Cogitare Enfermagem

ORIGINAL ARTICLE

# Sociodemographic and economic characteristics of nurses associated with patient advocacy

## HIGHLIGHTS

1. Sociodemographic and economic factors impact the practice of patient advocacy.
2. Patient advocacy helps to ensure patient rights.
3. Patients can become more informed about their rights.

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## ABSTRACT

**Objective:** Identify the association between the sociodemographic and economic characteristics of nurses and the practice of patient advocacy in a public university health complex in the state of Rio de Janeiro, Brazil. **Method:** Quantitative, descriptive-exploratory. Data collection used a characterization questionnaire and the *Protective Nursing Advocacy Scale*. Period: August 2021 to July 2022, sample of 182 nurses. Descriptive and inferential statistical analysis. **Results:** There was an association between family income of seven minimum wages or more and agreement to perform actions aimed at patient advocacy (p=0.018). However, there was no statistically significant difference in relation to barriers to practicing law, such as retaliation by employers or stigmatization as "troublemakers" (p > 0.05). **Conclusion:** The factors studied affect the safety and performance of nurses when defending patients. Patient advocacy reinforces the ethical nature of professional practice and the defense of the Unified Health System.

**DESCRIPTORS:** Nurses; Nurse's Role; Patient Advocacy; Socioeconomic Factors; Right to Health.

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## INTRODUCTION

Care for human beings is the focus of nursing, which is involved in teaching, care, research, and management at all levels of care and attention[1]. Nursing is a profession whose work practices are characterized by close contact with patients. In this sense, it has the potential to consider and act in the sphere of social practice, offering assistance in restoring the patient's citizenship[2].

In the current structure of the Brazilian healthcare system, nursing can be involved in care and/or administration. It is the profession that, compared to others in the health field, offers the most frequent opportunities to act on behalf of patients' rights and thus advocate for them[3].

A study conducted with nurses working in intensive care units using *the Protective Nursing Advocacy Scale*, covering a sample of 451 nurses, concluded that intensive care unit nurses are aware of patients' needs and therefore act in their favor by listening to their wishes and evaluating the best options for their care and treatment, together with the patient and their family[4].

However, in Brazil, nursing professionals do not always receive recognition for the important and indispensable work they do. It should be noted that during the coronavirus (SARS-CoV-2) pandemic, nursing played an essential role, yet many struggles were necessary to achieve better working conditions[5].

Given the economic and social climate that has aimed for minimal state intervention since the 2000s, the health and education sectors have experienced a shortage of materials and a reduction in workers' rights. There has also been a reduction in the number of professionals, lower salaries, and more flexible employment contracts, making work and workers more precarious[6].

Following this logic, most nursing professionals work double or even triple shifts to increase their income, which causes stress and overload, increasing the likelihood of illness[7].

Despite this adverse context, nursing continues to act in defense of patients, reaffirming its commitment to care, taking the lead in the fight for patient rights, and tirelessly seeking to improve health services. Although many professionals are unaware of this, these actions are based on a nursing theory called patient advocacy, also known as existential advocacy or Advocacy[8].

This theory discusses the role of professionals in defending the rights of patients and workers who operate in the service[9]. It aims to provide people with resources and knowledge so that they can reflect on and question decisions about treatments, procedures, and everything related to health, seeking to ensure safety, autonomy, respect, and various other aspects for the patient, and, consequently, the realization of the principle of human dignity[9].

This theory, although recognized by the International Council of Nurses, is little known in Brazil. Thus, understanding the sociodemographic and economic profile of nurses working in the health complex of a public university in association with the practice of patient advocacy will help to promote the care of defending, clarifying, and supporting patients in their rights to health, which, ultimately, may benefit the care provided.

Thus, analyzing how nursing practices and understands patient advocacy provides a scientific basis for nurses to act and guarantee the rights of these patients, as well as their autonomy, which can lead to improved health services, bring benefits to workers, and contribute to a stronger society that is more aware of health rights. Furthermore, it is assumed that nursing care in patient advocacy brings benefits to patients, because when they are aware of their rights, they have self-determination and autonomy in their decisions.

