



The effect of nursing ethics education through narration and lecture methods on patient advocacy by nurses in Iran in 2017: A quasi-experimental study

Nasrin Imanifar¹, Milad Derikvand², Seyyed Abolfazl Vagharseyyedin³

¹Master of Nursing, Instructor and Faculty Member of the Department of Nursing, Faculty of Basic Sciences, Lorestan Islamic Azad University, Khorramabad, Iran

²MSc Student of Emergency Nursing, Student Research Committee, Lorestan University of Medical Sciences, Khorramabad, Iran

³PhD in Nursing Education, East Nursing and Midwifery Research Center, School of Nursing and Midwifery, Birjand University of Medical Sciences, Birjand, Iran

Abstract

Background and aims: Patient advocacy role in nursing is affected by several barriers, such as the lack of nurses' ethical knowledge about their roles as patient advocates. Since this role can be learned, these barriers may be overcome by education through an effective method. The present study aimed to investigate the effect of ethics education on nurses' patient advocacy using ethics narration and lecture compared to a control group.

Methods: This quasi-experimental, three-group design study was conducted among nurses of hospitals in Birjand, South Khorasan province in 2016-2017. The sample size (n) was 27 in the narration group, 26 in the lecture group, and 22 in the control group. We used the Protective Nursing Advocacy Scale (PNAS) developed by Hanks to collect data, whose validity and reliability have been confirmed in Iran. Data analysis was performed using a trial version of SPSS 22 by descriptive and analytical statistics appropriate to the research objectives.

Results: The results of comparing the three groups after eliminating the effect of age indicated that lecture-based education increased the total patient advocacy ($P < 0.05$) and the impact of education and environment ($P < 0.05$) significantly compared with the control group. However, the narration method did not show any significant difference to the control group.

Conclusion: The lecture and narration methods increased nurses' patient advocacy. We recommend combining the two methods to achieve better outcomes.

Keywords: Ethics education, Ethics narration, Lecture, Patient advocacy

*Corresponding Author:

Nasrin Imanifar,
Email: nasrinimanifar@bums.ac.ir

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Introduction

Nurses account for the largest proportion of healthcare professionals at local, national and international scale and have been one of the most trusted employees for the past 19 years, so they play an important role in improving the quality of care provided (1). World nursing organizations have recognized the concept of patient advocacy to advance the provision of safe and effective care (1,2). This concept has been introduced as an inherent element of nursing professional ethics (3,4) and an effective method of empowering nurses in their professional roles (5). Patient advocacy is a dynamic concept that goes beyond mere support and compassion (4,6). Advocacy includes listening to the patient's voice, making ethical decisions, and promoting the patient's health, promoting patient safety, promoting quality of care, being patients' voice, safeguarding the patient's autonomy, acting on the patient's behalf, championing social justice, educating the patient's which may accomplished through measures such as speaking or writing, or may focus on personal

support, public awareness support, valuation, mediation, or legal and political support (6-8). Nurses have a close relationship with patients and their relatives and are also aware of their wishes and values (9). Therefore, patient advocacy provides a way for nurses to support and protect patients' interests and a bridge patients and the complex therapeutic environment (5).

In addition, patient advocacy is a strategy to help patients with serious problems and absence of patient advocacy has negative consequences such as increased hospital-acquired infections, mortality, and impolite and disrespectful attitude to patients (7,10,11). Ample evidence indicates that many patients are at risk of preventable injuries and death. Given the estimated 98 000 to 440 000 deaths per year, patient advocacy can effectively reduce the mortality rate (10). The effective role of patient advocacy realized by nurses can potentially reduce communication errors, increase patient safety, improve patient care quality, and empower nurses (4,6,7,12,13). Furthermore, evidence shows that a small proportion (10%-15%) (7,14)

