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PHYSICAL THERAPISTS' UNDERSTANDING
OF GERIATRIC PATIENT ADVOCACY: A MIXED METHOD STUDY

A Dissertation in

Adult Education

by

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ABSTRACT

This project focuses on physical therapists in their role as adult educators and advocates for their geriatric patients. As such, the purpose of this mixed methods study was two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. The theoretical framework of the study was grounded in critical perspectives of adult education and critical gerontology.

An Attitude toward Patient Advocacy Scale was modified to assess physical therapists' attitudes, beliefs and practices of geriatric patient advocacy. One hundred thirty eight licensed physical therapists completed the survey and indicated overall favorable attitudes, beliefs and practices of physical therapists who work with geriatric patients. The quantitative data also revealed significant differences in scores of physical therapists who have board certification in geriatric physical therapy.

Ten qualitative in-depth interviews were conducted from among those respondents whose scores were in the top 15th percentile. The qualitative findings on the shaping of their attitudes show that participants: became passionate about geriatrics through happenstance; perceive older adults as marginalized; embrace the professional challenges that help shape attitudes and beliefs of working with older adults. The findings on advocacy reveal how they: traverse the bureaucracy of health care; empower and protect geriatric individuals; and champion community and political responsibility. Lastly, the current findings describe the defining actions and experiences of advocacy

efforts including themes of challenging limits, seizing opportunities and preparing/protecting the future. As a result of the research, the critical perspectives of adult education and the framework of critical gerontology are merged to foster geriatric patient advocacy in all physical therapists.

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CHAPTER 1

INTRODUCTION

The purpose of this chapter is to provide a foundation of a mixed methods research study that examines physical therapy professionals understanding of geriatric patient advocacy from a critical gerontology perspective. Inclusive in this chapter is the background of the study, purpose, problem statement and guiding research questions. Also included is an overview of the conceptual framework, the design and methodology. Finally, the significance of the study, definitions, assumptions and limitations of the research are discussed as related to the professions of physical therapy and adult education.

Background to the Problem

Adult educators work in many contexts. They work in formal education contexts such as in higher education settings as professors; in non-formal education contexts such as museum curators; in industry settings providing teaching and training in home improvement, quilting and knitting; in community and government contexts educating about public policy issues; and in continuing professional education settings (Merriam & Bierema, 2013). One large area of adult education happens in health care settings, in the ongoing continuing education of health care providers, and/or in conducting patient education. Many health care providers also act as patient advocates, for numerous population groups.

This project focuses on one particular group of health professionals, and their role as adult educators and as advocates for their patients: physical therapists who work with geriatric patients. Due to the dramatic increases in older adults living in the U.S. today,

more entry-level physical therapists and physical therapist assistants are needed to care for patients across the continuum of care (Nalette, Dauenbauer, Frankel, Karuza & Katz, 2002). The Center for Health Workforce Studies of University of Albany (2006) projects the growth in the number of physical therapists needed for geriatric settings to increase thirty-three percent in the next ten years. These clinicians are also being asked to work in a health care environment that is rapidly changing. Health care economics are requiring workers to provide high quality care in an increasingly demanding, productivity-driven manner. In order to set the context for providing background to the problem to be investigated, in this section I first consider the changes in health care economics and resultant ethical dilemmas, and then issues in patient advocacy.

Health Care Economics and Ethical Responsibilities

Changes in healthcare reimbursement have caused the delivery of physical therapy services to change in recent years, often causing a conflict between dealing with health care economics and physical therapists professional and ethical responsibilities. The current reimbursement environment has dramatically altered the delivery of health care causing length of stays (LOS) and subsequent number of rehabilitation treatment visits to be decreased in every level of health care (Mellion, 2001). With the desire to reduce LOS, cost shifting is often an issue. Cost shifting occurs when health providers reduce their length of stay by shifting the burden of expenses to a downstream provider. This has resulted with patients being discharged earlier and shuffled down the line to the next level of care (Mellion, 2001). Hospital diagnostic related group (DRG) reimbursement has constrained hospital payments resulting in physical therapy services being limited to functional activities to allow the patient to be discharged to acute

rehabilitation or skilled nursing units if they are unable to go home. Acute rehabilitation units are then required to provide 3 hours of therapy a day to justify admission and therapists are pressured not to miss time with little regard to patient's medical condition or complications. Current payment systems to skilled nursing facilities encourage overprovision of therapy services (White, 2003) as skilled nursing units often rely on provision of therapy services to boost their CMG's (case-mix group) which increases the daily rate at which the facility is reimbursed. For patients at home or long-term residents of nursing homes, outpatient physical therapy services are often provided with focus on utilizing interventions and treatment times that will maximize reimbursement of Medicare or other insurance dollars. The 'business' of health care has caused physical therapy professionals, who work in areas that espouse patient centeredness, to be concurrently immersed in financially motivated procedural practices and treatment plan justifications. According to Stein (2012) "the intersection of financial considerations and patient care is fraught with conflicts of interest and, frequently, with accompanying ethical dilemmas" (p. 86).

Within the challenges of providing therapy services to geriatric patients in challenging health care settings, the professional role of the physical therapist is defined by several clinical and ethical responsibilities. The American Physical Therapy Association (APTA) has developed several documents that describe the behavior expected of its members including standards of practice, a code of ethics, and a guide for ethical conduct. Specifically, the APTA has identified seven core values of the profession: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility (Hack, 2005). While these values are defined

in general terms regarding professional and ethical behaviors, sample indicators are provided to describe how the value should be modeled by physical therapy professional. Within the ethical values, patient advocacy is described as a specific indicator for two core values and is implied in two other core values.

Being an advocate for patient's/client's needs is an indicator of the value of compassion/caring as it demonstrates the concern, empathy, and consideration for the needs and values of others. Advocating for the health and wellness needs of society, including access to health care and physical therapy services, is an indicator of social responsibility (Fowler, 1989). It promotes the mutual trust between the profession and the larger public that necessitates responding to societal needs for health and wellness. Advocacy is also implied in the core value of integrity as this includes using power judiciously and in the core value of altruism as the general regard for devotion to the interest of patients/clients assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist's self-interest.

In general, clinicians must be knowledgeable about professional evidence based practices performed within the framework of ethical core values to improve patient function and maximize independence, while working within a framework of restrictive reimbursement practices. Patient advocacy in this realm is one aspect that can be examined as an example of this professional/ethical intersection.

Patient Advocacy

One component of health care that is embedded in the professional roles of healthcare professionals involves patient advocacy. Rich (2011) summarizes "the role of clinicians is to address the needs and concerns of people when they are most vulnerable;

weakened by illness or injury; or distraught by the prospect of a loved one's suffering, death, or disability" (p.2). Advocacy is defined in the geriatric literature as "vigilant efforts by, with, or on behalf of older persons to influence decision makers in structures of imbalanced power and to promote justice in providing for, assisting with, or allowing needs to be met (Huber, Nelson, Netting, & Borders, 2008). An alternate definition in nursing literature views patient advocacy "as a process or strategy consisting of a series of specific actions for preserving, representing a/or safeguarding patients' rights, best interests and values in the healthcare system" (Bu & Jezewski, 2006, p. 104). Healthcare literature describes advocacy in terms of conceptual models with underlying assumptions of advocacy efforts and also in terms of professional roles which providers assume regarding advocacy responsibilities.

Conceptual models. A multidisciplinary review of healthcare literature suggests overall support for advocacy related to patient care. The conceptual development of advocacy with regard to foundational assumptions is absent in the rehabilitation literature. Nursing literature describes advocacy in general terms that deal with power and the imbalance that occurs for patients in healthcare settings and based on three basic assumptions (Huber, et al, 2006; Teasdale, 1998). First, efforts for advocacy focus on people who are vulnerable and are in need of something to happen due to lack of knowledge or limited legal or consumer rights. Second, advocates are persons who engage in efforts designed to influence change and rely on a relationship based on reciprocal trust. Third, persons with the power to change situations are located in various settings and need to be aware of their own values as they can become accustomed to acting in a paternalistic way.

Advocacy is also described as a morally based concept with components summarized in two arenas: individual autonomy and social justice (Bu & Jezewski, 2006; Fowler, 1989), which are underscored by the attributes of valuing, appraising and interceding (Baldwin, 2003). Advocacy based on individual autonomy is founded as (1) guardian of patients' rights; (2) preservation of patient values; and (3) conservator of patients' best interests. Guarding a patients' rights or safeguarding patient autonomy is presented in terms of patients legal rights to treatment supported on a case level. Within this attribute suppositions are made that individuals have a responsibility for their own care and are competent to make their own decisions though they may need information. Individual models also exemplify the need for health professional autonomy to empower patients and act for silent patients. In each of these areas the importance of valuing a patients individual beliefs, appraising or advising them with regards to implications or consequences of actions and interceding between patients and their families or healthcare providers.