The topic is relevant because it contributes to the professional practice of nursing, increasing the tools of knowledge. It can also contribute to the training of new and existing nursing professionals, exposing patient advocacy care practices in nursing consultations, such as guidance, health education, encouragement, conscious choice about treatment adherence, prevention, and health promotion. Improving assistance and offering individualized, humanized, and comprehensive care. In addition, it will increase the scope of studies on the subject, given that there is no significant volume of literature on the subject in the field of Brazilian nursing, disseminating and stimulating knowledge and practice of this theory recognized by the International Council of Nurses (ICN).

From this perspective, the question arose: what sociodemographic and economic factors related to nurses can affect the decision to advocate for patients? To answer this question, the objective was to identify the association between the sociodemographic and economic characteristics of nurses and the practice of patient advocacy in a public university health complex in Rio de Janeiro, Brazil.

## METHOD

This is a quantitative, cross-sectional, exploratory descriptive study, conducted in accordance with the recommendations of Strengthening the Reporting of Observational Studies in Epidemiology (STROBE).

The setting for the study was a hospital and a polyclinic center belonging to the health complex of a public university in the state of Rio de Janeiro. The institutions in question maintain their focus on care, health education, and clinical research, promoting continuous improvement in the quality of care and the development of evidence-based practices.

Data collection was carried out from August 2021 to June 2022. Regarding the inclusion criteria, nurses and nursing residents working in the two health units in the study setting were selected, whether in direct care and/or management. It should be noted that the units in question provide secondary and tertiary care. Nurses and nursing residents on vacation, medical leave, or other types of leave were excluded, totaling 420 nurses. Thus, a non-probability convenience sample consisting of 182 participants was selected.

In order to recruit more participants for the study, the following strategies were adopted: an email was sent by the Nursing Coordination of each unit inviting professionals to participate in the study; individual communication with the Nursing Manager of each sector within the units to convey the research to their team; and the study was presented individually to each nurse in different sectors of the institutions, taking into account their work shifts.

The Protective Nursing Advocacy Scale (PNAS) was used, adapted and validated for the Brazilian context[11]. This instrument aims to monitor the practice of patient advocacy by nurses and consists of 20 items divided into fiveconstructs[11].

The five constructs of the PNAS scale are: 1) negative implications of patient advocacy, 2) patient advocacy actions, 3) facilitators of patient advocacy, 4) perceptions that favor patient advocacy, 5) barriers to patient advocacy. These components enable an assessment of nurses' professional practice in comparison with the theory of patient *advocacy*.

The instrument is also quantified using a five-point Likert scale, established as follows: "1-I completely disagree," "2-I disagree more than I agree," "3-I neither agree nor disagree," "4-I agree more than I disagree," and "5-I completely agree."

In this study, we evaluated the PNAS scale items related to the construct of barriers and negative implications of advocacy, which prevent professionals from performing their advocacy role in healthcare institutions, and the items related to the construct of nursing actions focused on patient advocacy[11].

Thus, the construct "barriers and negative implications for the patient's exercise of advocacy" was obtained by evaluating the following questions: 31- Nurses who speak up for patients may suffer retaliation from their employers. 32- I may be punished by my employer for my actions when I inform patients about their rights, 33- Nurses who speak on behalf of vulnerable patients may be labeled as troublemakers by employers, and 34- When nurses inform and educate patients about their rights in the clinical setting, they may put their jobs at risk[11].

The construct "nursing actions focused on patient advocacy" was obtained by evaluating the following questions: 5 - I am acting on behalf of the patient when I am acting as their advocate, 6 - I am speaking on behalf of the patient when I am acting as their advocate, 7 - I am acting as the patient's voice when I am advocating for the patient, and 8 - I am acting as the patient's representative when I am acting as their advocate.