of nurses and other treatment staffs are concerned about patient advocacy, exposing patients to a very high level of vulnerability (4,11,13). However, many theorists in nursing argue that advocating the patient by the nurses is important and that all healthcare facilities should serve this purpose (7,11). Patient advocacy has both positive and negative consequences for nurses, including a sense of being valuable, improvement of self-concept, job satisfaction, motivation, and creating a good public image of nurses, as well as negative consequences that prevent them from performing this role (6). In addition, advocacy is a relatively new role for nurses⁴. Numerous studies have reported many obstacles faced by nurses to perform the role of patient advocacy, including the possibility of being labeled as a bad colleague, frustration, feelings of anger, job loss, rejection, change of the workplace, and reduction of salary (4,6,7,14,15). The nursing role in supporting and protecting the patient's interests may be theoretical because the organizational hierarchy limits the nurses' independence. Besides this, there is a lack of resources and underestimation of nursing knowledge (9). For instance, two nurses in Texas, USA were sentenced to 10 years of prison and fined \$10,000 for supporting a patient against a doctor (16). Josse-Eklund reported working conditions and organizational culture as the barriers to patient advocacy from the nurses' perspective. In a positive organizational culture, which supports patient advocacy, nurses feel more confident to support the patients when needed because it is accepted and supported by the organization (15). The workplace has also been described as an influential factor for patient advocacy, in non-supportive and unsafe workplaces and/or environments where there is a possibility of conflict with colleagues and doctors, nurses support patients less frequently, and if they decide to support patients, they are likely to feel isolated (15). Lack of advocacy from nursing managers, time, and communication constraints (3,4,8,15) as well as lack of knowledge about law and nursing ethics (11) are major barriers to patient advocacy. Furthermore, the mastery of medical knowledge over nursing values and knowledge, the lack of awareness of legal consequences, the alliance of the treatment team for silence, and not giving information to patients are factors affecting the nurses' supportive roles and prevent them performing their supportive roles satisfactorily (9). Since patient advocacy is both inherent (14) and acquisitive (14,17), nurses should strengthen patient advocacy through education (4,9). In this regard, ethics education has increased in importance in nursing education in recent years. Despite the availability of a variety of ethics education methods, there is still much debate among nursing educators about the best way to teach ethics to nurses so that they can fully resolve ethical issues at work (18). These issues include common ethics education methods, such as lectures, questionnaires, classroom discussions, role-playing, case analysis, workshops, discussions, and/or a combination of them (19). However, each of these methods suffers

from certain shortcomings; for example, even though a large amount of material is presented in ethics education through the lecture method in a short time, it is a one-way communication (20). Researchers believe that traditional methods of ethics education do not prepare nurses for ethical decision-making at the bedside (21). Thus, there is a need to change the method and content of ethics education. In this regard, the narration is a different method of ethics education that can teach ethical concepts (21,22). In this method, ethics is taught indirectly using stories and narrations, and even poetry. This method only sensitizes people to do ethical work without compelling them to do so and affects their attitudes and perceptions (18). Many articles have been published about this method (14,21-23). In the culture of Iran, this method has been widely used to teach general ethics. For instance, *Masnavi-i Ma'navi of Mawlānā*, *Saadi's Bustan and Golestan*, and *Hāfez-e Shirāzī* books suggest the development and promotion of ethics in readers through stories and poetry (22). The motivation of this study is that patient advocacy could be primarily learned through fulfilling the profession (8) and could be learned through education (14,24). According to the study of Nsiah et al, the main challenge facing patient advocacy is limited educational programs (11). There are still inadequacies in defining and implementing the advocating role of nurses, and education plays an important role in educating nurses to advocate patients (25). Also, we conducted this study given the importance of narrative ethics for patient advocacy (26), ethics education to promote ethical components, and insufficient evidence to determine the effectiveness of the ethical narration method on patient advocacy.

Methods

This double-blind, quasi-experimental, three-group design study was conducted among nurses working in three hospitals, Valiasr, Imam Reza, and Social Security, in Birjand, capital of South Khorasan province (northeast of Iran), in 2016-2017. The sample size with a significance level of 0.05%, and a test power of 90% was 24 per group based on similar studies in Iran (27). Finally, we considered 28 individuals per group with a 15% probability of dropout.