Advocacy performed as a champion of social justice in the provision of health care is indicated on a class level. This model requires the consideration of inequalities and inconsistencies of health care and social contexts of culture. While Baldwin (2003) does not specifically discuss social justice, the attributes of valuing, appraising and interceding are implied in this area for effective advocacy on a larger scale.

Each conceptual model, while worded differently, suggests the complexity of advocacy as noted by the multitude of persons involved and the relationships that connect them. The many attributes of advocacy are also complex in that they represent the patient advocacy role in the micro social level, acting as representatives, delegates and surrogates

(case advocacy), and in the macro social level, acting as social activists for health, education, and welfare for people in all levels of the healthcare system (class advocacy).

Professional Roles. Nursing and rehabilitation literature also discuss advocacy in terms of professional role. Willard (1996) and Hack (2010) define the role of nurses in patient advocacy consisting of three responsibilities: 1) related to patient autonomy, 2) related to interests in healthcare, and 3) as a moral role of patient rights. The nurse must protect the fundamental right of the patient's self-determination in the patient's care. The professional role also implies a duty to respect the interests of healthcare in regards to resource allocation that may deprive others in favor of one. Finally, the professional respect for autonomy can't be an absolute obligation since this may conflict with professional responsibility to act with beneficence toward all patients. Hanks (2010) adds a fourth role in terms of using expert knowledge to challenge traditional healthcare power structures and empower patients and building relationships for communication between nurses and patients.

Nursing literature also describes the nurse's role of advocacy in relation to patients and includes: to build a caring relationship, to include gathering information from a holistic perspective, to carry out a commitment, and to empower (Lindahl & Per-Olof, 1998). Specific responsibilities include informing and educating, valuing and respecting, supporting physically, emotionally and financially, protecting and representing and promoting continuity of care (Negarandeh, et al, 2008). Lindahl & Per-Olof (1998) also state that advocacy is a commitment to take on the responsibility to promote the welfare of another human being whose autonomy is threatened, including protection, meeting

basic needs and professional competence. Empowerment is the role expressed in educating and encouraging the patient to participate in the health care process.

While patient advocacy in the nursing literature is discussed in broad conceptual terms, advocacy in the rehabilitation literature is presented via narrow descriptions of actions or situations that indicate need for advocacy. Physical therapy and occupational therapy literature describe patient advocacy in terms of whistleblowing (Banja, 1985; Guccione, 1980, Mansbach, Bachner, & Melzer, 2010), constrained physical therapy (Guccione, 1980; Nalette, 2010, Triezenberg, 1996, 2005), advocating for specific causes (Doherty, 2005; Leong & Euller-Ziegler, 2004; Nelson, 2005; Sullivan & Main, 2007), and encouraging health care reform (Sullivan, 2009).

Whistleblowing, or the act of speaking up “in dealing with situations that may be ethically reprehensible or harmful to patients” (Banja, 1985), is discussed as a tool for advocacy and social intervention. Included in this discussion is willingness to take action to prevent misconduct or to prevent misconduct or protect a patients’ interest in (Guccione, 1980; Mansbach, et al, 2010). Guccione (1980) attempted to identify ethical decisions frequently encountered and determined respondents did not frequently make the decision to report questionable practices of another physical therapist, physician or other health professional.

Constrained physical therapist practice occurs when the clinician understands the patient legitimate needs and, while acting to meet those needs, may be compelled to provide less than necessary care (Nalette, 2010). This practice is described as a situation where clinician or provider advocacy creates a moral dilemma for physical therapists.

Nalette (2010) proposes that the primary moral roles of the physical therapist are to be in relationship with the patient and advocate for that patient's best interest.

Advocacy is also discussed in physical therapy literature in relation to specific patient needs or causes. (Doherty, 2005; Leong & Euller-Ziegler, 2004; Nelson, 2005; Sullivan & Main, 2007). Doherty (2005) describes advocacy as a core value held by the rehabilitation practitioner and the need for strong patient advocates for functional applications of technology. She argues for advocating for the patient who has no voice and for the technology that will allow patients greater control over their own health care. In a separate cause, Leong and Euller-Ziegler (2004), portray patient advocacy and empowerment as a pivotal role for arthritis patients and their families indicating personal advocacy enables patients with arthritis to make informed decisions about their disease and become responsible members of the healthcare team. Nelson (2005) discusses the need for clinician advocacy for patients with lymphedema by representing this disease as an "under-recognized medical entity" (p. 107). Finally, Sullivan and Main (2007) discuss the conflicting role of advocacy for patients with chronic pain. These authors present the differences in the role of service provider and advocate and while advocacy may be seen as a logical and legitimate extension of the provider role, the rehabilitation provider must bear in mind the negative impact of any form of protective behavior for patients with chronic pain.

A final situation of advocacy noted in the physical therapy literature is advocating for health care reform (Sullivan, 2009). Health care reform is a critical issue for physical therapy due to the inequalities in our health care system. Sullivan (2009) stipulates, "many patients live in relative social isolation due to lack of transportation, receive

inadequate long-term health care for routine medical conditions and require the assistance of overburdened family members to provide their daily care” (p. 171).

The assumption that advocacy is required in healthcare implies that the process of becoming a patient results in reduction of autonomy and the patients’ rights may not be respected (Willard, 1996). Ultimately, advocacy is about power and influencing those who have power on behalf of those who do not (Teasdale, 1998), and what theorists in critical gerontology (Minkler, 1996, 1999) deal with (as will be discussed in detail later). Critical gerontology is described as “a more value-committed approach to social gerontology- a commitment not just to understand the social construction of aging but to change it (Phillipson & Walker, 1987, p. 12) and also casts a “critical eye on society and the field of gerontology itself” (Ray, 2007, p. 97). Informed and inspired by the tradition of critical theory associated with such figures as Adorno, Horkheimer, Marcuse, and Habermas, critical gerontology is concerned with the problem of emancipation of older people from all forms of domination (Moody, 1993) and stands in opposition to the conventional positivism and empiricism long dominant in gerontology (Moody, 1992). But despite physical therapy literature arguing for and supporting patient advocacy and critical gerontology identifying power issues, there is a lack of data based research regarding physical therapists understanding of geriatric patient advocacy in general or in relation to advocacy needs in the context of challenging and rapidly changing health care environments.

Study Purpose and Research Questions

Given the lack of empirical research in the areas of patient advocacy for physical therapists and critical perspectives that deal with geriatric patients, the purpose of this

mixed methods study was two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. In this study, physical therapists perceptions of advocacy were examined through a survey research to determine understanding of conceptual assumptions of patient advocacy from a critical perspective. Subsequently, I performed in-depth interviews, from a purposeful sub-sample of survey participants who demonstrated strong understanding of advocacy in order to explore the meaning of and experiences with patient advocacy with respect to practitioners, patients, and patient's families and to explore the dynamics of advocacy efforts in health care settings.

The study of physical therapists understanding of patient advocacy for geriatric patients was guided by the following questions:

1. What are physical therapist professional's attitudes and beliefs regarding patient advocacy when working with the geriatric population in various healthcare settings based on four advocacy constructs of:
 - a. Safeguarding patients' autonomy?
 - b. Acting on behalf of patients?
 - c. Championing social justice in the provision of health care?
 - d. Understanding of past patient advocacy efforts/actions?
2. What are the perceived practices or actions for geriatric patient advocacy in various health care settings in regard to:

- a. Experiences of patient advocacy performed within the framework of critical gerontology?
- b. Types of antecedents, barriers and consequences experienced when providing advocacy efforts?
- c. Perceived meanings of patient advocacy for the practitioner, for the patient and for their families?

Theoretical Framework Overview

As patient advocacy is a broad concept that can be discussed in many ways, it is necessary to identify an established structure in which to ground this inquiry. Merriam and Simpson (2000) discuss theoretical framework as the “underlying structure, orientation, and viewpoint of your study” (p. 23-24). The framework reveals the underlying assumptions of the researcher. The theoretical framework that informs this study is that of critical gerontology referred to above which is similar to and informed by the adult education philosophies of critical/radical which will be discussed further in Chapter Two.

