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# Patient advocacy actions by intensivist nurses*

## Ações de advocacia do paciente pelos enfermeiros intensivistas

## Acciones de abogacía del paciente por los enfermeros intensivistas

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## ABSTRACT

**Objective:** To explore the actions and factors associated to patient advocacy by intensivist nurses using the Protective Nursing Advocacy Scale. **Method:** A quantitative, descriptive-exploratory, cross-sectional study. The questionnaire was answered by nurses who worked in Intensive Care Units in the South and Southeast regions of Brazil. A factorial exploratory analysis of the data, T-tests and the chi-square test were used for association between factors. **Results:** 451 nurses participated in the study. A greater number of nurses disagreed with the negative consequences that patient advocacy may have or bring to them. Greater dialogue among nursing staff would enhance teamwork results. Nurses with two or more job relationships need more physical and mental effort, which compromises their quality of life and work, leading to them being those who least practice patient advocacy. **Conclusion:** Nurses understand patient advocacy as an important part of their work, as well as factors which may influence their decision to defend their patients, but are still unaware of the benefits of advocacy.

## DESCRIPTORS

Patient Advocacy; Critical Care Nursing; Intensive Care Units; Ethics, Nursing.

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## INTRODUCTION

Nursing demands ethical skills from its professionals more and more, since technical and theoretical knowledge often do not address patients' and family issues. Therefore, the care provided by the nurse is also evaluated based on their communication, protection, defense and relationship with patients and relatives[1-2].

Patient advocacy in Brazil was proposed as an ethical role of the nurse's professional practice with patients and aims to ensure their rights, contributing to their autonomy. This defense by the nurse can be defined as an intervention to help patients obtain services and benefits that are within their rights, facilitating their care, treatment and well-being[3-5].

As members of a care team, Intensive Care Unit (ICU) nurses critically act in the inpatient care at these units and also support their family members. This practice in patient advocacy assures factors such as quality assurance and comprehensive care of the patient, defending autonomous action in the decision-making process for patients and their families, as well as assisting in understanding their rights[6-7].

Therefore, nurses who attend these patients must be theoretically, technically and ethically competent, meaning they should be qualified to advise on the best decision-making. It is understood that patient advocacy is an ethical component of nurses' work and requires, in addition to improvement in professional autonomy, the existence of situations which impel a nurse to decide to defend the patient[8-10].

Nurses' decisions to defend their patients, especially those who work in the ICU, is due to the fact that these professionals understand that the patients are in a vulnerable situation, since there is a need for specialized care in these units due to the critical condition in which the patient is in, and the great influence of technologies integrated into nursing care. Also, a nurse in the ICU becomes a care reference for both the patient and their family due to the greater closeness between them[11-12]. Finally, the importance of interpersonal communication of the nurse who performs healthcare in the ICU is evident, be it with a doctor, nursing team, other professionals or with patients and their relatives[1,12].

Despite being a relevant part of their work, nurses advocating for patients is not well explored in studies, since this role of the nurse in advocacy is little disseminated among nurses and there is no national research on the subject. In order to investigate the beliefs and actions of nurses in protecting patients through their role in patient advocacy, we sought to use the Protective Nursing Advocacy Scale (PNAS) developed by Hanks (2010). The scale was transculturally adapted and validated in Brazil, with this Brazilian version being a valid and reliable instrument for evaluating the beliefs and advocacy actions of Brazilian nurses[1,13].

The objective of this study was therefore to explore the actions and associated factors in patient advocacy by intensivist nurses using the Protective Nursing Advocacy Scale – Brazilian version.

## METHOD

### Study design

This is a quantitative, descriptive, exploratory and cross-sectional study.

### Scenario

This study was conducted from May 2015 to December 2016, with 451 nurses working in ICUs in the South and Southeast regions of Brazil, selected by non-probabilistic sampling by convenience according to their presence and availability during the Brazilian Nursing Association (*ABENTI – Associação Brasileira de Enfermagem e Terapia Intensiva*) and the Brazilian Intensive Care Medicine Association (*AMIB – Associação de Medicina Intensiva Brasileira*) events or by accessing the online questionnaire by the social media. Nurses with at least 1 year of work experience in intensive care were included in the study.