Sampling was performed around one month before the educational interventions after obtaining the necessary permissions from the university and hospital officials. A list of nurses with inclusion criteria working in the studied hospitals was first prepared by purposive sampling. The inclusion criteria were as follows: At least a year of clinical experience, at least a bachelor's degree in nursing, and not having a managerial position. Exclusion criteria were withdrawing the study and lack of attending one of the sessions.

After preparing a list of all nurses with inclusion criteria in all three hospitals, the wards were divided into two intensive and general categories in each hospital due to the

multiplicity and diversity of hospital wards. Based on the number of nurses with inclusion criteria in each hospital, we determined the necessary sample size of each hospital quota using the stratified random sampling and separation of general and intensive wards. The samples in the classes were selected by a systematic random sampling method. Finally, 84 nurses were selected from the three hospitals and randomly divided into narration education, lecture, and control groups. Before and after the intervention, participants responded to the advocacy questionnaire. Hanks developed the Protective Nursing Advocacy Scale (PNAS), which examines nurses' protective advocacy in terms of ideas and practices. The questionnaire has 43 items rated on a 5-point Likert scale, from strongly agree (5) to strongly disagree (1). The questionnaire has 4 subscales including: "Acting as an Advocator", "Working conditions and advocacy actions", "Impact of Education and Environment" and "Advocacy and Barriers" (17).

The validity and reliability of the tool were confirmed by Hanks. He reported a content validity index (CVI) of 0.79 for the scale. The reliability of all items was obtained at 0.80 by Cronbach's alpha coefficient (28). In a study in Brazil, the validity and reliability of the questionnaire have also been confirmed (3).

To use the questionnaire, we first translated it from English into fluent Persian after obtaining permission from the developer of the questionnaire. Then, the translated questionnaire was back translated into the original version language by a skillful translator and matched with the original text, and minor corrections were made to it if necessary. Afterward, it was given to ten faculty members of Birjand University of Medical Sciences to determine the content validity, and the necessary corrections were made to it based on their comments. To determine the tool's reliability, we asked 17 nurses blind to the study to fill out it, and Cronbach's alpha coefficient was calculated to be 0.74.

Educational content included ethical theories, the charter of patients' rights, and four bioethics principles, including respect for patient independence (informed consent, patient advocacy, confidentiality, and privacy), profitability (honesty, loyalty, and paternalism), non-harm (mutual effect and perseverance), and justice (distributive justice) (29). Five experts in ethics approved the educational content and its homogeneity for the lecture and narration groups in terms of validity. The groups went through three-hour sessions of teaching ethics held separately once a week for four consecutive weeks. We used three narratives regarding patients' experiences of illness and hospitalization. The narratives chosen carefully to reflect ethical issues and also same with educational content of lecture group. The intervention method in the narration group was such that nurses were asked questions, including whether the narration had an ethical point or not. Then, they commented on the ethical point and duty of the narration and expressed their personal experience. These questions were asked to

draw the participants' attention to the moral elements of the narrative and stimulate their sensitivity to recognize the ethical points of the narration. At the completion of reading the narration and asking questions, a conclusion was made by the teacher. In the lecture group, the prepared content was presented through the lecture. At the beginning of the sessions, the objectives of the session were introduced, and the content of the previous session was reviewed. The control group received no training. To prevent the exchange of information between groups, we asked the participants not to talk to each other about the research topics.

Data analysis was performed by a person other than the participants. One participant in the narration group and two in the lecture group were excluded due to irregular participation in training sessions. In the control group, six incomplete questionnaires were returned and therefore were excluded from the data analysis. The terms for each subscale included "Acting as the advocator" (Items: 12, 25, 26, 27, 28, 37, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10), "Working conditions and advocacy actions" (Items: 30, 31, 32, 33, 34, 36), "Advocacy and barriers" (Items: 16, 17, 18, 23, 40, 41, 42, 43), "Impact of education and environment" (Items: 11, 13, 14, 15, 19, 20, 21, 22).

