The Nurse as Advocate: A Philosophical Foundation for Nursing

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NURSES seem to be moving in the direction of the medical model with its emphasis on science, technology and cure. As individual nurses and as members of a profession we are seeking fundamental clarifications and asking radical questions. In partial reaction to this move toward the medical model we seem to be diverting to what is essentially a historical model of nursing with an emphasis on an intuitive approach. The answers that we reach, the direction that we choose will determine the future parameters of nursing.

Some sociologists have suggested that rather than developing as nursing professionals, professional nurses are evolving out of nursing! "Nursing will still be nursing, but it will be carried on by persons of other occupational affiliations."[1(p528)] What then will nurses be doing while someone else is doing nursing?

According to some nursing leaders, nurses will be moving on to "meta-

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nursing."[2] Travelbee claims that "The role of the nurse must be transcended in order to relate as human being to human being."[2(p49)] If the role of the nurse is viewed in such a manner, it is no wonder that nurses wish to move on to better things.

What is nursing? What is the role of the nurse? What is it that makes a nurse a nurse? Is it indeed the functions that we perform? How is it then that the director of nursing service, the administrator of a nursing home, the dean of a college of nursing, the primary care nurse, the operating room nurse, the public health nurse, the psychiatric nurse all claim to be nurses? We perform radically different functions and yet each of us claims the title "nurse." How can it be that those who, in the eyes of the sociologists, have moved beyond nursing still consider themselves nurses? Could it be that rather than evolving out of nursing, these nurses are actualizing new possibilities within nursing?

Could it be that nursing *should not* be defined sociologically, but rather philosophically? Nursing can and should be distinguished by its philosophy of care and *not* by its care functions. Nurses themselves must formulate this philosophy and when they do, they transcend any particular function of nursing only to realize a more developed concept—a concept that embraces and unifies the experience of all nurses rather than denying or denigrating any of that experience.[3]

NURSING—A MORAL ART

The end or purpose of nursing is the welfare of other human beings. This end is not a scientific end, but rather a moral end. That is, it involves the seeking of good and it involves our relationship with other human beings. The science that we learn, the technological skills that we develop are both shaped and designed by that moral end—much as an artist uses a brush. Therefore, nursing is a moral art.[4] The wise and human application of our knowledge and skill is the moral art of nursing. Nursing science serves this art, and this art would not be possible without nursing science. This art is a moral art because it involves other human beings, our relationship with those human beings and the promotion of what we see mutually as "good"—health.

The Concept of Advocacy

Anyone acquainted with the history of nursing is familiar with the various models proposed as models of nursing, such as the nurse as caretaker, the nurse as champion of the sick, the nurse as health educator, the nurse as physician assistant (extender, surrogate, etc.), the nurse as parent surrogate, and the nurse as healer. None of these seems adequate.

Perhaps the philosophical foundation and ideal of nursing is the nurse as *advocate.* The concept of advocacy implied here is not the concept implied in the patients' rights movement nor the legal concept of advocacy, but a far more fundamental advocacy founded upon the simplest and most basic of premises. This concept is not simply one more alternative to be added to the list of past and present concepts of nursing nor does it reject any of them—it embraces all of them. It is not structured rigidly so as to preclude alterna-

tives, rather it involves the basic nature and purpose of the nurse–patient relationship. It is proposed as a very simple foundation upon which the nurse and patient in any given encounter can freely determine the form that relationship is to have, i.e., child and parent, client and counselor, friend and friend, colleague and colleague and so forth through the range of possibilities. This foundation is philosophically prior to any particular relationship and, in fact, enables that relationship to exist.

This proposed ideal of advocacy is based upon our common humanity, our common needs and our common human rights. We are human beings, our patients or clients are human beings, and it is this commonality that should form the basis of the relationship between us. It often seems that we have permitted traditionalism, elitism and more recently legalism to obscure this most basic of facts.

We are human beings, our patients or clients are human beings, and it is this shared humanity that should form the basis of the relationship between us.

What It Means to Be a Human Being

To even begin to understand what the human relationship in the professional context means, we have to examine who we are and where we come from. We must approach these questions in the only way we know how, as individuals whose knowing begins with our senses. What we are examining are human beings, very special kinds of beings who exist in a visible ambience at a determinable point in time and space, beings who know and who know that they know, beings who laugh and cry—and sometimes know why.

Human beings cannot be fragmented. One of our deepest convictions, confirmed by all of our experience, is that each person is a unity.[5] I who think, I who know, I who feel, I who hope, I who fear, I who believe am one! As we grow and mature we come to realize that although we are separate and distinct from all other creatures and the world, we belong to them and with them because we have grown out of the growth of others, learned from their knowledge and benefited from their sufferings. Each person is an integrity, a unity, but a unity that is interrelated and interdependent.