A minimum sample number was used for sample reliability and to generalize the results for the study population. In January 2016 there were a total of 19,927 ICU beds in the South and Southeast of the country according to the National Registry of Health Establishments (*CNES – Cadastro Nacional de Estabelecimentos de Saúde*), and considering the Resolution of the Collegiate Board of Directors No. 7 of 2016, a nurse must attend a maximum of 10 ICU beds per work shift, which results in a total of 1,993 nurse vacancies. Considering nurses work a 30-hour weekly regime, there would be six nurses required for each of these available positions, totaling 11,958 nurses occupying these jobs in the ICU; further considering a total of 11,958 nurses, with a sample loss of 10% and reliability of 95% of the data collected, a minimum sample of 409 nurses was obtained[14-15].

### Data collection

Data collection was performed in two different ways: in person, with nurses who participated in *ABENTI* and *AMIB* events during the collection period. To do so, a brown envelope was sent without identification containing the questionnaire and a Free and Informed Consent Form (ICF). The envelope was to be returned closed with the questions answered or not; the second way was through social media on a webpage created by the researchers on a social network with international reach, where the questionnaire and the ICF were made available online to be answered.

The instrument used for data collection was the Brazilian version of the PNAS, composed of two stages: 1) sociodemographic data; and 2) a questionnaire about nurses' beliefs and actions acting in patient advocacy. The PNAS contains 43 questions answered using a Likert scale, where participants indicate 1 to strongly disagree, 2 to disagree more than agree, 3 to neither disagree nor agree, 4 to agree more than disagree, and 5 to totally agree.

### Data analysis and processing

The collected data were analyzed with the aid of Statistical Package for Social Sciences (SPSS), version 22.0 for Windows.

The results of the Exploratory Factor Analysis (EFA) were used to identify the relationship between PNAS variables, resulting in two factors with reliability ascertained by Cronbach's Alpha scale. An exploratory and descriptive analysis of medians and frequencies were developed with the factor

data, as well as an analysis of the sociodemographic data of the study participants. All analyses of qualitative variables was done from the median, which is the value that divides all the results into two groups of equal size. It was not possible to use means for the found factors, since it does not represent the general response of the nurses because the answers were given in nominal variable, and not in numerical scale[16].

The factors were dichotomized from the factor medians to perform statistical tests, dividing the variables into two categories so that the differences between the extreme opposite groups were found.

The independent t-test was applied to the quantitative variables to compare the means in order to identify significant differences (level of 5%). The nominal qualitative variables were analyzed with Pearson's chi-square test of independence, which tests whether two categorical variables arranged in a contingency table are associated[16].

### Ethical aspects

This study was approved by the Research Ethics Committee of the Oncology Research Center under Opinion no. 863.112 of 2014, observing the recommendations of Resolution 466/12 of the National Health Council. Participants signed the ICF when participating in the research, giving authorization to use collected data.

## RESULTS

The study participants were 451 nurses who worked in Intensive Care Units of the South and Southeast of Brazil. Table 1 summarizes the sociodemographic data of the study participants.

**Table 1 –** Sociodemographic data of ICU nurses – Florianopolis, SC, Brazil, 2017.

| Variables | | |
|---|---|---|
| **Gender** | Female | 380 (84.3%)[#] |
| | Male | 71 (15.7%)[#] |
| **Age** | | 34.72 (7.84)* |
| **State** | São Paulo | 140 (31%)[#] |
| | Rio de Janeiro | 84 (18.6%)[#] |
| | Rio Grande do Sul | 69 (15.3%)[#] |
| | Minas Gerais | 62 (13.7%)[#] |
| | Paraná | 56 (12.4%)[#] |
| | Santa Catarina | 28 (6.2%)[#] |
| | Espírito Santo | 12 (2.7%)[#] |
| **Has specialization** | Yes | 302 (67%)[#] |
| | No | 149 (33%)[#] |
| **Type of specialization (n=302)** | Intensivist | 255 (56.5%)[#] |
| | ICU Training | 68 (15.1%)[#] |
| | Master's degree | 23 (5.1%)[#] |
| | Doctorate degree | 10 (2.2%)[#] |
| **Employment relationships** | 1 relationship | 322 (71.4%)[#] |
| | + 1 relationship | 120 (26.6%)[#] |
| **Working hours/week** | Up to 30 hours | 135(29.9%)[#] |
| | + 30 hours | 305 (67.6%)[#] |

[#]Total frequency (Percentage).
*Mean (Standard deviation).
Note: (n= 451).

The training time was calculated in years since graduation and ranged from 1 to 39 years, with an average of 10.32 years. ICU work time was calculated in years, with a mean of 6.64 years and varied from 1 to 33 years of work. In addition, the number of ICUs with up to 30 beds is 365, or 80.9% of the 451 ICUs.