In this subscale, items 17 and 18 were advocacy items while 40, 41, 42, 43, 23, 16 were advocacy barriers. Since negative items of 24, 29, 35, 36, 38, and 39 did not belong to any subscale, they were interpreted separately. The present study only addressed four subscales. The data analysis was performed using a trial version of SPSS 22.

Furthermore, we used appropriate descriptive and analytical statistics to conduct data analysis. Fisher's exact test and chi-square test were run to compare demographic variables in the three groups. Also, the paired *t* test, one-way analysis of variance (ANOVA), analysis of covariance (ANCOVA), and the post hoc Bonferroni correction test were performed to compare mean values of the three groups. We received the necessary approvals from the Ethics Committee of the university and hospital officials to start sampling. Oral consent was also obtained from the participants. The participants were ensured that their information would be kept confidential and that they would be completely free to enter and/or withdraw from the study without affecting their working.

Results

Among 75 nurses, 27 (36%) were in the narration group, 26 (34.7%) in the lecture group, and 22 (29.3%) in the control group. Participants' mean age was 29.30 ± 6.08 years in the lecture group and significantly lower than in the narration groups (36.37 ± 5.64 years) and the control group (33.86 ± 5.64 years) ($P < 0.001$, Table 1).

The ANOVA results indicated that the mean scores of protective advocacy in total and its domains were not significantly different among the three groups before ($P = 0.30$) and after the intervention ($P = 0.06$). Furthermore, the mean changes in protective advocacy

score in total ($P=0.64$) and its domains were not significantly different among the three groups before and after the intervention ($P>0.05$, Table 2).

The paired t-test results indicated that the mean scores of protective advocacy in total ($P=0.046$) and working conditions and advocacy actions domains ($P=0.020$) were significantly higher in nurses of the narrative group after the intervention than before the intervention. However, no significant difference was observed in scores of before and after the intervention between other groups ($P>0.05$).

Since the nurses' mean age was significantly different

in the three groups ($P<0.001$), we used the ANOVA to remove the confounding effect of age. The results indicated that the mean scores of protective advocacy in total ($P=0.047$) and the domains (i.e., the impact of education and environment ($P=0.043$)) were significantly different among nurses of the three groups. Also, the post-hoc Bonferroni correction test results (Table 2) indicated that mean scores of protective advocacy in total and the domains (i.e., the impact of education and environment) after the intervention were significantly higher in the lecture group than in the control group ($P<0.05$). The

Table 1. Comparison of participant demographic characteristics in three groups of narration, lecture, and control

Demographic characteristics		Group			P value
		Narration	Lecture	Control	
		No. (%)	No. (%)	No. (%)	
Gender	Male	1 (3.7)	4 (15.4)	4 (18.2)	0.216 ^a
	Female	26 (96.3)	22 (86.4)	18 (81.8)	
History of ethics education during the past year (as a learner)	Yes	2 (8)	4 (15.4)	7 (38.9)	0.057 ^a
	No	23 (92)	22 (84.6)	11 (61.1)	
Ward	Internal and surgery	9 (34.6)	10 (38.5)	6 (27.3)	0.604 ^b
	Intensive	14 (53.8)	10 (38.5)	10 (45.5)	
	Other	3 (11.5)	6 (27.3)	6 (27.3)	
Work experience	1-5 years	7 (35.9)	15(65.2)	10 (47.6)	0.052 ^b
	6-10 years	7 (35.9)	5 (21.7)	5 (23.8)	
	>10 years	13 (48.1)	3 (13.0)	6 (28.6)	

^a Fisher's exact test; ^b Chi-square test.