As a field, Minkler (1996, 1999) notes that critical gerontology has evolved along two paths. The first path embraces a broad political economy of aging framework. In this sense critical gerontology views the ‘problem’ of aging in structural rather than individual terms. The second path in critical gerontology emerges from an humanistic orientation and provides a supplement to the political economy perspectives by putting a “human face- an human body and spirit- on aging and growing old” (Minkler, 1966, p. 470).

The political and humanistic threads of critical gerontology appear to cross paths in the discussion of critical gerontology from a feminist philosophy due to the complexity of biography, social and cultural norms, and public policy (Estes, 2006; Formosa, 2005; Holstein & Minkler, 2003, Ovrebo & Minkler, 1993). While the critical perspective recognizes that to understand old age, we must also understand the effects of gender, class, race, ableness and other intersecting positionalities, the particular lens of gender reminds us that our bodies are more than the location of illness and health, they are an interface between the public and private worlds of meaning (Holstein & Minkler, 2003). Poverty, widowhood, caregiving and other life events primarily affect women along with far higher poverty rates. Women also experience a greater burden of chronic illness and functional limitations that “couple with differential societal norms that continues to assign a higher value to physical appearance and ‘youthful physical attractiveness’ to women” (Holstein & Minkler, 2003, p. 793). Townsend (2007) claims discrimination against older people has become as deep as forms of discrimination against women and minority ethnic groups.

Minkler (1996) concludes “one of the most vital roles that critical gerontology can play...is to help policy makers, the mass media, and the general public see the human face behind the statistics” (p. 483). The assumptive correlation of good health with successful aging (and by extension, disability and poor health with failure) together with the simplistic popularization of these proscriptive views in popular culture fail to honor the many ways in which individuals face the physiological, emotional or contextual changes that accompany aging (Holstein & Minkler, 2003). Critical gerontology allows for challenge of the status quo, enlivening thought and stimulating debate, with the

intention of keeping mainstream gerontology from becoming complacent and consistent with the insights of critical theory recognize the need for change as “advocating for change is central to the critical agenda” (Ray, 2008, p. 99.).

The foundational adult education assumptions of both humanistic and critical/radical philosophies align themselves with the basic tenets of critical gerontology as proposed by Minkler (1999). Humanist philosophy identifies with the humanity pathway of critical gerontology in that both emphasize the individual’s perception of meaning and understanding. Critical gerontologists in this realm assume the teacher role of humanistic philosophy: to help, facilitate and act as a resource to promote and advocate for individual meaning of older persons. The source of the authority or primary interest in this pathway is the individual self, similar to humanistic viewpoints.

Critical/radical philosophy identifies with the political economy pathway of critical gerontology in that it emphasizes the fundamental social, political and economic aspects of society that must change in order to eliminate dominant, exploitive practices in regards to older persons. Older persons can certainly be considered oppressed in the context of Freire’s (1970) description and seen as marginalized in a culture that values youth, health and vitality, characteristics often not seen in the elderly population. The critical gerontologist must step beyond the hegemony of current social gerontology and act in a conscious-raising fashion by encouraging critical thinking and praxis to overcome negative perceptions associated in areas of ageism, the aging enterprise, deinstitutionalization and empowerment within the capitalist and market economy.

Overview of Methodology

This study makes use of a mixed methodology research paradigm (commonly referred to as mixed methods) to explore physical therapists' understanding of geriatric patient advocacy in healthcare settings (further discussed in Chapter Three). Research questions in healthcare fields are often multifaceted since the phenomena of interest are highly complex and intertwined with each other. Tashakkori and Teddie (2010) suggest that mixed methods researchers immersed in a topic area are typically not only interested in what has happened (causal effects) but also in how or why it has happened (causal mechanisms) indicating why mixed methods are often required in research in this area. The increasing recognition of the complexity of factors affecting health and health care and the desire to answer a wider range of questions about them, have often supported the use of mixed methods research (O'Cathain & Thomas, 2006).

Mixed methods research contains both quantitative and qualitative techniques. This study employs sequential mixed-methods research (Creswell, 2009). This study first gathers a wide view of physical therapist practitioner perceptions of advocacy through a quantitative survey of geriatric clinicians. Next, based on participant responses to questions on the survey, a purposeful sub-sample was chosen for in-depth qualitative interviews that added meaningful exploration to physical therapists experiences with geriatric patient advocacy. The purpose of mixing methods is to address two linked and equally important questions (O'Cathain & Thomas, 2006) and combining elements for "breadth and depth of understanding and corroboration" (Johnson, et al, 2007, p. 123). Understanding of patient advocacy issues in geriatric patients leads to two related but separate questions: What are physical therapist professionals' beliefs, attitudes, and

practices of patient advocacy when working with the geriatric population, its importance, and use in the clinical setting. Second, how are those advocacy efforts carried out and what do they mean for the practitioner, for the patient and for the patients' family. The first of these questions was answered by using quantitative descriptive and inferential methods (Creswell, 2009). The second of these questions was answered by obtaining rich descriptive data regarding meaning of experiences through semi-structured interviewing since qualitative research examines the particular in-depth and focuses on meaning questions (Merriam, 2009).

A sequential approach (Creswell, 2009), using the quantitative analysis first optimized the cases for qualitative analysis and provided insight into relevant research questions. For the quantitative aspect, survey methods were used to examine physical therapy professionals understanding and use of patient advocacy practices and were performed with focused consideration to the ethical and critical nature of these actions. Survey design provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population (Creswell, 2009). A purposeful sample of physical therapists working in geriatric settings was obtained by using information from the geriatric section of the American Physical Therapy Association. A mid-range patient advocacy survey instrument developed by Bu and Wu (2008) was modified to identify participants understanding of three conceptual advocacy factors including: (1) safe guarding patients' autonomy; (2) acting on behalf of patients; and (3) championing social justice in the provision of health care; and (4) recent practices or actions of geriatric patient advocacy. Data analysis included descriptive and

inferential statistics which assisted to identify practitioners who understand and utilize patient advocacy practices with a geriatric population.

The qualitative aspect involved in-depth, semi-structured interviews of practitioners based on quantitative analysis. Interviews are often the major source of qualitative data used to uncover the essence of an individual's experience (Merriam, 2009) and also allow the researcher to reach areas of reality that would otherwise remain inaccessible such as people's subjective experiences and attitudes (Perakyla & Ruusuvaori, 2011). Focused questions were utilized to understand participants' meanings, perspectives and viewpoints regarding patient advocacy and professional imperatives and practices involved when working with geriatric clients. Thematic data analysis was performed based on a basic qualitative research framework with the purpose to understand how participants make sense of their professional lives and experiences.

A fundamental assumption about mixed methods research in the social, behavioral, and health sciences is that it might potentially provide a better (broader, more credible) understanding of the phenomena under investigation rather than a dichotomous qualitative or quantitative approach (Tashakkori & Teddie (2010). A detailed discussion of the methodology, quantitative hypotheses, and sampling strategies can be found in Chapter Three.

Significance

This study of physical therapists understanding of geriatric patient advocacy is significant on many levels. In the broadest sense, the healthcare landscape is constantly changing in terms of cost, reimbursement and access for geriatric patients in all levels of care. Physical therapists have the privilege of developing significant relationships with

their patients and therefore are placed in a good position to become a patient advocate. The professional role also implies that physical therapists act as advocates and therefore navigate the social, cultural and structural issues that geriatric patients endure in the complex healthcare environment. Through the perceptions and experiences of participants, this study provides a better understanding of how geriatric patient advocacy is exemplified in regards to practitioners, patients and families from an individual and social justice perspective. In addition, this research adds to the body of knowledge of critical gerontology, particularly in connecting theory to practice. It is also significant to the field of adult education as a means to promote a sharing of ideas and cross discipline research with the healthcare field. The critical/radical philosophies of adult education are exemplified in the framework of critical gerontology. While adult education has extensive literature emphasizing the positionalities of gender, class, and race, little is written in regard to ableness and age. This study adds empirical research in adult education as it relates to patient advocacy for the geriatric population.

This study is personally significant for me as I am a physical therapist who works with geriatric patients in a long-term care setting and also am an instructor of physical therapist students in an academic setting. My personal experiences of working with geriatric patients in a variety of healthcare settings over a 20 year period has caused me to see the vast changes that have occurred in healthcare and the resulting impact on all patients, especially the marginalized elderly. Physical therapists can and should take on the role of patient advocate for geriatric patients, however need to understand the complicated context in which healthcare is delivered and how this affects intentions and actions of advocacy efforts. My role in educating future physical therapy professionals

allows me to share my passion for working with geriatric patients in a field that I love. It is important to send students into clinical settings with the knowledge and understanding of all aspects important to patient care, including patient advocacy. Critical gerontology provides a framework for discussion of context on an individual and a social justice level. Therefore, this study arose out of my experiences in the clinic and my understanding of critical theory and how these two must meet to provide truly patient centered care.