The main employment relationship of nurses is mostly public (47.5%), 82.3% are effective, and 63.9% are highly complex. The ethics committee is present in 64.7% of the ICUs, and there are nursing team meetings in 72.7%.

An exploratory factorial analysis was carried out with the data collected from the 451 nurses, enabling identification of two factors that are relevant to act in patient advocacy of the ICU nurses. These factors provided an understanding of the nurses' actions in enacting patient advocacy and the influences on these advocacy actions. Factor 1 is entitled "Background, barriers and negative implications of performing patient advocacy by the Intensive Care Unit nurse", and refers to aspects that can be considered problematic and/or conflicting in advocacy practice. Factor 2, "Nurses' actions and benefits of patient advocacy in the Intensive Care Unit", portrays the actions of intensive care nurses in patient advocacy and the benefits of this advocacy.

The PNAS scale which was used for data collection does not allow us to sum the scores for analysis. Therefore, descriptive statistics of factor scores from their medians were performed instead of using the mean results. The median of Factor 1 had a value equal to three, and the median of Factor 2 had a value equal to five.

The factor medians were dichotomized in order to analyze the qualitative and quantitative variables of the sociodemographic questionnaire. The factor medians less than or equal to three were considered as disagreement with the questions of the analyzed factors, and the medians of more than three as agreement with the questions of the analyzed factors.

The relative frequencies and percentage of the ICU nurses' responses to Factor 1 were 272 (61.3%) nurses who disagreed and 172 (38.7%) of nurses who agreed with the questions of this factor. In Factor 2, 66 (14.9%) of nurses disagreed, and 378 (85.1%) who agreed with the questions in considering the percentage of valid nurse responses (n=451).

The parametric test-t was performed to compare the groups of nurses who answered Factors 1 and 2 and the quantitative variables of the sociodemographic questionnaire (age, graduation time and ICU time). The t-test indicates whether or not there is equality in the means of the analyzed groups. Statistical losses were considered for these tests, resulting in a sample of 444 nurses.

The t-test (with a significance level of 5%) showed that the mean age, time since graduation and ICU time for Factor 1 did not present statistical difference between the nurses who disagreed and those who agreed with the analyzed questions. The same was found for Factor 2 when the t-test was analyzed for age, time since graduation and ICU time.

For the nominal qualitative dependent variables, the non-parametric chi-square test was performed to evaluate

the association between the independent and dependent variables, analyzing the dependence of these variables. The results pointed out that only Factor 1 ("Background, barriers and negative implications of performing patient advocacy by the Intensive Care Unit nurse") had a p-value with significance at 5%. Factor 2 ("Actions of nurses and benefits of patient advocacy in the Intensive Care Unit") had no significant association that could be better analyzed. Statistical losses were considered, resulting in a sample of 444 nurses performing the chi-square test.

The dependent variables analyzed in association with Factor 1 are shown in Table 2. Some variables had to be dichotomized: the number of employment relationships, classified in (1) one or (2) more than one relationship; weekly working hours: (1) up to 30 working hours, and (2) more than 30 working hours per week, noting that the World Health Organization recommends that nurses work up to 30 hours per week; number of ICU beds: (1) up to 30 beds and (2) more than 30 beds, with 30 beds being the average number of beds found in the study from the number of nurses responding.