In addition to items related to patient advocacy factors, the research instrument consisted of sociodemographic and economic variables (gender, age, race, marital status, income, education, length of training, type of institution, length of service at the institution, working hours, workload, number of employment contracts, and participation in continuing education activities) aimed at characterizing the sample.

It is worth noting that the data collection for this study was conducted in a virtual environment using Google Forms®, an electronic survey form created and managed by Google® that enabled the structuring of questionnaires and storage of data in Excel® spreadsheets. This electronic form was accompanied by the Free and Informed Consent Form (FICF), where nurses could express their interest in participating in the research and authorize the use of the collected data.

Microsoft Excel® and Statistical Package for the Social Sciences (SPSS) software, version 21.0 for Windows, were used for data analysis. An exploratory descriptive analysis of sociodemographic and economic data was also performed. According to the nature of the variable, means, medians, and standard deviations were calculated and transformed into dichotomous categories to facilitate the identification of possible associations between these variables.

In the inferential analysis of these categorical variables, Pearson's chi-square test was calculated, with a significance level of 5%, to verify the presence of an association between the characteristics of the participants and the limits and possibilities of the patient's ability to practice law.

This research was approved under opinion No. 4,821,948 issued by the research ethics committee of the public university responsible for the health complex where the study was conducted. Each participant signed the informed consent form electronically using the download link provided and was thus able to decide whether or not to participate in this study by submitting the completed form. It is important to note that the use of the *Protective Nursing Advocacy Scale* (PNAS) was authorized by the author who validated it.

## RESULTS

The research sample consisted of 182 nurses and nursing residents working in direct care and/or management at a hospital and polyclinic belonging to the health complex of a public university in the state of Rio de Janeiro.

Regarding the sociodemographic and economic characteristics of the participants, it was observed that female nurses; professionals aged 38 years or younger; those who identified as black or brown; those with a family income of less than seven minimum wages; postgraduate education; and training time of less than or equal to five years had greater agreement regarding the existence of barriers and negative implications of patient advocacy. Similarly, nurses working in polyclinic services; professionals with less than or equal to three years of experience; those working night shifts; those with other employment relationships; and those who participated in continuing education activities (Table 1).

**Table 1.** Association between the degree of agreement between Construct 1 and the sociodemographic and economic characteristics of nurses. Rio de Janeiro, RJ, 2022

(continue)

| | Construct 1 - Barriers and negative implications of patient advocacy | | | |
|---|---|---|---|---|
| **Features** | **Disagreement n(%)** | **Agreement n(%)** | **$X^2$** | **p-value** |
| **Sex** | | | | |
| Women's | 77(48.4) | 82(51.6) | 0.527 | 0.468 |
| Male | 13(56.5) | 10(43.5) | | |
| **Age (in years) Average (SD) = 38.5(9.85)** | | | | |
| < 38 | 46(47.9) | 50(52.1) | 0.191 | 0.662 |
| >38 | 44(51.2) | 42(48.8) | | |
| **Race/color** | | | | |
| Black/brown | 38(42.2) | 46(54.8) | 0.840 | 0.359 |
| White | 50(52.1) | 46(47.9) | | |
| **Marital status** | | | | |
| Married/civil union | 48(48.5) | 51(51.5) | 0.081 | 0.776 |
| Single/separated | 42(50.6) | 41(49.4) | | |

**Table 1.** Association between the degree of agreement between Construct 1 and the sociodemographic and economic characteristics of nurses. Rio de Janeiro, RJ, 2022