Assumptions of the Study

The assumptions that are inherent in this research are:

1. This study assumes that a primary role of physical therapists is to act as an advocate for their geriatric patients.
2. Patients in healthcare settings, especially the elderly, become marginalized by the nature of their illness and the need to navigate a complex health care system.
3. Past, current, and future changes in healthcare costs, reimbursement and patient access (especially the unknown consequences of Obama Care) require a critical perspective for understanding advocacy efforts.
4. Patient advocacy efforts are necessary in both the individual realm and the broader social justice realm.
5. By critically examining physical therapist advocacy efforts, we will be able to see how dominant ideology and hegemony are relevant in the discussion of patient advocacy.
6. Finally, studying patient advocacy from a critical perspective can inform program and curricula design to assist learners in examining how social

structures and hegemonic ideas regarding aging shape their beliefs and actions.

Strengths and Limitations

All research has limitations as well as strengths embedded within the design and researcher and participant involvement. This study has the following limitations: First, the definition of patient advocacy in physical therapy is sometimes ambiguous and often related solely to legislative efforts, therefore even though the survey encourages thoughtful consideration of perspectives of geriatric patient advocacy experiences, physical therapy professionals may not recognize or acknowledge all advocacy efforts performed or opportunities for advocacy that they have missed. Second, by utilizing the provider database from the geriatric section of the APTA, efforts to reach a diverse sample was restricted due to the high cost of membership in this association. Third, this study was dependent on voluntary participation of geriatric physical therapist practitioners. Low participation may affect generalizability of findings of the descriptive and inferential statistics. Finally, my experiences in the field of physical therapy practice and education may have caused bias and influenced either my analysis of the qualitative interview data or the qualitative interview responses. As with all qualitative inquiry, my awareness of this possible bias and influence was extremely important and efforts were taken to mitigate any personal bias.

In spite of these limitations, this study has some definite strengths. First, the mixed methods research paradigm offers the opportunity to gain an overall understanding of physical therapist's geriatric patient advocacy attitudes and perceptions through survey data and thick rich descriptions. This leads to a better understanding of beliefs, intentions

and actions involving geriatric patient advocacy in multiple healthcare settings. Second, the use of a critical theoretical framework leads to a better understanding of the role of context, dominant ideology and hegemony in healthcare settings and the resultant effect on individual and social justice patient advocacy efforts.

Definition of Terms

There are several significant terms that warrant definitions as used in this study.

1. **Advocacy-** Advocacy is defined in the geriatric literature as “vigilant efforts by, with, or on behalf of older persons to influence decision makers in structures of imbalanced power and to promote justice in providing for, assisting with, or allowing needs to be met (Huber, Nelson, Netting, & Borders, 2008).
2. **American Physical Therapy Association (APTA)-** the principal membership organization representing and promoting the profession of physical therapy in order to further the profession’s role in the prevention, diagnosis, and treatment of movement dysfunction and the enhancement of the physical health and functional abilities of members of the public.
3. **Case Mix Group (CMG) -** a system of payment that measures the intensity of care and services required for each resident in a skilled nursing facility and then translates it into a payment level based on the utilization of services (e.g. the hours of nursing or therapy services, etc.).
4. **Critical Gerontology-** a more value-committed approach to social gerontology- a commitment not to just understand the social construction of aging but to change it (Phillipson & Walker, 1987) and also places a critical eye on society and the field of gerontology. (Ray, 2007).

5. Critical Theory-An approach to analyzing society that does not accept positivist value-free assertions, but seeks to analyze social structure and systems that are socially constructed and result in oppression and valuing certain members of society and knowledge over others.
6. Diagnostic Related Group (DRG)- established, fixed prices for reimbursement prospectively set on a cost-per-case basis based on the diagnosis.
7. Length of Stay (LOS)- number of days spent as an in-patient in an acute care hospital, rehabilitation hospital or skilled nursing facility.
8. Marginalized Populations- Persons not being in the center group due to sociological factors such as gender, race, class, etc. The center group is the dominant, often Euro-American heterosexual males, with power and access to resources and influence over the politics affecting them (Bierma, 2010).
9. Mixed Methods Research- Research study design that contains both quantitative and qualitative techniques
10. Physical Therapist- a person who is a graduate of an accredited physical therapist education program and is licensed to practice physical therapy whose primary purpose is the promotion of optimal human health and function through the application of scientific principles to prevent, identify, assess, correct, or alleviate acute or prolonged movement dysfunction.
11. Sequential Exploratory Methods- sequential explanatory strategy utilizes components of quantitative and qualitative methods of equal status. This design strategy is typically used to explain and interpret quantitative results by collecting and analyzing follow-up qualitative data (Creswell, 2009).

12. Social Justice- a key value in adult education to correct social ills, such as poverty and inequity through an analysis of power and privilege (Bierma, 2010).

CHAPTER 2

LITERATURE REVIEW

The purpose of this mixed methods study is two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. In line with the purpose of this study, this chapter begins by providing a discussion of the literature relating to the study's theoretical framework, critical perspectives in adult education and critical gerontology. The next body of literature addresses the concept of patient advocacy presented in terms of conceptual and empirical literature from the general healthcare and physical therapy realms. Critical gerontology complements the discussion of patient advocacy and allows for the exploration of advocacy from micro-social and macro-social perspectives along with its impact on advocacy practices and experiences. Finally, literature discussing the role of the geriatric physical therapist articulates the context of current health care practices and professional and ethical responsibilities that guide the current research study.

Theoretical Framework:

Critical Adult Education and Critical Gerontology

The theoretical framework for this research study lies in the intersection of two bodies of literature: the critical perspectives of adult education and critical gerontology. A key issue that provides the foundation for the diverse topics in adult education is social

justice and a concern with equity and the disenfranchised (Kasworm, Rose, & Ross-Gordon, 2010). Within the field of adult education, critical perspectives on adult learning have emerged as prominent discourses for promoting social justice in education. These have connections to dealing with people with disabilities and the elderly, especially as they intersect with the dominant system of healthcare. The purpose of this section is to provide an overview of the critical discourses in adult learning, including critical pedagogy, feminist pedagogy, and critical disability studies in adult education. Subsequently, I will briefly compare the ways these discourses are similar to critical gerontology and how these theories intersect and merge to inform the current research.

Critical Perspectives in Adult Education

The critical pedagogies of adult education offer an essential lens for my research. Social justice is a guiding framework for understanding the role and mission of adult education (Kasworm et al., 2010) and is a key value in viewing education as an important variable in correcting the social ills such as poverty and inequity through an analysis of power and privilege (Bierema, 2010). The ideas of power relations, social capital, and oppression point to the contribution that a critical sociological orientation can bring to the role of adult education for social justice (Butterwick, & Egan, 2010). “Critical theory assumes that inequality is a permanent structural reality and is accepted without complaint because dominant ideology has convinced the majority that inequity is normal and predictable” (Brookfield, 2010, p. 72). The assumptions of critical theory, and its related adult learning pedagogies, provide this study important context to view the system of healthcare and its impact on geriatric patients and their providers.

Critical theory. Critical theory, as it is discussed in adult education, has its origins in the Frankfurt School, or the Institute for Social Research, in Frankfurt, Germany. Critical theory tradition “draws on Marxist scholarship to illuminate the ways in which people accept as normal a world characterized by massive inequities and the systemic exploitation of the many by the few” (Brookfield, 2005, p. 2). Foundational works by Horkheimer, Gramsci, Marcuse and Foucault all wrote from the perceptions of Marxist theory to discuss critical theory and refute positivism. Horkheimer, a one-time director of the Institute, postulates critical thought presupposes freedom and the need for self-awareness of thought to discover “the relationship that exists between intellectual positions and their social location” (Horkheimer, 1972, p. 209). “The task of critical theory, according to Horkheimer, is to penetrate the world of things to show the underlying relations between persons” (Aronowiz, 1972, p. xii). Brookfield (2005) summarizes Horkheimer’s five distinct characteristics of critical theory: (1) critical theory is firmly grounded in a particular political analysis with the primary unit of analysis being the conflicting relationship between social classes; (2) critical theory’s main concern is to provide people with knowledge and understandings intended to free them from oppression; (3) critical theory breaks down the separation between subject and object, of researcher and focus of research; (4) critical theory is normatively grounded, not only does the theory criticize current society but envisions a fairer more democratic world; and (5) critical theory assumes that verification of the theory is impossible until the social vision it inspires is realized.