Table 2. Comparison of mean scores on protective advocacy in total and on its domains in nurses before and after intervention in three groups

Domains of protective advocacy	Group	Before intervention	After intervention	P value ^a	Mean change of scores before intervention	After intervention (after removing the effect of age)
		Mean ± SD	Mean ± SD		Mean ± SD	Mean ± SD
Acting as an Advocator	Narration	66.15 ± 6.39	68.85 ± 6.41	0.204	1.70 ± 6.80	66.80 ± 7.01
	Lecture	64.65 ± 8.29	67.31 ± 7.68	0.168	2.65 ± 9.52	68.57 ± 7.18
	Control	63.50 ± 4.92	64.50 ± 6.67	0.488	1.00 ± 6.64	64.49 ± 6.67
	P value ^b	0.392	0.215	-	0.762	0.153
Work conditions and advocacy actions	Narration	17.18 ± 2.84	18.59 ± 2.87	0.020	1.41 ± 2.95	18.47 ± 3.63
	Lecture	19.04 ± 3.78	18.50 ± 3.94	0.523	-0.54 ± 4.24	19.07 ± 3.71
	Control	17.05 ± 3.81	16.36 ± 3.54	0.246	-0.68 ± 2.67	16.60 ± 3.45
	P value ^b	0.082	0.052	-	0.053	0.057
Impact of education and environment	Narration	31.85 ± 3.44	32.11 ± 3.72	0.602	0.26 ± 2.55	31.41 ± 3.32
	Lecture	31.19 ± 4.16	31.27 ± 3.03	0.928	0.08 ± 4.33	32.19 ± 3.40
	Control	30.91 ± 3.29	29.82 ± 3.16	0.198	-1.09 ± 3.85	29.74 ± 3.16
	P value ^b	0.648	0.062	-	0.390	0.043
Advocacy and barriers	Narration	24.93 ± 3.49	25 ± 4.66	0.908	0.07 ± 3.30	25.20 ± 4.40
	Lecture	27.04 ± 5.68	25.31 ± 4.07	0.095	-1.73 ± 5.08	25.08 ± 4.50
	Control	24.64 ± 3.39	25.73 ± 3.55	0.145	1.09 ± 3.38	26.08 ± 4.18
	P value ^b	0.109	0.831	-	0.053	0.691
Total supportive advocacy	Narration	140.11 ± 9.59	143.56 ± 10.11	0.046	3.44 ± 8.53	141.88 ± 10.84
	Lecture	141.92 ± 16.63	142.38 ± 12.30	0.896	0.46 ± 17.82	144.92 ± 11.11
	Control	136.09 ± 12.27	136.41 ± 10.25	0.904	0.32 ± 12.20	136.90 ± 10.31
	P value ^b	0.305	0.063	-	0.641	0.047

^a Paired t test; ^b One-way analysis of variance.

mean scores of patient advocacy in total and the domains were not significantly different among the three groups in terms of demographic variables ($P > 0.05$).

Discussion

The comparison of results indicated that the mean changes of the three groups were not significantly different. Nevertheless, comparing the three groups after eliminating the effect of age revealed that education through lecture significantly increased patient advocacy in all dimensions, mainly the impact of education and environment, in comparison with the control group. However, the narration method did not cause any significant difference compared to the control group. Despite this, Gazarian et al in a study with a similar design and tool found the use of narration to be effective in nursing students' perception of their role of advocating the patient (14). Nasiriani et al also found that narrative ethics training has a positive effect on nurses' moral sensitivity (21). To explain the findings of the present study, there was no significant difference in the narration group compared to the control group. Notably, patient advocacy has cognitive and physical dimensions associated with the nurse's knowledge, work environment, nurses' relationship with physicians, and organizational climate, in addition to the emotional dimension (14). Therefore, the narration method does not suffice to advocate the patients who need the nurses' knowledge of ethical duty and the organizational support to consider the patient advocacy as an ethical duty. The reason is that this method indirectly exerts more impact on the conscience and emotional dimension of people who listen to the narration so as to motivate them to do ethical work. In a similar study by Priscilla et al, all participants were female and had a mean age of 27 (14). This explanation of the effect of feminine nature on such perception is related to their being more emotional and compassionate, while the mean age was 36 in the narration group and 29 in the lecture group in our study. We can infer that the younger the nurses are, the better they support their patients because they are not afraid of the consequences of helping patients. Another explanation is that they might not have unpleasant experiences of patient advocacy such as labeling, replacement, and dismissal, as well as factors as barriers to patient advocacy (14,15). In the study by Hussein Abdel-Fattah et al, the average age of nurses was 23 years and about 80.2% of them had a high perception of patient advocacy. In that study, female gender and previous education were positive predictors of patient advocacy, while old age and night shift were negative predictors (13). Results of a descriptive study by Beigzadeh et al indicated that the older the nurse was, the more positive his/her attitude and subsequently his/her behavior is toward patient advocacy (30). Cato and Costello also found it easier for experienced nurses to advocate patients than novice nurses who are expectedly younger (1). Studies also suggest that nurses' personality characteristics are the most influential factors for nurses'