**Table 2 –** Association between Factor 1 and sociodemographic data of ICU nurses – Florianopolis, SC, Brazil, 2017.

| Factor 1: Background, barriers and negative implications of advocacy | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1 | | 2 | | $X^2$ | P |
| | | AF | RF | AF | RF | | |
| **Gender** | Female | 233 | 61.8 | 147 | 38.3 | 0.003 | 0.954 |
| | Male | 39 | 60.9 | 25 | 39.1 | | |
| **State** | RS | 43 | 62.3 | 26 | 37.7 | 1.779 | 0.939 |
| | SC | 17 | 60.7 | 11 | 39.3 | | |
| | PR | 34 | 60.7 | 22 | 39.3 | | |
| | SP | 91 | 65.0 | 49 | 35.0 | | |
| | RJ | 49 | 58.3 | 35 | 41.7 | | |
| | ES | 3 | 60.0 | 2 | 40.0 | | |
| | MG | 35 | 56.5 | 27 | 43.5 | | |
| **Courses** | None | 25 | 59.5 | 17 | 40.5 | 0.871 | 0.929 |
| | Training | 40 | 58.8 | 28 | 41.2 | | |
| | Specialization | 189 | 62.6 | 113 | 37.4 | | |
| | Master's degree | 12 | 54.5 | 10 | 45.5 | | |
| | Doctorate degree | 6 | 60.0 | 4 | 40.0 | | |
| **Intensivist** | Yes | 163 | 63.9 | 92 | 36.1 | 4.076 | 0.130 |
| | No | 98 | 56.6 | 75 | 43.4 | | |
| **Employment relationship** | Public | 134 | 62.6 | 80 | 37.4 | 1.916 | 0.590 |
| | Private | 99 | 60.4 | 65 | 39.6 | | |
| | Mixed | 30 | 55.6 | 24 | 44.4 | | |
| **Type of relationship** | Effective | 230 | 62.0 | 141 | 38.0 | 0.433 | 0.805 |
| | Temporary | 28 | 57.1 | 21 | 42.9 | | |
| **Care (complexity)** | Low | 8 | 72.7 | 3 | 27.3 | 2.404 | 0.493 |
| | Medium | 64 | 57.1 | 48 | 42.9 | | |
| | High | 177 | 61.1 | 111 | 38.5 | | |
| **Ethics committee** | Yes | 181 | 62.0 | 111 | 38.0 | 1.338 | 0.720 |
| | No | 52 | 57.1 | 39 | 42.9 | | |
| | Does not know | 27 | 61.4 | 17 | 38.6 | | |
| **ICU meetings** | Yes | 217 | 66.2 | 111 | 33.8 | 19.201 | <0.001* |
| | No | 44 | 43.1 | 58 | 56.9 | | |
| **Number of employment relationships** | (1) | 212 | 65.8 | 110 | 34.2 | 10.244 | <0.001* |
| | (2) | 59 | 49.2 | 61 | 50.8 | | |
| **Weekly working hours** | (1) | 75 | 55.6 | 60 | 44.4 | 2.771 | 0.096 |
| | (2) | 195 | 63.9 | 110 | 36.1 | | |
| **Number of beds** | (1) | 220 | 60.3 | 145 | 39.7 | 0.806 | 0.369 |
| | (2) | 50 | 65.8 | 26 | 34.2 | | |

Scores: 1 – Disagree; 2 – Agree.
$X^2$ - Pearson's chi-square test for association between variables.
In the cases smaller than 5, the Fisher test was considered.
*p-value<0.05 at 5% significance level.
AF – Absolute frequency; RF – Relative Frequency or percentage.
Note: (n= 444).

As a result of the chi-square tests between sociodemographic variables and Factors 1 and 2, there was an association between the significance level of 5% of Factor 1 and the variables Number of employment relationships (p-value <0.001) and ICU Meetings (p-value <0.001).

The variable ICU Meetings presented a higher-than-expected frequency of nurses who disagreed with the questions about Factor 1 (Background, barriers and negative implications) of the group of nurses who answered yes (ICU meetings occur where they work), as 217 nurses disagreed when the expected was 200.9. Therefore, the number of nurses who agreed was lower than expected: 111 nurses agreed, when the expected was 127.1.

Still on this variable of ICU Meetings, the nurses who answered no (there are no meetings in the ICU in which they work) disagreed less than expected, meaning that 44 nurses disagreed, and the expected would be 62.5. In addition, nurses agreed more than expected with Antecedents, barriers and negative implications of Factor 1, where 58 agreed in this case, and the expected would be 39.5.

The variable Number of employment relationships also had a different frequency than expected associated with Factor 1 (the Antecedents, barriers and negative implications of advocacy). Nurses who had one employment relationship (1) disagreed 212 times, when the expected was 197.4 times, while the nurses who agreed was 110, and the expected was a total of 124.6. Nurses who had more than one employment relationship (2) had lower than expected frequency of those who disagreed with Factor 1, being 59 nurses when the expected was 73.6; and a higher than expected frequency among those who agreed being 61, when the expected was 46.4.

## DISCUSSION

From the frequency calculation, it was found that a greater number of nurses disagreed with the factor "Background, barriers and negative implications of performing patient advocacy by the Intensive Care Unit nurse". Thus, it was evidenced that these professionals do not agree with the negative consequences that patient advocacy may have or bring to the nurse.

It can then be shown that the nurses in this study do not understand the influences, both internal and external, as barriers to advocacy practice, nor do they see the failure of the advocacy provided or the impediment to carry out such advocacy as negative, which may be understood as the fact that the nurses do not understand the reason for the stress they are experiencing, or worse, do not understand their fatigue as stress. It is also possible to show that nurses perceive advocacy practice as positive, since similar studies infer that performing patient advocacy can increase nurses' professional and personal satisfaction, as well as their confidence and credibility when exercising nursing in the workplace[13,17-18].