In addition to Horkheimer, Gramsci, Marcuse, and Foucault also discuss critical theory in the Marxist tradition that help to inform this study. Gramsci describes critical

thought in terms of hegemony. The concept of hegemony includes the sense in which dominated groups are controlled through processes of socialization into a particular ways of seeing the world which are accepted as common place and natural (Guy, 2004).

Gramsci (1991) uses the term hegemony to signify the predominance of one social class over others as manifested in the political and economic control of subordinate groups.

Marcuse speaks to the importance of understanding critical theory in the concept of repressive tolerance. Repressive tolerance is the tolerance, in the name of impartiality or fairness, of intolerable ideologies and practices and the consequent marginalization of efforts for democratic social change (Brookfield, 2005). Marcuse (1965) argues that such tolerance is often passive, is deceptive and not liberating, and serves the cause of oppression serves to contain qualitative change rather than promote it.

Foucault is a critical theorist who focuses on how existing power relations (such as dominant discourses) reproduce themselves and is ever present in the oppositions of everyday life including the power of men over women and of medicine over the population (Foucault, 1982). He further discusses power relations as “rooted in the system of social networks” (p. 793), assumed to exist universally, and is not a function of consent.

Critical theory is grounded in a vision of a society in which people live collectively in ways that encourage the free exercise of their creativity without foreclosing that of others (Brookfield, 2005). The concepts of critical theory, hegemony, repressive tolerance and power relations provide the foundation for critical pedagogy and also the foundation for the discussion of advocacy in healthcare as each of these concepts need to be considered in the context of advocacy actions.

Critical pedagogies in adult education. Critical pedagogies approach adult learning from a critical, power relation's perspective to analyze not the individual learner, but analyze the economic, historical and sociocultural context in which learning takes place (Merriam, Caffarella, & Baumgartner, 2007). Questioning and critiquing taken-for-granted worldviews of individuals, structures and institutions is the first step in changing oppressive and non-emancipatory practices. Foundational to the work of adult education for critical consciousness was Brazilian adult educator Paulo Freire (2000) who developed his pedagogy of the oppressed based on his experience of teaching literacy to adult learners and taught about the systems that oppressed them. Brookfield (2005) proposes the core of adult learning should allow society to see their individual well-being as integrally bound up with that of the collective, act toward each other with generosity and compassion, and be ever alert to the presence of injustice, inequity, and oppression. Specifically, Brookfield (2005) proposes seven interrelated "learning tasks" embedded in critical learning theory that need to be included in adult education practice: (1) challenging ideology; (2) contesting hegemony; (3) unmasking power; (4) overcoming alienation; (5) learning liberation; (6) reclaiming reason; and (7) practicing democracy.

Understanding the theoretical assumptions of critical theory in regards to adult learning provides the foundation for pedagogy of teaching adults in this framework. Brookfield (2005) proposes pedagogical suggestions to integrate into critical practice. First, to teach critically is not just a question of how we teach, but also about what we teach. Second, specific methodological approaches emerge from critical theory's analysis. He further stipulates "critical teaching begins with developing students' powers of critical thinking so that they can critique the interlocking systems of oppression

embedded in contemporary society” (p. 350). Teaching becomes inherently political as critical thinking is not just a cognitive process but is bound up in realizing and emphasizing common interests, rejecting the privatized, competitive ethic of capitalism, and preventing the emergence of inherited privilege (Brookfield & Holst, 2011). Freedom, fairness, equity, liberation, the ethical use of power are all ideas central to teaching in the critical tradition that intends to help people learn how to replace the exchange economy of capitalism with truly democratic socialism (Brookfield, 2005).

Emerging from the diversity in adult learning within critical theory discussions are four different approaches to teaching adults in this framework (Brookfield, 2005). The first of these approaches is teaching a structuralized worldview that analyzes private problems and personal dilemmas as structurally produced. Second is the need for abstract and conceptual reasoning that can be applied to considering broad questions such as how to organize society fairly or what it means to treat each other ethically (Brookfield & Holst, 2011). In a third approach, Brookfield (2005) promotes the practices of self-directed learning to connect with critical theory to allow private, separate and isolated reading original critical material before discussion in small groups. The final pedagogical approach is using cohort groups. Brookfield (2005) cites Fromm and Habermas, who believe “that decisions arrived at through fully participatory, inclusive conversations are the cornerstone of democracy” (p. 354).

The varying methods of pedagogic approaches suggested for critical theory in practice make evident the range of cultural backgrounds, learning preferences, intellectual abilities, and mix of racial, class and gender identities evident in many adult education classrooms (Brookfield, 2005). “Situating pedagogy in the realities of

classroom dynamics, cultural traditions, and learning rhythms, while simultaneously attempting to introduce people to a critical theory perspective, could be described as critical pragmatism” (p. 356). This calls for emphasis on the relevance and applicability of critical theory’s understandings at the same time as it takes a self-critical perspective on that theory.

Critical theory and critical pedagogy inform the current research in several ways. Critical theory provides a framework to view the healthcare system. When a person becomes ill or disabled accessing healthcare can be an overwhelming process. All aspects of care have different financial reimbursement mechanisms and requirements and the current healthcare economy has created vast disparities in access to comprehensive healthcare insurance. Once in the system, patients become dependent on physicians and other professionals to make decisions regarding diagnostic and treatment options that often fosters dominant or paternalistic attitudes. Geriatric patients easily become marginalized in their ability to be active and informed members of their own healthcare process. Critical pedagogy offers methods for healthcare professionals to become informed regarding marginalization and oppression and the impact the system has on patients in their care. The role of the physical therapist is to provide education and treatment to geriatric patients. Critical pedagogy is a method to facilitate understanding of marginalizing practices and allow discussion for advocacy or other avenues to support geriatric patients in a complex system.

Feminist pedagogy. Critical feminist theory places women’s concerns and the centrality of gender at the forefront of analysis and undertakes a power analysis of gender-based inequality across personal and social relationships, work, politics and

ideologies of sexuality (Brookfield, 2010). Feminist theory and feminist pedagogy have relevance to this study in the attention to inequalities based on gender that also occur in the elderly. The majority of the elderly population is female and experience marginalization that becomes compounded when becoming ill or disabled. Feminist theories that inform feminist pedagogy focus on the concerns of women in the teaching-learning transaction (Merriam, Caffarella, & Baumgartner (2007) and are categorized by Tisdell (2000) in three realms: psychological, structural and post structural.

Individual or psychologically focused feminist theories “are concerned with women as individuals, how they have come to internalize patriarchy as the norm and what needs to be done to obtain equal access, rights and opportunities” (Merriam et al. 2007, p. 248). Patriarchal practices are one form of hegemony and considered the norm in societal practices. Women’s learning can be understood primarily based on Women’s Ways of Knowing (Belenky, Clinchy, Goldberger, & Tarule, 1986) whose authors interviewed 135 women about their experience and problems as learners and knowers, as well as their changing concepts of self and relationships with others. They identified five perspectives on ways women construct knowledge including silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. Their work suggests that knowledge is something that each individual constructs and the result of this process is a sense of individual empowerment, of gaining a voice along with the ability to effect change in their personal lives (Merriam et al., 2007). In the psychological model, a connected approach to learning is advocated, where life experiences are valued, where women can come to have a voice and hence, an identity (Merriam et al., 2007). Adult education attempts to provide a safe classroom where

members can support and nurture each other. Individual pedagogy promotes that women learn best in situations that emphasize connection, relationship, affectivity, rationality and a sharing of the authority of the teacher-facilitator with learners (Tisdell, 2000).

Structural theories frame women's learning in terms of societal structures and institutions, such as capitalism and patriarchy, which oppress women (Merriam et al., 2007). Central to structural models are themes recurrent in feminist pedagogy: how knowledge is constructed, voice, authority, identity as shifting, and dealing with difference (Tisdell, 2000). Tisdell further concludes "the structural models emphasize what the psychological models downplay: the theme of difference and how to deal with it" (p. 167). Adult education can create a space where those who have been marginalized can come to voice and construct new knowledge. Structural feminist pedagogy denotes that "power relations based on gender, race, and class should be analyzed or confronted proactively by the instructor as they are manifested in the classroom" (Tisdell, 2000, p. 166).

