigation services with ongoing care. Since that time the role of the nurse as navigator is well recognized, and navigator roles for both laypeople and nurses have increased worldwide.

**Operating Room and Surgical Units:** Although unique difficulties confront nurses in perioperative care to ensure patient safety and wellbeing, the perioperative nurse, and especially the circulating nurse, has progressed from a technical role to a role ensuring patient well-being. However, barriers exist such as fear of damaging collegial relationships with surgeons, lack of personal assertiveness, and lack of support from hospital administration. (For related topics, see Quick Lesson About ... Legal Issues...Foreign Bodies Retained After Surgery; Quick Lesson About ... Legal Issues...Communication Barriers: an Overview, at Units Potentially Involved, subheader, Operating Room). Advocacy in the perioperative field designed to protect patients from harm and to respect their rights is especially important because patients are unconscious or sedated some of the time and also lack accessibility to family members in the operating room. Advocacy can involve such issues as ensuring relief from pain and protecting a patient from an incompetent colleague.

Practical advice is available to perioperative nurses involved with older patients undergoing surgery. These patients need special attention and advocacy on their behalf. They have more complex health issues, and they require the personal guidance that nurses are able to provide in navigating the maze of diagnoses, tests, and treatments needed.

A research survey at a graduate school in Troy, NY elicited some chilling anecdotes on perioperative nurses’ personal experiences with advocacy. These incidents narrowly missed becoming court cases. Two of them: A kidney patient was one minute from having the wrong kidney removed in the operating room when the nurse reviewed the chart that referenced the right kidney. The X-rays were displayed backwards and the nurse told the operating team that the right kidney was the one to be removed. They looked at the X-ray screen and realized that it had been flipped around. In another incident a patient was on 5,000 units of heparin per hour, five times the lethal dose. The nurse said it was too much but her colleague responded that she checked with the resident three times and he said it was okay. The nurse insisted it was wrong and was forced to pull the order where it said never give more than 1,000 units. It turned out that the same colleague had written the order for 1,000 units.

**Acute Care:** A study was made of advance care planning in an Adelaide, South Australia acute care hospital. The purpose of the study was to explain the role of advocacy in the advance care planning process. Nurses are needed to develop a therapeutic relationship with patients, involve the patient in decisions about end-of-life choices, and mediate with the family concerning advance directives. It was found that acute care hospitals are not designed to accept and implement advance directives but nurses were assisted by a special program that gave them the opportunity to improve their use and implementation.

As a result of intensive advocacy by the California Nurses Association the state of California enacted a statute in 1999, the first in the nation, requiring certain minimum levels of staffing by registered nurses in California acute care hospitals. In some circumstances the existing Patient Classification System may require a hospital to exceed these minimum levels of staffing. Licensed vocational nurses are not counted as part of these minimum levels, which include only registered nurses. Different
hospital units such as critical care units, burn units, and emergency departments are each assigned their own minimum staffing levels.\(^{36}\)

**Nursing Homes:** Registered nurses in nursing homes for older adults in Sweden owe a special duty of advocacy to these residents to speak up on their behalf because they are vulnerable and need the special care which they are entitled to.\(^{51}\)

**Dermatology:** The Dermatology Nurses Association is affiliated with the Coalition of Skin Diseases, which introduced the Skin Advocate iPhone App that assists those diagnosed with skin disease. It helps connect them to patient advocacy organizations that are members of the Coalition of Skin Diseases. The patients receive helpful information on skin diseases.\(^{42}\)

The Dermatology Nurses Association has a Web page announcing and explaining the App.\(^{48}\) and also conducts public advocacy activities such as campaigning for legislation to regulate tanning salons.\(^{47}\)

## Court Cases and Legislation

In Pennsylvania an inexperienced nurse was alone on night shift. A patient, male, 24, with an aggressive brain tumor, had been admitted with uneven pupils. The nurse observed that the left pupil was fixed and dilated, which she recorded in a progress note. She called the neurosurgeon who later contended that the nurse told him that the pupils were not equal, which was no change in the patient’s condition and so he did not come in. The nurse did nothing and at 6am the patient was rushed into surgery where it was discovered that he did not have a tumor, but a rapidly growing brain abscess. The patient died. The hospital had a procedure in place for a nurse to call a “Condition C” to get immediate assistance for a critical patient. The hospital also had a policy requiring a nurse to go up the nursing chain of command if she believed that the patient was endangered by a physician’s failure to act. The court held that the nurse should have complied with the policy and procedure and was negligent in failing to do so, and upheld a $2.5 million award to the patient's family.\(^{37}\)

While one can accept a finding of nursing negligence in this situation, no mention is made in the opinion on whether the physician closely questioned the nurse when she called, to ascertain whether a pupil was fixed and dilated since this would have indicated a serious condition. Also, it seems strange that the nurse noted in the progress note that a pupil was fixed and dilated and that she reported that the pupils were not equal. (For more comments on lack of communication in hospitals see *Quick Lesson About... Legal Issues...Communication Barriers: an Overview*. For an analysis of the fundamental causes of mistakes in hospitals, see *Quick Lesson About... Legal Issues...Never Events: Wrong Site Surgery*).