The existence of ICU meetings where nurses work was statistically relevant with the factor which points out the barriers and negative implications of patient advocacy, since nurses who do not have meetings in their workplace agree more with these barriers and implications. Although articles do not report experiences of meetings with the theme of patient advocacy, in the literature it is found that workplace meetings are a way to improve the interaction among nursing staff, enabling an exchange of ideas about care technologies, technical and ethical training, routine information for professionals who did not participate in training or previous meetings due to lack of incentive or initiative. More personal questions from each team are also addressed in these meetings, such as encouraging dialogue, as well as seeking solutions to ethical issues that are experienced daily by the team. It is understood that the greater dialogue among the nursing team professionals to solve ethical problems, in addition to the biomedical care, potentiates teamwork results[19-21].

With its managerial responsibility in the hospital, Nursing should perform care planning and activities with its staff, be they educational, problem or conflict solving or leadership; and in order to do so, skills are needed to positively influence the team. Frequent meetings in the health unit support the leadership of nurses, providing collective discussions, reflections and rapprochement between professionals[19-21].

Another statistically significant point is the fact that professionals with more than one employment relationship agree with the Antecedents, barriers and negative implications of ICU patient advocacy, which are pointed out in Factor 1. Understanding or confronting these barriers by nursing professionals with two or more employment relationships are based on the greater physical and mental effort exerted, which compromises their quality of life and their motivation for work, which can also have repercussions on the dissatisfaction of the managers of the units. This employment relationship of two or more jobs is mainly attributed to low wages, precarious employment relationships, work overload in some units and scarcity of human resources. The reports about this workload linked to the double employments show the importance of hiring enough professionals to meet the demands of the institution and remuneration consistent with professional qualification so as to minimize an accumulation of professional relationships[22-26].

Important factors which may impose barriers and negative implications on performing patient advocacy by the nurse are the most diverse and well reported in the literature, although they were not found in the results of this study with ICU nurses. Among them, stress is a sign of the moral distress frequently found among ICU nurses due to the ethical nature of the problems experienced by these professionals, who must always make decisions for patients and staff in different situations. Stress is also a negative implication of the nurse's work in the ICU when the professional is not able to perform their work in the best way or they believe that the patient is not receiving the best treatment, care, or being heard in their decisions[6,10-11,18].

Stress can also come from stressful situations with the nursing team, since team conflicts must be managed by nurses, who are always dealing with people who are stressed at work. Conflicts between patients, family members and health professionals are also common and mediated by nurses. When acting in this role of mediator in the ICU, the

nurse is exposed to stressful situations daily, thus constituting a barrier to the effective advocacy of patients by this professional, who can face moral suffering or deviate from their professional beliefs and values[6,10-11,18].

Shortcomings in the training process of nurses, as well as the little training in the ICU result in resistance on the part of nurses to provide the best care to their patients. This is also pointed out in studies as an action barrier to patient advocacy. Therefore, it is recommended that nurses' training must be rethought to provide ethical support to these professionals who work in units with daily stressful situations[7,11].

Factor 2 (Nurses' actions and benefits of patient advocacy in the Intensive Care Unit) presented a higher frequency of nurses who agreed to such actions and benefits. In this sense, it is observed that nurses understand the patient care in the prevention of injuries, whether physical, mental or deliberate, or due to the deprivation of necessary treatments and care, as advocacy of this patient and agree that such actions are their responsibility. Still, they consider themselves the professionals closest to the family and the patients, so they are expected to defend them in situations of conflict with doctors or health managers, assuring the patient the best treatment and care available, as long as it is also possible listen and fulfill their desires, guaranteeing comfort and safety to the ICU patient[6,11,14-15,17].

Nurses' communication regarding the education of patients and their relatives on their rights and duties during hospitalization and information about the patient's health status, prognosis, treatments and potential recovery are also considered to be patient advocacy actions by the nurse. This professional should have communication skills and personal interaction, and recognize teamwork as an essential piece of patient advocacy and the need for the family to be involved during hospitalization[6,11,14-15,17].

Statistical relevance of the factors with age, time since graduation and length of service in the ICU variables was not found, which differs from previous studies performed with the same scale (PNAS). These studies have shown that barriers to advocacy and the negative implications of advocacy are most evident among long-term and longer-term nurses in the ICU. This is also pointed out as a consequence of the greater experience of nurses in these environments and greater experience of patient advocacy, which may have resulted in greater exposure to stress and dissatisfaction for not having successful advocacy[3-4,6,18].