Post structural or postmodern theories "focus on how social structures of gender, race and class inform our individual identity and development and on how these can be analyzed and reframed in educational settings to facilitate working for social change" (Tisdell, 2000, p. 157). Feminist post structural discussions build on and critique the structural theories and promote the significance of gender along with other structural systems of privilege and oppression, such as race, class, and sexual orientation. bell hooks (1989) notes women's identities are fundamentally affected by systems of sexism, racism and classism and "feminist thought must continually emphasize the importance of sex, race, and class as factors that together determine the social construction of

femaleness” (p. 23). There are two major differences between structural and poststructuralist theories (Tisdell, 1995). First, poststructuralists argue that structural theories do not account for the individual's capacity for agency, or the fact that individuals exert some power and control over their lives even though they may experience some forms of structural oppression. Second, structural theorists deal only with systems of oppression or privilege from the standpoint of whatever structure is their unit of analysis, and do not account for the fact that some groups are more privileged than others.

Poststructural feminist theory of adult learning is further described in relation to teaching pedagogy in themes of positionality, construction of knowledge, and giving voice which directly helps to conceptualize the role of the adult educator (Tisdell, 2000). First, the role of the educator is to help adult learners examine positionality of educators and learners and their interconnections. Second, educators maintain a proactive role as challengers of unequal power relations and work for social change. Third, educators take into account people's emotions as well as critical-thinking skills in learning and working for social change. Fourth educators directly consider how their own gender, race, or class might affect the way learners deal with them as authority figures. Finally, although educators have an agenda for social change and emancipation, they more directly discuss the limitations of their own capacity to facilitate social action.

Feminist pedagogy, ultimately, is about women as learners and refers to the interactive process of teaching and learning, particularly in relation to what facilitates women's learning (Tisdell, 2000). While each strand of feminist pedagogy has different theoretical underpinnings, “all versions are concerned about women's choices and status

in society, and all note the importance of connection, relationship and the role of affectivity in learning” (p.156). Practiced in a feminist key “critical pedagogy is never innocent, never uncomplicated, never without contradictions” (Brookfield, 2005, p. 320).

Feminist theory and pedagogy provide a lens for this research in the observation of patriarchal practices that occur in healthcare settings. While these practices may be more easily identified due to the predominance of female geriatric patients, the education, treatment and advocacy efforts needed in healthcare apply to males as well because they espouse patient-centered practices. Feminist pedagogy affords healthcare providers understanding of giving geriatric patients a voice in their care and also for perspective on the value of life experiences in regard to the choices they make. With this lens, physical therapists can provide education, treatment or advocacy efforts specific to the needs of geriatric patients.

Critical disabilities studies. Similar to other critical pedagogies, people with disabilities can be understood as a minority group struggling for civil rights as people with disabilities constitute possibly the largest minority group whose access to public places, education and the political sphere has been limited (Rocco & Fornes, 2010). Disability should be an important concern for adult education and adult educators for three reasons: (1) the process of becoming disabled provides opportunities for the person and his/her family to learn about the disability; (2) increasing numbers of students with disabilities enroll in formal education programs, and (3) disability is an identity marker that diminishes opportunities for work, education and leisure (Rocco & Delgado, 2011).

The field of disability studies provides the location for the deconstruction of disability and an examination of the cultural, political and social ramifications of

disability in society (Rocco & Fornes, 2010). The Americans with Disabilities Act (ADA) defines disability as a physical or mental impairment that substantially limits a person's life in one or more major life activities. Clark (2006) provides the distinction between disease and disability: Diseases or illnesses are related to biological processes and follow a course of progression that can proceed through recovery, whereas disability defies recovery, and as such cannot be healed to allow a disabled body to function as a nondisabled body. Disability can be considered a social construct and therefore provide insight to adult education regarding pedagogy for teaching and learning.

Disability is socially constructed, and it is the person-created environment that is disabling, not the physical, cognitive, or mental variation that an individual experiences (Hahn, 1986). In an alternate perspective, Campbell (2008) describes disability in terms of disablism and ableism. Disablism is a set of assumptions and practices promoting differential or unequal treatment of people because of actual or presumed disabilities. Disablism relates to the production of disability and fits a social constructionist understanding of disability, whereas the production of ableism is associated with the production of able-ness, the perfect body. Ableism also includes paternalistic elements such as sympathy and subordination.

Hahn (1986) describes:

Paternalism enables the dominant elements of society to express profound and sincere sympathy for members of a minority group while, at the same time, keeping them in a position of social and economic subordination. It has allowed the non-disabled to act as the protectors, guides, leaders, role models, and intermediates for disabled individuals who, like children, are often assumed to be

helpless, dependent, asexual, economically unproductive, physically limited, emotionally immature, and acceptable only when they are unobtrusive. (p. 130)

The social construction of disability negates that people with disabilities have a unique voice emerging from individual and group experiences and makes invisible the discrimination and oppression experienced by people with disabilities as a minority group (Rocco & Delgado, 2011).

Critical disability theory has been presented by Rocco (1995, as noted in Rocco & Delgado, 2011) to include six principles that can provide insight to adult educators: (1) disabled people have a unique voice and complex experience; (2) disability should be viewed as part of human variation; (3) disability is socially constructed; (4) ableism is invisible; (5) disabled people have a right to self-determination, and (6) commodification of labor and disability combine to maintain a system of poverty and isolation among people with disabilities. Applying these tenets and principles in adult education and disability “will unmask systemic oppression and move adult educators away from the assumption that disability is a private, personal and individual concern” (Rocco & Delgado, p. 8). The foundational principles of critical disability theory further outline the marginalization of patients in healthcare systems and hegemonic practices that occur that point to the need for a firm understanding of patient advocacy.

Adult education pedagogy can be informed by critical disability studies as “just as some in adult education have invited and made space for African American and feminist scholars, we need to make space for disability so that students feel comfortable with exploring research agendas centered on disability and adult education” (Rocco & Delgado, 2011, p. 9). The authors also recommend disabled people be included when

discussing multicultural issues, and disability be integrated into the stream of research on power and privilege. The critical perspective acknowledges “the field of adult education maintains this asymmetrical power relationship with people with disabilities by centering on issues of disease and health and not on the experience of adults with disabilities as a social justice issue (Rocco, & Fornes, 2010, p. 385). Critical disability theory and pedagogy provide a lens for research on advocacy to allow the patient with disabilities to be viewed and understood as an individual first and foremost with wants and needs that need to be respected, valued and protected.

The need for construction of critical gerontology. The above perspectives of critical theory, feminist theory, and critical disability studies are similar in that each group (lower socio-economic-class, feminist, and disabled) is considered marginalized and exemplifies how the distribution of resources and power occur so some groups in society are privileged, and some are oppressed (Merriam, Caffarella, & Baumgartner, 2007). Within these pedagogies learning is approached from a critical, power relations framework where “the camera moves from the individual to an analysis of the context where learning takes place” (p. 241). While there is discussion of age and aging in the adult education literature there is little discussion of the critical aspects of age similar to other social constructs such as gender, class, race and disability. Age and ageism can also be viewed as a socially constructed identity and critical gerontology is a venue to give this issue a voice.

Critical Gerontology

The primary framework informing this research study is critical gerontology. Critical gerontology is described as “a more value-committed approach to social

gerontology- a commitment not to just understand the social construction of aging but to change it” (Phillipson & Walker, 1987, p. 12) and also casts a “critical eye on society and the field of gerontology itself” (Ray, 2008, p.97). Informed and inspired by the tradition of critical theory associated with such figures as Adorno, Horkheimer, Marcuse and Habermas, critical gerontology is concerned with the problem of emancipation of older people from all forms of domination (Moody, 1993) and stands in opposition to the conventional positivism and empiricism long dominant in gerontology (Moody, 1992).

As a field, Minkler (1996, 1999) notes that critical gerontology has evolved along two paths. The first path embraces a broad political economy of ageing framework. In this sense, critical gerontology views the ‘problem’ of aging in structural rather than individual terms. The second path in critical gerontology emerges from a humanistic orientation and provides a supplement to the political economy perspectives by putting a “human face- a human body and spirit-on aging and growing old” (Minkler, 1996, p. 470).

Political economy perspective. The political economy perspective of critical gerontology supposes that the phenomenon of aging and old age cannot be considered or analyzed in isolation from other societal forces (Holstein & Minkler, 2007). Moody (1988) defines this path of critical gerontology in terms of its opposite: instrumental gerontology.