A 2011 California case\(^{38}\) prompts the question whether a nurse’s duty to advocate for the patient requires her to exercise authority over, and discipline, tardy and non-responsive physicians. A patient, male, 23, in the ICU with serious injuries from a motorcycle accident, was given a tracheostomy and a PEG tube was inserted for feeding. After transfer to the med/surg unit a nurse negligently “popped” the tube while flushing it. When the patient later showed decreased blood pressure and increased heart rate, the nurse reported this to the on-call surgeon who told her to call the cardiologist. The latter never came in and the nurse did not follow up. The next morning the nurse called the surgeon again and reported abdominal pain and elevated pulse and that the cardiologist had not come in. Two hours later the cardiologist was called again. He ordered medication and a transfer to the cardiac unit. The cardiologist and the surgeon came in two hours later and ordered a transfer back to the ICU. The ICU nurse called the hospitalist physician to report a pulse of 180 but the hospitalist took two hours to come in. The patient continued to deteriorate and coded but was revived. Later that afternoon he was taken to surgery where the tube was found free-floating in the abdomen along with widespread sepsis. The patient has remained in a coma ever since. The hospital paid most of the settlement for the nurse who “popped” the tube and the nurses who failed to appreciate the gravity of the situation and advocate for the patient by getting the physicians to respond in a more timely way.

A Texas patient, male, 57, was in a nursing home with schizophrenia, vascular dementia, diabetes and other conditions. After he developed a cough, cold, and bronchitis he was given cough syrup but nothing else was done, although there were clinical indications of pneumonia. A month later he was sent to the emergency room. He had oxygen saturation of only 88%, acute respiratory failure, septic shock, and pneumonia. He died in the ICU. The court held that there were grounds for the lawsuit filed against the nursing home, attending physician, and the two nurses responsible for his care. The court held that the nurses should have advocated for the patient under the applicable standard of care, but failed to do so (see *Recommendations*, below). They should have realized that he had pneumonia, which was dangerous if not treated. They also should have urged the physician to repeat X-rays and to review his antibiotic medication.\(^{39}\)

An orthopedic surgeon with a history of questionable outcomes cut a patient’s right internal iliac artery during lumbar laminectomy and discectomy surgery but did not realize he had done so. The patient came out of the operating room with a grossly swollen abdomen and other signs of hemorrhage. The nurses did not recognize the obvious signs of hypovolemic shock indicating internal hemorrhage. The patient later died of hypovolemic shock. The nurses should have called the surgeon to
attend to her and also should have obtained orders for intravenous fluids and made an operating room available for immediate surgery. The nurses should have instituted the hospital’s chain of command when the orthopedic surgeon failed to take appropriate action. Their supervisor would have had the authority to get another surgeon to come to the bedside to provide appropriate care.\(^{(40)}\)

The unlawful and egregious retaliation against nurses in Winkler county, Texas, for reporting physician misconduct resulted in the passage of the Texas Patient Advocacy Protections Law, 2011 advocated by the Texas Nurses Association. This legislation provided immunity from criminal liability and protection from employer retaliation for reports of medical errors if the reports are made in good faith.\(^{(41)}\)

**Recommendations**

The American Nurses Association publishes its *Code of Ethics for Nurses with Interpretive Statements* in which it discusses and promotes nursing advocacy.\(^{(42)}\) This document is available for purchase.\(^{(43)}\) An ANA Position Statement, *Risk and Responsibility* also covers the issue of advocacy.

The International Council of Nurses goes so far as to include advocacy within the very definition of nursing.\(^{(44)}\)

A policy statement promoting advocacy was published by a British Columbia, Canada nurse’s professional organization, the RNABC, in 2001.\(^{(45)}\) Emphasis is placed on patients’ autonomy and self-determination. Also, advocacy is not confined to nurses but extends to other health care professionals, family and friends. The statement notes that the Canadian Nurses Association also directs nurses to act as advocates in its *Code of Ethics for Registered Nurses*.

It was recommended in 2016 that nurse practice acts in the various states of the US should be broadened so that they expressly include the function of nurse as patient advocate and are no longer confined to merely describing task-based care.\(^{(55)}\)

A panel appointed by the American Nurses Association stated in 2016: “As caregivers, RNs are engaged as advocates on behalf of the patients, families, and communities they serve to positively influence the systems in which care is provided.”\(^{(56)}\)

In 2009 the Texas Appeal Court endorsed a full statement of what constitutes the nursing advocacy standard of care, obtained from an expert witness in the case they were adjudicating. Highlights of the statement: If a physician responds inadequately to a nurse’s concerns reported by phone she must insist on the physician seeing the patient in person. Failing this, she must go up the chain of command under hospital policy to ensure that patients are cared for and not ignored.\(^{(46)}\)
References