A limitation of this study was its performance in only two regions of the country, which makes it impossible to generalize throughout Brazil. In this case, it is considered that there are structural and systemic differences between the ICUs of the South and Southeast regions and those of the North, Northeast and Center-West regions. The lack of studies on ICU patient advocacy in Brazil (as most of the literature used was international) makes it difficult to compare the findings of this study with those of other studies.

## CONCLUSION

It is possible to see that nurses agree with the issues that express the actions of intensivist nurses in patient advocacy and the benefits of this attitude. Still, the nurses in this study disagree with aspects that may be considered problematic and/or conflicting for practicing patient advocacy by the ICU nurse. This was found differently in some studies and similarly in others, showing the importance of more in-depth studies on the barriers to practicing patient advocacy and professional dissatisfaction in the deprivation of the nurse in practicing advocacy.

Significant statistical differences were found in the items that refer to meetings in the ICU. In this case, nurses in ICUs where meetings occur have a greater frequency of disagreement with the issues of antecedents, barriers and negative implications. Another statistically significant point was the variable Number of employment relationships, since nurses with more than one relationship had different frequency than expected associated with Factor 1 (Background, barriers and negative implications of advocacy). The greater number of relationships generates greater suffering, stress and fatigue in the workers, causing a barrier to performing patient advocacy by these nurses.

Patient advocacy is a subject that still requires much study in order to understand nurses' actions in patient advocacy, as well as factors that can positively or negatively influence their actions.


## RESUMO

**Objetivo:** Explorar as ações e os fatores associados à defesa do paciente pelos enfermeiros intensivistas utilizando a escala *Protective Nursing Advocacy Scale*. **Método:** Estudo quantitativo, descritivo-exploratório, de delineamento transversal. O questionário foi respondido por enfermeiros que atuavam em Unidades de Terapia Intensiva das regiões Sul e Sudeste do Brasil. Realizaram-se a análise fatorial exploratória dos dados, os testes T e qui-quadrado para associação entre fatores. **Resultados:** Participaram da pesquisa 451 enfermeiros. Um número maior de enfermeiros não concorda com as consequências negativas que a advocacia do paciente possa ter ou trazer para eles. Um maior diálogo entre profissionais da equipe de enfermagem potencializaria os resultados do trabalho em equipe. Enfermeiros com dois vínculos, ou mais, de emprego necessitam de mais esforço físico e mental, o que compromete sua qualidade de vida e de trabalho, sendo esses os que menos exercem a advocacia do paciente. **Conclusão:** Enfermeiros entendem a defesa do paciente como parte importante de seu trabalho, bem como os fatores que podem influenciar a decisão em defender seus pacientes, mas ainda desconhecem os benefícios da advocacia.



## DESCRITORES

Defesa do Paciente; Enfermagem de Cuidados Críticos; Unidades de Terapia Intensiva; Ética em Enfermagem.



## RESUMEN

**Objetivo:** Explorar las acciones y los factores asociados con la defensa de los derechos del paciente por los enfermeros intensivistas utilizando la escala *Protective Nursing Advocacy Scale*. **Método:** Estudio cuantitativo, descriptivo y exploratorio, de corte transversal. El

cuestionario fue respondido por enfermeros que actuaban en Unidades de Cuidados Intensivos de las regiones Sur y Sureste de Brasil. Se llevaron a cabo el análisis factorial exploratorio de los datos y las pruebas T y chi cuadrado para asociación entre factores. **Resultados:** Participaron en la investigación 451 enfermeros. Una cifra mayor de enfermeros no está de acuerdo con las consecuencias negativas que la abogacía del paciente pueda tener o resultar para ellos. Un diálogo entre profesionales del equipo de enfermería potenciaría los resultados del trabajo en equipo. Enfermeros con dos vínculos laborales, o más, necesitan más esfuerzo físico y mental, lo que compromete su calidad de vida y trabajo, siendo esos los que menos ejercitan la abogacía del paciente. **Conclusión:** Los enfermeros entienden la defensa del paciente como parte importante de su trabajo, así como los factores que pueden influenciar la decisión en defender a sus pacientes, pero todavía desconocen los beneficios de la abogacía.

**DESCRIPTORES**

Defensa del Paciente; Enfermería de Cuidados Críticos; Unidades de Cuidados Intensivos; Ética en Enfermería.

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