Moody (1988) describes:

Instrumental gerontology, the domain of conventional social science research, acts to reify the status quo and provide new tools to predict and control human behavior. The hegemony of instrumental gerontology also serves to legitimate

professional interventions that reinforce a pattern of domination in both theory and practice of the bureaucratic state. (p. 33)

The political economy path provides multidisciplinary lenses and multiperspective framework within which to view and better understand old age and provides a much needed supplement to the study of the biological and psychological aspect of ageing, which reveal little about the social construction of ageing in a broader sociopolitical context (Minkler, 1996). General areas of critique from this view of gerontology include challenges to scientism and the hegemony of biomedical research in gerontology (Moody, 1988, 1992, 1993); the normative construction of the life course (Katz, 2005); and insensitivity of indifference to race, class and age relations (Ovrebø & Minkler, 1993). Specific examples of critical gerontology critique are described within the topics of the aging enterprise, structured dependency and empowerment.

Aging enterprise. Minkler and Cole (1999) combine the political economy framework with a moral economy framework as a means to better understand developments in aging and aging policy. The authors define moral economy as collectively shared assumptions or views of social norms or obligations. “Among the greatest challenges of our aging societies are those concerned with the provision of humane and affordable health and social services in ways that empower, rather than disempower their recipients” (Minkler, 1999, p.6). The critical nature of the biomedical model in this framework is discussed as the ‘aging enterprise’ or the vast array of bureaucracies, interest groups, providers, and programs that have contributed to the commodification and treatment of the needs of the elderly in ways that often work to benefit professionals and organizations more than they do the elderly (Estes, 1979).

Structured dependency. Social policies and practices in gerontology have also been critiqued in regard to the issue of individual and population dependency (Estes, 1999, Townsend, 2007). The idea of structured dependency is explained as “the box before death within which many older people are placed” (Townsend, 2007, p. 43). Estes (2007) further attributes dependency to social practices that permit age discrimination; lower incomes of retired persons; high and growing out-of-pocket health costs; treatment of functional debility and chronic illness with acute medical care rather than rehabilitative support; and asymmetrical power relations between older persons and the professional caregivers who provide services to them. Townsend (2007) adds that older persons may assume the mantle of dependency and become resigned to external conditions and restrictions, as well as condescending expectations.

Empowerment. Forms of ageism (exclusion of the old) have been shaped by nations’ interplay of culture and history as well as their position within the global economy (King & Calasanti, 2006). Empowering older people is “the process by which individuals and communities are enabled to take power and act effectively to transform their lives and their communities” (Minkler, 1996, p. 472). The need for empowerment, in the perspective of critical gerontology, stems from the dependency in old age as a social construction, underpinned by the social relations of capitalism and the market economy. Empowerment works either “through social transformations in the redistribution of wealth and income or through the creation of new rituals and other means to facilitate transitions to and through later life” (p. 471). Critical gerontologists must encourage the old to “speak their minds, stake their claims, and guide us in intention of policies and services that will empower them all” (King & Calasanti, 2006, p. 151).

Humanistic perspective. From the humanistic perspective, critical gerontology is particularly focused on the larger question of meaning, or lack of meaning, in the lives of older people (Minkler, 1996). This pathway poses a world-view or way of thinking that asks questions about individual meaning from a perspective that one can understand only from the inside (Holstein & Minkler, 2007) and critiques our notions of “what we can know, of what is ‘true’ and ‘real’ about ageing and being old” (Minkler, 1996, p. 471). To improve understanding of individual meaning Moody (1993) notes that cultural and literary material, including individual life narratives, can be used for social criticism and putting forward alternate images of aging that can serve to integrate lives and celebrate shared meanings. Personal narratives of older adults are also effective to show the complex interplay between presently realized and remembered experiences of elders that may add to our understanding of health across the course of life (Cohler, 1993).

The subject of healthy and successful ageing is used to shed light on the humanistic perspective of critical gerontology in order to describe individual perceptions of meaning experienced by older adults. “Concepts like healthy or successful ageing, used uncritically, can contribute to the stigmatization and disempowerment of those elders who fail to meet our criteria of aging well (Minkler, 1996, p. 472). This critique on aging focuses on the intersection of culture and biology and suggests that the successful aging framework attaches moral values to busy lifestyles and declares this activity a normative ideal (Holstein & Minkler, 2003, 2007) rather than seeking to understand and describe how different people make meaning of their lives as they age (Chapman, 2005). Successful aging discourse sustains not a multitude of ‘cultures of aging’, but unified normative stereotypes about how individuals are expected to age, in

line with the state-driven promotion of containing the costs of elder care (Rozanova, 2010). Within this critique McCullough (1993) critically addresses the topic of successful and unsuccessful aging in terms of the possibility of arrested aging. Arrested aging occurs “when time, the past in particular, has the power to arrest some lives, to bring them to a stop, without death occurring” (p. 185). Arrested aging and successful aging are concepts of ageing that promote the need to recognize and reinforce the essential meaning of old age which transcends the state of our bodies and involve the right to flourish and grow in whatever ways are possible (Minkler, 1996).

Feminist perspective in critical gerontology. The political and humanistic threads of critical gerontology appear to cross paths in the discussion of critical gerontology from a feminist philosophy due to the complexity of biography, social and cultural norms, and public policy (Estes, 2006; Formosa, 2005; Holstein & Minkler, 2003, Ovrebo & Minkler, 1993). While the critical perspective recognizes that to understand old age, we must also understand the effects of gender, class and race analysis, the particular lens of gender reminds us that our bodies are more than the location of illness and health, they are an interface between the public and private worlds of meaning (Holstein & Minkler, 2003). Poverty, widowhood, caregiving and other life events primarily affect women along with far higher poverty rates. Women also experience a greater burden of chronic illness and functional limitations that “couple with differential societal norms that continues to assign a higher value to physical appearance and ‘youthful physical attractiveness’ to women” (Holstein & Minkler, 2003, p. 793). Townsend (2007) claims discrimination against older people has become as deep as forms of discrimination against women and minority ethnic groups.

Minkler (1996) concludes “one of the most vital roles that critical gerontology can play...is to help policy makers, the mass media, and the general public see the human face behind the statistics” (p. 483). The assumptive correlation of good health with successful aging (and by extension, disability and poor health with failure) together with the simplistic popularization of these proscriptive views in popular culture fail to honor the many ways in which individuals face the physiological, emotional or contextual changes that accompany aging (Holstein & Minkler, 2003). Critical gerontologists, therefore, challenge the status quo, enlivening thought and stimulating debate, with the intention of keeping mainstream gerontology from becoming complacent and consistent with the insights of critical theory recognize the need for change as “advocating for change is central to the critical agenda” (Ray, 2008, p. 99.).

Summary of the Theoretical Framework

As with the discussion of gender, class, race and disability, age is an ‘ism’ that can be observed in individual and structural systems in terms of privilege, power and oppression. Critical gerontology describes the social representations of age with critically similar themes of self-meaning, sociocultural context, positionality, hegemony and self-determination. Critical gerontology also stems from a social justice orientation similar to the critical social theories of adult education. Understanding such perspectives can help adult educators examine their own personal assumptions about teaching, learning and organizational change, as well as the degree to which existing classroom and organizational practices either challenge or support inequalities (Kasworm, Rose, & Ross-Gordon, 2010).

Adult education can be discussed as related to critical gerontology similar to that of other critical discourses. Each of these “power relations perspectives addresses the nature of truth and the construction of knowledge” (Merriam et al., p. 251). Each truth or knowledge is relative to the sociocultural context of which the learner is a part. Older persons, viewed from the humanist strand of critical gerontology, can develop knowledge similar to psychological feminist views that knowledge results from individual empowerment and gaining a voice to effect change in their personal lives (Merriam et al., 2007). Alternately knowledge in older adults, seen in the political strand of critical gerontology, can be viewed from critical or emancipatory models that “examine the political and social mechanisms that have controlled the knowledge production process and marginalized the contributions of women and people of color (Tisdell, 1995, p. 70).

Critical discourses, including critical gerontology, offer insight and guidance for this research study. To further illuminate the study, it is necessary to examine two other bodies of literature. Subsequent sections of this chapter provide an overview of the current literature of patient advocacy and on how advocacy is considered in the practice of physical therapy. Finally, the current practice of geriatric physical therapy will discuss issues and trends in health care to further support the need for this research.