Slowly and painfully, we have come to understand and demand our own dignity. We now know that freedom, respect and integrity are essential to our full development as persons. These concepts have crystallized in what we call human rights.[6] Although it has taken us a bit longer, we now realize that these rights belong to all persons—young and old, black, white, red and yellow; healthy and sick. The progress in this direction has not been smooth, nor is there anything to keep us from backsliding, but progress has been made.[7]

Those concepts we call human rights derive essentially from human needs—*not* human wants, but real, fundamental human needs. Whether the right is physical (such as the right to bodily integrity) or intellectual (such as the right to learn), each is essential to our integrity—our unity—as persons.

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HUMAN RIGHTS AND THE NURSE–PATIENT RELATIONSHIP

The relevance of this concept of human rights to the nurse–patient relationship is profound because the patient/client's human needs are magnified by disease. Moreover, the process of the disease itself renders the patient/client far more vulnerable to abuse. Furthermore, the disease process itself may well create new, fundamental needs, needs that must be addressed if the person is to maintain unity-integrity as a unique human being.

Nurses are in a unique position among health professionals to attend the patient/client as a unity because they are able to experience patients as human beings.[3] Not only do nurses attend patients when distress is immediate, but they attend them for sustained periods of time, often providing those intimate details of physical and emotional care that lead to a knowledge of this person as a distinct and unique human being. This knowledge is a precondition for the fundamental type of advocacy referred to here—not legal advocacy, not even health advocacy, but human advocacy.

The only way in which the *unique* human needs of patients or clients can be met is for nurses to attend them as unities. This requires not only an understanding of patients as human beings, but an understanding of each patient as a unique human being. Nurses must be sensitive to individuals and to their reactions to those needs created by illness that threaten the unity or integrity of the person.

Not only must nurses understand the specific physiological damage caused by disease processes, but they must also understand what illness does to the humanity of the sufferer. The wounds produced by illness stretch far beyond the person's physiological or even psychological limits and penetrate the existential depths of the person's being.[8] These very special wounds create very special needs—needs that must be met if we are to minister to the patient as a human being. These wounds must be addressed if we are to respect the human rights of patients/clients, if we are to accept human advocacy as the foundation of the nurse–patient relationship.

HOW DISEASE DAMAGES OUR HUMANITY

Loss of Independence

One of the very first things that illness does to human beings is to infringe upon their autonomy or independence as people. At the very least, individuals are required to go to another person, to place themselves before this person, to admit that they have a deficiency or a defect and to ask to have it alleviated. In effect, disease makes a petitioner out of an independent individual and threatens the person's self-image. The more personal or more threatening the disclosure is, the more difficult it is for a person to reveal the problem.

Ordinarily, when we meet with a threat we either fight or flee.[9] Yet we cannot flee from ourselves, nor can we fight that within ourselves which we cannot control. This is the ultimate threat, the threat that comes from within, and no matter how

hard we try, we cannot have it alleviated without becoming a petitioner. The position of a petitioner is so repugnant to many that they will go to great lengths and take great risks to avoid it. If we are sensitive to this difficulty, the pain it imposes, the humiliation it brings, we can take some steps to alleviate it. So often it seems that health professionals (and nurses are no exception) are so caught up in their own business, their own knowlege and their own self-importance that they fail to consider this first humiliation of the patient or client. We must be willing to unravel the "medical mystique," to become more accessible and to remember that we too are human beings. It is only in doing so that we can begin to heal this first wound to the humanity, to assist individuals to overcome this first obstacle.

Loss of Freedom of Action

The second wound that impinges upon the humanity of the individual is the loss of freedom of action. The human being uses the body to transcend the body itself.[10(p28-29)] That is, unlike animals, we use our bodies for more than the fulfillment of physiological needs and instinctual drives. Human beings are bodily creatures, but they use their bodies to express their hopes, dreams, ideals and values. When we are ill we cannot command our bodies to do what we want them to do and thus in this sense our humanity is wounded, sometimes very seriously.

Insofar as possible we must assist the patient/client to communicate these essential aspects of their humanity. If they cannot do so, we must take steps to discover their value systems and then to respect them. The losses of freedom of action (verbal, locomotive, often intellectual) inflict another wound to the individual's humanity—and sometimes a very serious one!