(conclusion)

| Features | Construct 1 - Barriers and negative implications of patient advocacy | | | |
|---|---|---|---|---|
| | Disagreement n(%) | Agreement n(%) | $X^2$ | p-value |
| **Family income (in minimum wages)** | | | | |
| <7 | 43(48.3) | 46(51.7) | 0.090 | 0.764 |
| ≥7 | 47(50.5) | 46(49.5) | | |
| **Education** | | | | |
| Undergraduate degree | 15(55.6) | 12(44.4) | 0.473 | 0.492 |
| Postgraduate studies | 75(48.4) | 80(51.6) | | |
| **Training time (in years)** | | | | |
| <5 | 60(46.2) | 70(53.8) | 1.978 | 0.160 |
| >5 | 30(57.7) | 22(42.3) | | |
| **Type of Institution** | | | | |
| Hospital | 82(50.3) | 81(49.7) | 0.458 | 0.499 |
| Polyclinic | 08(42.1) | 11(57.9) | | |
| **Length of service at the institution (in years)** | | | | |
| ≤3 | 45(44.1) | 57(55.9) | 2.640 | 0.104 |
| >3 | 45(56.3) | 35(43.8) | | |
| **Working hours** | | | | |
| Daytime | 62(51.2) | 59(48.8) | 0.462 | 0.497 |
| Night/Day and night | 28(45.9) | 33(54.1) | | |
| **Workload (in hours)** | | | | |
| ≤ 40 | 32(49.2) | 33(50.8) | 0.002 | 0.965 |
| > 40 | 58(49.6) | 59(50.4) | | |
| **Has another link** | | | | |
| Yes | 54(47.4) | 60(52.6) | 0.529 | 0.467 |
| No | 36(52.9) | 32(47.1) | | |
| **Participated in continuing education** | | | | |
| Yes | 69(48.3) | 74(51.7) | 0.384 | 0.536 |
| No | 21(53.8) | 18(46.2) | | |

Caption: SD = Standard deviation; n = 182.

Source: The authors (2022).

Regarding the sociodemographic and economic characteristics of the study participants, workers, whether male or female, regardless of age and with any level of education or training, agreed on nursing actions focused on patient advocacy. However, it should be noted that there was greater agreement on this factor among professionals who identified as white; those who were married or in a stable relationship; and those with a family income greater than or equal to seven minimum wages.

It is also evident that nurses working at the Polyclinic; professionals who have been working at the institution for more than three years; and those who participated in continuing education activities agreed more on the existence of nursing actions for the practice of patient advocacy. Similarly, there was agreement among day and night

shift workers, regardless of whether their total working hours were greater or less than 40 hours and regardless of their employment status (Table 2).

**Table 2.** Association between the degree of agreement with Construct 2 and the sociodemographic and economic characteristics of nurses. Rio de Janeiro, RJ, Brazil, 2022

| | Construct 2 – Nursing actions focused on patient advocacy | | | |
|---|---|---|---|---|
| **Features** | **Disagreement n(%)** | **Agreement n(%)** | **$X^2$** | **p-value** |
| **Sex** | | | | |
| Women's | 77(48.4) | 82(51.6) | 0.697 | 0.404 |
| Male | 09(39.1) | 14(60.9) | | |
| Age (in years) Average (SD)=38.5(9.85) | | | | |
| < 38 | 44(45.8) | 52(54.2) | 0.164 | 0.685 |
| >38 | 42(48.8) | 44(51.2) | | |
| **Race/color** | | | | |
| Black/brown | 44(52.4) | 40(47.6) | 1.338 | 0.247 |
| White | 42(43.8) | 54(56.2) | | |
| **Marital status** | | | | |
| Married/civil union | 42(42.4) | 57(57.6) | 2.031 | 0.154 |
| Single/separated | 44(53.0) | 39(47.0) | | |
| **Family income (in minimum wages)** | | | | |
| <7 | 50(56.2) | 39(43.8) | 5.569 | 0.018 |
| ≥7 | 36(38.7) | 57(61.3) | | |
| **Education** | | | | |
| Undergraduate degree | 10(37.0) | 17(63.0) | 1.327 | 0.249 |
| Postgraduate studies | 76(49.0) | 79(51.0) | | |
| **Training time (in years)** | | | | |
| <5 | 64(49.2) | 66(50.8) | 0.714 | 0.398 |
| >5 | 22(42.3) | 30(57.7) | | |
| **Type of Institution** | | | | |
| Hospital | 82(50.3) | 81(49.7) | 0.458 | 0.499 |
| Polyclinic | 08(42.1) | 11(57.9) | | |
| Length of service at the institution (in years) | | | | |
| ≤3 | 53(52.0) | 49(48.0) | 2.064 | 0.151 |
| >3 | 33(41.3) | 47(58.7) | | |
| **Working hours** | | | | |
| Daytime | 57(47.1) | 64(52.9) | 0.003 | 0.956 |
| Night/Day and night | 29(47.5) | 32(52.5) | | |
| **Workload (in hours)** | | | | |
| ≤40 | 30(46.2) | 35(53.8) | 0.049 | 0.825 |
| > 40 | 56(47.9) | 61(52.1) | | |
| **Has another link** | | | | |
| Yes | 53(46.5) | 61(53.5) | 0.071 | 0.790 |
| No | 33(48.5) | 35(51.5) | | |
| **Participated in continuing education** | | | | |
| Yes | 66(46.2) | 77(53.8) | 0.323 | 0.570 |
| No | 20(51.3) | 19(48.7) | | |

