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Original Article

Advocacy, 'defacto' partner to neonatal nursing practice

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Abstract Advocacy is married to nursing practice in every sense of the word. Woven through the very fabric of our practice, it is the demonstration of our responsibility to those in our care in an area where it is paramount. Neonatal care facilities generally accept that parents/guardians are the best advocates for their children and act in their best interest. At times social and family demands make it impractical for parents to be with an infant throughout each day and hence the concept of an advocate is most relevant. The level of vulnerability of the infant and parents in the neonatal unit in all aspects of care further strengthens the call for advocacy. Being an advocate in nursing not only refers to those in our care but relates to a wider effort to improve accessibility, excellence, research and overall service delivery. Advocacy within the profession of nursing and our codes of practice refers to organisational/management support for its nurses extending their role at a local and national level alike.

Introduction

Advocacy is inherent to neonatal nursing practice. In conjunction with our medical colleagues we aim to champion our families and infants as we provide a second protector to ensuring the best interest of the infant and family are met. The family are an integral part of neonatal nursing akin to the team of health care professionals.

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Advocating for parental autonomy

There is potential for loss of liberty in the neonatal unit (Goering, 2009). The unfamiliar 'high tech' environment, encountering foreign and unfamiliar medical terminology, whilst potentially traumatised from an abrupt unpredicted turn of events compromises parental autonomy.

In the tradition of the Hippocratic Oath, beneficence may be considered a duty to do only good or ones best for the patient, and has been identified as bound by other virtues such as justice and professional responsibility (Crisp, 2014). Beneficent actions also seek to protect autonomy whilst non maleficence is our duty to do no harm. Madden (2011) suggests that this 'duty' implies an obligation on the medical profession to ensure doctors/practitioners are adequately trained to provide care and no harm to the patient or family. This duty of care or duty to do no harm is not only pertinent to clinical aspects of care.

The unanticipated admission of an infant to the neonatal unit gives newly made parents little time to adapt to the role of decision makers. For some of these couples parenthood is an event that is thrust upon them with little time to prepare and adapt, bringing with it anxiety and fear for their offspring amidst this unfamiliar environs of the neonatal unit. This environment can be intimidating when parents come to seek and understand details and implications of care. Irrespective of reason for admission we need to acknowledge the need for time to ingest and digest information, to ask questions, and to adjust to the situation and new environment. Let us not forget that the basis of parental autonomy is that the parent has the right to determine what happens to the infant's body. Whilst acknowledging the infants best interest, there is potential for bias in a neonatal environment pending on the personal beliefs/attitudes of all neonatal health care professionals and perhaps potentially steering parents toward a specific path of care that is inconsistent with parents views.

Respect for autonomy stems from acknowledgement of the unconditional worth of all persons with the ability to make 'moral' choices pertaining to their own destiny (Beauchamp and Childress, 2009). Potential peril exists amidst our most beneficent actions in neonatal care where despite the best efforts of doctors and nurses, time constraints can limit our enhancement of parental autonomy as we 'assume consent' and proceed with treatment/investigations/care. Allowing the assumption of consent to erode the concept of informed consent does little to elevate parents to a position of power and confidence.

Cultural variances must be acknowledged as a contributing factor to parent's concerns and at times reluctance to get involved. The world is made up of many cultures and religions which may be considered to have minimal shared norms. A prima facie moral requirement is that this individual, and cultural variability is protected. The key to achieving this is acknowledging our own values and beliefs and respecting those who differ. If we are to provide holistic nursing, we require a good understanding variances amongst families in our care, in conjunction with information pertaining to emotional, spiritual, psychological and social implications of the infants medical condition for the family (Nurses and Midwives Board of Ireland, 2015).

Advocacy in nursing practice

An emphasis on human rights and autonomy in nursing/medicine has led to the emergence of advocacy. Bu and Jezeweski's (2007) theory suggests that 'advocacy *is a process or strategy consisting of a series of specific actions for preserving, representing and/or safeguarding patients' rights, best interests and values in the health care system*' (p. 104). This broad definition focuses on safeguarding patient/parental autonomy, acting on behalf of parents in representing their beliefs, values and rights when unable (or does not wish) to attend to themselves, and to strive to recommend, promote, defend and reduce inequalities and inconsistencies.

In turn advocacy reflects codes of nursing practice. It is acknowledged by codes of practice that we *must protect and promote autonomy of service users, respect their choices, priorities, beliefs and values* (Nursing and Midwifery Board of Ireland, 2014, p. 8). These codes advocate for service users rights and for best practice in neonatal and maternal health care.

As a neonatal nurse I have a moral and legal obligation to act as each infants/parent's advocate. However it may take courage and negative consequences may also develop for the individual professional concerned. Nurses are professionals responsible and accountable for their practice, attitudes and actions including inactions and omissions (Nurses and Midwives Board of Ireland, 2014, p. 16). Being neutral or