patient advocacy because there will be no advocacy until the nurses do not tend to conduct patient advocacy (15). Hence, this subject needs further investigation.

The present study also revealed that education through significantly increased patient advocacy in the domain of education and environment compared to the control group. This domain was related to the effect of nurses' knowledge and inner environments (e.g., values, beliefs, and self-confidence). In other words, the subscale referred mainly to nurses' self-understanding as patient advocates because most nurses did not receive sufficient training in this field (3). Meanwhile, evidence suggests that nurses' perceptions of patient advocacy determine how and whether they will support their patients (7). Alanezi found a significant relationship between nurses' beliefs and behavioral aspects of patient advocacy (2). In this regard, Brown et al found that simulation training had a positive effect on students' patient advocacy skills (31). Nesime and Belgin found that education had a positive effect on patient support (25). Gazarian et al also found that narration improved the nursing students' understanding of their supportive role in the domain of education and environment (14). Nsiah et al also reported that nurses might have a knowledge gap in understanding the meaning of patient advocacy (7). Many other studies consider nurses' beliefs, values, and preferences as factors controlling patient advocacy (6,15). According to a study, some nurses do not believe in advocacy as part of nursing (11). Ware et al (8) and Vitale et al (4) reported nursing knowledge and skills as being facilitators of patient advocacy. Nsiah et al found lack of education and inadequate knowledge to be barriers to patient advocacy (11).

A study in Turkey highlighted the importance of training and education in fostering nurses' perception of patient advocacy (32). According to a survey by Abbasinia et al, appraisal is an integral part of patient advocacy (6); hence, ethics education is expected to increase the nurses' knowledge of their advocacy role by informing and providing information to patients and favorably affect patient advocacy.

The results indicated no significant difference in mean changes in advocacy scores before and after the lecture training, although there was a considerable corresponding difference in the narration group. According to the mean scores of the three groups at baseline, the mean score of advocacy in the lecture group was higher than those in the other two groups. As a result, even though the advocacy score increased in the lecture group, the increase was not much different to the previous score because the sample size was small. Therefore, further studies with larger sample size are recommended to investigate this issue.

Some studies indicate that the narration should be done by a skilled, trained, and influential person to achieve desirable objectives. In this regard, a limitation of the present study was the lack of previous formal training for a person who performed interventions, as we only used the recommendations of previous studies in this field. Other

limitations, including the existence of some variables such as nurses' cultural, educational, and personality background, might be effective on their answers to questions and their supportive roles. Also, the request from nurses who did not have any formal or informal ethics training during the research intervention due to lack of attending training sessions and little possibility of information exchange was another issue that should be considered in future studies.

Conclusion

According to the results, we suggest to use a combination of two methods of lecture and narration to teach ethics because patient advocacy has cognitive and emotional dimensions. However, further studies in this field are needed with a further emphasis on the effects of environmental and personality characteristics of nurses and patients.

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Conflict of Interests

The authors declare no conflict of interests.

Ethical Approval

This study was approved by the Research Council and the Ethics Committee (code: 9302) from the Graduate Studies Committee of Birjand University of Medical Sciences, Birjand, Iran (Ethics Code: LR.BUMS.REC.1394.465).

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