Caption: SD = Standard deviation; n = 182.

Source: The authors (2022).

## DISCUSSION

The results indicate greater agreement with the construct of barriers and negative implications of patient advocacy in most characteristics. However, they also show greater agreement with the construct of nursing actions focused on patient advocacy in most of the socioeconomic and occupational characteristics of nurses in this study.

The construct of barriers and negative implications of patient advocacy consists of situations that discourage nurses from acting in defense of patients, contrary to the knowledge and values acquired throughout their training and professional experience. Expressions such as "suffering retaliation," "I may be punished," "labeled as troublemakers," and "job at risk," present in the items, highlight the concern and insecurity with asymmetrical relationships at work, such as harassment and abuse of authority, generating distress/moral suffering and burnout syndrome[12].

A study conducted at a university hospital in Brazil showed that nurses presented a prevalence of moral distress at moderate levels of intensity and frequency, and a significant association was found between moral distress and burnout syndrome[12]. Comparing with the results of the present study, where there was greater agreement among women, professionals who identified as black or brown, and those with less than or equal to five years of training for the predictor barriers and negative implications of the patient's exercise of law, points to the risk of moral suffering and *burnout* syndrome in the studied population.

It was noted that characteristics such as being female, young, black or brown, lower income, recent graduates, outpatient practice, institutional affiliation of less than three years, double work shifts, and night shifts contributed to a greater perception of barriers to patient advocacy. The characteristics listed appear in the literature as negative implications for the patient's exercise of advocacy, conditions in which moral harassment is most strongly identified[4].

One study considered it important for health service management to support nurses in patient advocacy, emphasizing that professionals' actions in defense of patient rights contribute to patient safety, in addition to highlighting the need for guidelines for the provision of this care, such as the formulation of administrative procedures[13].

It was observed that, for some occupational characteristics of nurses in this study, there was greater agreement regarding the barriers and negative implications for the application of patient advocacy. This corroborates international literature that highlights the importance of institutional support for the practice of this type of care, which is patient advocacy[14].

A study conducted with intensive care nurses at a hospital showed that professionals must be culturally aware and sensitive to avoid prejudices that could interfere with patient advocacy or cast doubt on their actions when practicing it. By applying this theory, nurses are ensuring that patients effectively defend their rights, which is important for patients who are unable to freely express their autonomy due to the critical situation they find themselves[15].

White, male professionals, married/in stable relationships, with higher incomes and more than five years since graduation, with more than three years of experience, showed greater agreement with the actions, clearly revealing the polarization/dichotomy between those who face the most barriers and those who most frequently practice patient advocacy[16-17].