Interference with Ability to Make Choices

In a third dimension our humanity is damaged by the interference of disease with our ability to make choices—not our right to make choices, but our ability to exercise that right. While there are many factors operant in decision making, it still remains that a decision to be truly valid, must be rational. This is a particularly sensitive area. Often professionals may consider only those decisions that agree with their own to be rational. This is not necessarily the case. However, we must be aware that pain, disability, trauma and drugs all becloud the ability to make choices as does the trauma caused by the loss of wholeness and the loss of ability to act.

Nevertheless, in all circumstances the right to consent rests within the individual. Under certain circumstances we may presume consent; in others we may obtain authorization to act; but the right always remains within the individual. If we are sensitive to this fact, we are far more likely to try to discover and act upon the patient's value system rather than our own or that of significant others. Because this situation has been greatly magnified by our increasing technological power to intervene in an individual's life, the responsibility to discover and respect the patient's value system has assumed vastly increased significance.[11]

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Power of Health Care Professionals

A corollary of these factors, and perhaps one of the most devastating attacks on our personhood, is that we are placed in the power of others. Many institutions in society exercise enormous power over us, but these powers have been recognized and surrounded with legal safeguards. It has been widely recognized, for example, that consent obtained under duress is not legally binding.[12] Few things in life are as coercive as the threat of suffering and death (in this instance imposed by illness). Yet what legal advocate, what laws of state, can protect us from these? Thus those persons whom we see as capable of relieving these threats can and do exercise enormous power over us. Not only do patients, generally speaking, lack the knowledge necessary to define the threat, but they also lack the ability to reduce the threat. Whether we as health professionals want it or not, whether we like it or not, we exercise enormous power over those whom we should serve. How do we use this power? What does this power mean in the light of human advocacy?

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RESPONSIBILITIES OF HUMAN ADVOCACY

Information must be provided—at least enough to enable patients/clients to choose among options; but how and when patients/clients are told are at least as significant as what they are told. In the past (and often today), patients were uninformed largely because it was assumed that the health professionals, perhaps in concert with the families, knew what was best for the patients. Usually professionals do know what is best from the technical viewpoint, but it is doubtful that such knowlege extends into the realm of values.

Today, largely because of legal requirements, patients may be subjected to a tyranny of information. More as a hedge against malpractice than out of respect for human rights, patients are fed an enormous, disagreeable and indigestible lump of information—and all at one sitting. How much more patients would benefit from small amounts of information provided when they are ready for them and as they ask for them. If nurses and physicians worked collaboratively rather than jealously protecting territorial limits, the patient would greatly benefit. Because nurses have the opportunity to experience the patient as a unique human being and because they spend more time with the patient, nurses can more readily provide information as the patient requests it and when the patient is prepared for it.

Because individuals have been damaged by trauma or disease, and perhaps because they have been placed in the power of others, they have to a large extent *lost their freedom to define for themselves their own image of what it is they should be.* For example, there was a case of a 22-year-old male patient who was diagnosed as having primary cancer of the testes. He was a jockey, a husband and the father of two

young sons. There was no evidence of metastasis. He was told of his diagnosis, the need for an orchiectomy and the effect this operation would have on his relationship with his wife. He and his wife discussed the situation and, considering the alternative, decided upon surgery. What he was not told, however, was at least as significant as what he was told. He was not told that he would lose his facial hair, develop breasts and develop a feminine speaking voice. How much did we impinge upon this person's identity? What did we do to his self-image? What image did he present to his sons? To his wife? What kind of comments did he have to endure at the race track? We do not know, but what we do know is that he committed suicide nine months after surgery.

So often by trying to do what we think is right by our value system, we trespass upon the authenticity of the person. Although in many cases our transgressions are not so great, in some cases they are profound. This man's decision might not have been any different if he had known all the facts, but the real question is whether or not the *individual rather than the professional* should make such value decisions. If we decide that a person cannot, how do we reach this conclusion? Can we not, should we not, ought we not assist the patient in decision making AND YET RESPECT THE PATIENT'S DECISION once it is made?

If these wounds are not addressed, and indeed if they are exacerbated, the most devastating of existential wounds develops. Insofar as patients' values are ignored, or replaced with others' values, patients cease to exist as unique human beings. Depersonalization may be partial or complete, but those individuals will die as the persons they were. If the depersonalization is complete, those individuals will not be able to create new values and goals in their life and they will lose a sense of meaning or purpose in their existence.[13] As the philosopher Nietzsche put it, "He who has the why to live can bear with almost any how."[14]

We must—as human advocates—assist patients to find meaning or purpose in their living or in their dying. This can mean whatever the patients want it to mean; it can range from enlisting religious aid to cracking irreverent jokes, from finding a new vocation to adjusting to the old one, from fighting the inevitable to the last breath to complete acceptance of death. Whatever patients define as their goal, it is their meaning and not ours, their values and not ours, and their living or dying and not ours.