To advocate for patients, professionals must also feel secure in the practice of their profession. Therefore, it is necessary to participate in policy-making processes and social struggles to ensure protection for both professionals and patients. This analysis is corroborated by a study conducted in the US on education, which shows the importance of nursing professionals having knowledge and involvement in advocating for health policies and greater political engagement. Thus, it has the potential to influence future health policy and guarantee rights and safety for professionals and patients[17-18].

Using the same scale as this article, another study conducted in Brazil with ICU nurses showed that age, older professionals, and length of service in the sector and profession are factors that increase the practice of patient advocacy by such professionals. Years of experience lead them to feel more confident and empowered to advocate for patients[19].

The factor of nursing actions focused on patient advocacy and the occupational characteristics of nurses showed greater agreement for nurses working at the Polyclinic; professionals who have been working at the institution for more than three years; and who participated in continuing education activities. To maintain and encourage the practice of patient advocacy by professionals, factors such as education and autonomy at work are important[20].

When people are defended and informed about their rights, they can become more aware and demanding of their rights and use means of popular participation, such as the Health Council, Women's Council, among others. What points to the importance of nursing practice in healthcare recognized by nurses in the study conducted. One study found that patient advocacy that reaches the sphere of public policy formulation is important in ensuring the quality of healthcare effectively and including the healthcare resource and provision system, in addition to considering systemic change as important as bedside change[21].

A review article concluded that the theory of patient advocacy in nursing is recognized as an essential activity in the profession and is seen as a valued and expected activity in nursing, although the concept of patient advocacy needs further study on the action of defending patients[22].

Regarding nursing actions focused on patient advocacy, most respondents agreed that nurses act and recognize the importance of advocating for patients in defense of their rights. The care to safeguard and protect patients from errors, incompetence, or misconduct by other professionals; to inform patients of their rights, such as diagnosis, treatment, and prognosis; to value patient autonomy while respecting culture and beliefs; to mediate healthcare with other professionals and services, and to advocate for social justice in healthcare provision, were attributes of patient advocacy demonstrated in a review study[23-24].

Regarding the limitations of this study, it should be noted that the research was conducted in only two health units at a public university in Rio de Janeiro, which makes it impossible to generalize the findings to the entire Brazilian territory. However, it is hoped that this will contribute to spreading the concept of Patient Advocacy Theory, as well as stimulating new research on the topic and allowing this discussion to be incorporated among professionals and during academic training.

## CONCLUSION

The study identified the sociodemographic and economic factors of nurses associated with barriers and negative implications of patient advocacy. These elements have an impact on the safety and performance of professionals when defending patients, ensuring the rights of these individuals. In addition to reinforcing the ethical nature of professional practice, the uncompromising defense of the principles of the Unified Health System and the Brazilian Constitution.

In this sense, patient advocacy, that is, the defense of rights and interests, plays a crucial role in the evolution and strengthening of nursing. In addition to consolidating the ethical and legal conduct of nurses, it defends the profession against legislation and regulations that may affect its practice. Among its contributions are the promotion of patients' rights, ensuring access to quality care, privacy, and autonomy in health decisions; influencing the formulation of public policies; valuing the profession; reducing health inequalities; and encouraging the value of continuing education and professional development, promoting more qualified and safer practices.

It should be noted that, in any work context, asymmetrical relationships tend to constitute barriers to the development of patient advocacy by nurses, highlighting the need for safe environments for professionals to perform their duties autonomously.

Nevertheless, it is essential to understand that the workplace is not a neutral space, but should be perceived as a *locus* for the reproduction of social relations and their power structures. Therefore, it is essential that priority be given to democratic processes that minimize asymmetrical relationships.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **de Lima BS, Souza MHN, Peres PLP, Carvalho EC.** Drafting the work or revising it critically for important intellectual content - **de Lima BS, Souza MHN, Souza NVDO, Soares SSS, Peres PLP, Carvalho EC.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **de Lima BS, Souza MHN, Peres PLP, Carvalho EC.** All authors approved the final version of the text.

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