Any application of human advocacy is subject to personal and situational interpretation by the practitioner. This is precisely why human advocacy can serve as a foundation upon which any practitioner in any given situation can develop the framework of the nurse–patient relationship according to the unique needs presented by that particular relationship.

According to Garver, violence is not so much a matter of force as it is a matter of violating persons physically, intellectually or psychologically.[15] Certainly not every limitation of a person's autonomy can be seen as an act of violence. To take this position would be to take the moral "punch" out of the notion of psychological violence. For example, one simply cannot equate a regulation limiting how loud patients may tune their television sets

with the rendering of patients incompetent in various degrees by withholding information, thus interfering with their rational processes. The concept of psychological violence must be reserved to those cases in which grave or systematic harm is done to the person. The ability to distinguish those cases requires a sensitivity to the human needs created by illness and the unique manifestation of these needs in each patient, NOT IN SERIOUS MATTERS ONLY, but in the daily living experience of patients/clients.

Consider the daily living experience of an institutionalized patient. An individual comes into the patient's room to insert an I.V., and the patient does not even know about the I.V. or why it is being given. Another person comes in to administer a medication that the patient does not even know about or why it is being given. Still another person comes in to catheterize the patient, to administer an enema, to draw blood, to examine every part of the patient's body, to transport the patient here or there for this test or that, and the patient doesn't even know where they are going, what is being done or why it is being done.

Each individual violation may or may not amount to a serious infringement on the patient's autonomy, but collectively they constitute both physical and psychological violence. Note that the effect on the patient is systematic. Confusion, lack of knowledge, lack of explanation, the pervasive assumption that the patient's body belongs to the "professionals" to do with what they will—all lead to reduced possibilities for decision making. Such systematic violation leads to reduced possibilities for making decisions in other, perhaps critical, areas. Human beings are reduced to objects acted upon, in effect a wholesale reduction of autonomous decision making.[16] Patient and family are thus rapidly socialized into obedience patterns and nonconformity is swiftly punished in both subtle and not so subtle ways.

ESSENCE OF NURSING

Nurses can and do control the environment of the institution, and nurses can institute progressive and humanizing changes if they so desire. Explanations and working together with a patient are not extras that nurses may choose to do, they are the essence of nursing, the essence of the nurse–patient relationship. Obviously, in certain critical situations, there is no time for an in-depth discussion of values or even explanations. These circumstances, however, constitute only a minute portion of nurse–patient interactions and should not be used to negate patient rights in the majority of situations.

Explanations and working together with a patient are not extras that nurses may choose to do; they are the essence of nursing, the essence of the nurse–patient relationship.

To claim that nurses can institute progressive change is not to ignore the many organizational and social barriers that nurses face. We can control our own actions. To be sure there are inflexible policies and insensitive orders from physicians, but the professional nurse has a great deal of latitude in the implementa-

tion of such policies and orders. Our ethical responsibility is not reduced by the actions of others, but in fact may be magnified by them.[17] Discretion and maturity are necessary components of the truly effective professional.

Nursing and the individual nurse are in very vital positions to help create a climate respectful of the human rights and needs of patients. No other profession and no other professional can exercise as great an influence over the environment of the institution (the environment of the patient) as do the nurse and nursing. If we, as a profession, work together to create an atmosphere that is open to and supportive of the individual's decision making, we may well perform our greatest service to patients/clients and their families.

In many instances nurses are not free to disclose certain information to patients/clients and their families. That is, they are not free unless they are willing to pay the price, a price that may well include loss of employment or even liscensure. This situation is wrong because it violates both the patient's and the nurse's integrity.[18] Moreover, it constitutes a direct infringement of the nurse's right to practice nursing and interferes directly with the nurse–patient relationship.[19] This situation must, can and will be changed.

However, even the existence of such factors does not justify the daily violation of the patient in those matters that nurses do control. It is not an excuse for the psychological violence to which the person is subjected in the daily living experience as an institutionalized patient. The concept of human advocacy transcends even those situational problems created by physicians who knowingly withhold information from patients because it is based on the patient's humanity and the professional's humanity. This is certainly not a complex concept; rather it is so simplistic that it seems almost ludicrous to propose it. All patients—surgical patients, psychiatric patients, medical patients, pediatric patients, dying patients—are still living human beings with all that this implies. If we remember this—and remember too that we are also human beings—the concept of human advocacy is as natural as living and dying.

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