Patient Advocacy

One component of health care that is embedded in the professional roles of healthcare professionals is that involving patient advocacy. Rich (2011) summarizes “the role of clinicians is to address the needs and concerns of people when they are most vulnerable; weakened by illness or injury, or distraught by the prospect of a loved one’s suffering, death, or disability” (p.2). Advocacy is defined in the geriatric literature as

“vigilant efforts by, with, or on behalf of older persons to influence decision makers in structures of imbalanced power and to promote justice in providing for, assisting with, or allowing needs to be met (Huber, Nelson, Netting, & Borders, 2008). An alternate definition in nursing literature views patient advocacy “as 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 healthcare system” (Bu & Jezewski, 2006, p. 104). I view advocacy as a responsibility of all healthcare providers to serve the best interests of patients based on their own individual values and principles. Therefore it is imperative that professionals seek out the patients understanding and goals and customize practices and interventions in all areas of care.

The assumption that advocacy is required in healthcare implies that the process of becoming a patient results in the reduction of autonomy and the patient rights may not be respected (Willard, 1996). Ultimately, advocacy is about power and influencing those who have power on behalf of those who do not (Teasdale, 1998). This review begins with a brief discussion of the levels and types of patient advocacy summary from two foundational books. Next is a lengthy section summarizing the conceptual and empirical literature about advocacy found in the nursing and rehabilitation literature. Third is a section highlighting the implications the advocacy has for educating physical therapists. Finally, this section ends with a discussion of the insights from critical gerontology about advocacy.

Types and Levels of Patient Advocacy

The patient advocacy literature highlights types of patient advocacy and levels of advocacy. Four basic types of patient advocacy are self-advocate, third party citizen

advocate, legal advocate and provider advocate (Huber et al., 2008; Teasdale, 1998).

Individual self-advocacy is an everyday, informal activity that occurs when you assert influence over your external environment to meet a need or speak up for yourself.

Citizen or third party advocates serve to protect or empower those who cannot effectively defend or fend for themselves. Legal advocates are a group of paid professional agents whose duties are prescribed by law to forcefully defend the rights and welfare of clients. Provider advocates are professionals in which advocacy is just one aspect of their professional role. This type of advocacy is intrinsically complex due to “the central defining characteristic of provider advocates- inherent role conflicts between their professional/occupational roles and their advocacy roles” (Huber et al., 2008, p. 40).

However the responsibility of professional advocacy in health care stems from the premise that “professionals have the technical knowledge of health, illness, and the range of treatment options (that) places them in a good position to give detailed information to vulnerable people and to help them appreciate the full range of choice which is open to them” (Teasdale, 1998, p. 23).

Advocacy is also described in health care literature is in terms of levels of advocacy, specifically class advocacy and case advocacy (Huber et al., 2008). Class advocacy is to champion the needs or rights of groups of people or groups of organizations with similar needs. This type of advocacy may involve political change at all social levels. Case advocacy is needed when an identified individual case, a person, small group or a specific organization, is the subject of change efforts. Case advocacy efforts will seek change that will result in direct benefits to themselves or clients. Huber et al., (2008) also discusses advocacy relationships consisting of external or internal

advocates. External advocates, those outside the system needing change, may be more objective and more zealous as their jobs are not on the line. Internal advocates work from within their agency and have firsthand knowledge of the players, politics and persons in power. These advocates are usually more invested, however, face the challenge of structural pressures involved with their employment status, relationships with colleagues, and protecting organizational interests.

Key Themes from Healthcare Literature

There are no studies of patient advocacy in physical therapy literature, and only a limited discussion of patient advocacy in the theoretical and conceptual literature on physical therapy. There is however, considerable discussion and a number of studies that deal with patient advocacy in the nursing and general rehabilitation literature. There were four main themes that stemmed from the analysis of this literature: conceptual models of advocacy, the professional role of advocacy, antecedents and consequences of advocacy, and specific examples of advocacy performed in healthcare.

Conceptual models of advocacy. A multidisciplinary review of healthcare literature suggests overall support for advocacy in regard to patient care. The conceptual development of advocacy with regard to foundational assumptions is absent in the rehabilitation literature and described primarily in the nursing literature. Two books and three theoretical articles were found to describe conceptual models of advocacy. The two books portray advocacy in general terms that deal with power and the imbalance that occurs for patients in healthcare settings derived from three basic assumptions (Huber et al., 2006; Teasdale, 1998). First, efforts for advocacy focus on people who are vulnerable and are in need of something to happen due to lack of knowledge or limited

legal or consumer rights. Second, advocates are persons who engage in efforts designed to influence change and a relationship based on reciprocal trust is needed. Third, persons with the power to change situations are located in various settings and need to be aware of their own values as they can become accustomed to acting in a paternalistic way.

The three theoretical articles discuss advocacy as a morally based concept with components summarized as based in two arenas: individual autonomy and social justice (Bu & Jezewski, 2006; Fowler, 1989) underscored by the attributes of valuing, appraising and interceding (Baldwin, 2003). Advocacy based on individual autonomy is founded as (1) guardian of patient rights; (2) preservation of patient values; and (3) conservator of patients' best interests. Guarding a patient rights, interests or safeguarding patient autonomy is presented in terms of patients legal rights to treatment supported on a case level. Within this attribute suppositions are made that individuals have a responsibility for their own care and are competent to make their own decisions though they may need information about decisions. Individual models also exemplify the need for health professional autonomy to empower patients and act for silent patients. In each of these areas the importance of valuing patients individual beliefs, appraising or advising them with regards to implications or consequences of actions and interceding between patients and their families or healthcare providers.

Advocacy performed as a champion of social justice in the provision of health care is indicated on a class level. This model requires the consideration of inequalities and inconsistencies of health care and social contexts of culture. While Baldwin (2003) does not specifically discuss social justice, the attributes of valuing, appraising and interceding are implied in this area for effective advocacy on a larger scale.

Each conceptual model, while worded differently, suggests the complexity of advocacy as noted by the multitude of persons involved and the relationships that connect them. The many attributes of advocacy are also complex in that they represent the patient advocacy role in the micro social level, acting as representatives, delegates and surrogates (case advocacy), and in the macro social level, acting as social activists for health, education, and welfare for people in all levels of the healthcare system (class advocacy).

Roles in advocacy. Nursing literature presents conceptual and empirical articles to discuss advocacy in terms of professional role. Conceptual articles from Willard (1996) and Hack (2010) define the role of nurses in patient advocacy consisting of three responsibilities: 1) related to patient autonomy, 2) related to interests in healthcare, and 3) as a moral role of patient rights. The nurse must protect the fundamental right of the patient's self-determination in the patient's care, specifically the right not to endure activities that will cause deterioration of patient health and the right to information and informed choice. The professional role also has a duty to respect the interests of healthcare in regards to resource allocation that may deprive others in favor of one. Finally, the professional respect for autonomy can't be an absolute obligation since this may conflict with professional responsibility to act with beneficence toward all patients. Hanks (2010) adds a fourth role in terms of using expert knowledge to challenge traditional healthcare power structures and empower patients and building relationships for communication between nurses and patients.

Two qualitative studies informed the role of nursing in regard to patient advocacy. Lindahl & Per-Olof (1998) questioned six Swedish critical care nurses to qualify the concept of professional role advocacy relative to the patient, the patients' next of kin and

co-workers. Negarandeh, Oskouie, Ahmade and Nikraves (2008) interviewed 24 nurses in a large Tehran hospital to inquire the meaning of patient advocacy. Qualitative data from these studies indicate nurse's role of advocacy in relation to patients includes: to build a caring relationship, including gathering information from a holistic perspective, to carry out a commitment, and to empower (Lindahl & Per-Olof, 1998). Specific responsibilities included informing and educating, valuing and respecting, supporting physically, emotionally and financially, protecting and representing and promoting continuity of care (Negarandeh et al., 2008). Lindahl & Per-Olof (1998) also state that advocacy becomes a commitment to take on the responsibility to promote the welfare of another human being whose autonomy is threatened, including protection, meeting basic needs and professional competence. They define empowerment as the role expressed in educating and encouraging the patient to participate in the health care process. The role of advocacy in relation to patients' next of kin includes engagement in interaction to inform, collaborate and influence family and friends in care needs, coping with difficult situations and understanding cultural competence. The role of advocacy in relation to co-workers includes the role of risk taker and acting as a moral agent. A moral agent is needed in the case of patient's powerlessness and dependency to act in response to patients' rights and values.

Antecedents and consequences to advocacy. There are both antecedents and consequents to advocacy. Huber et al. (2008) and Teasdale (1998) identify the three principal agents in advocacy as patients, advocates and persons with the power to effect changes. The literature discusses the need for advocacy based on assessment or antecedents that may be facilitators or barriers in the process. A critical argument for

patient advocacy describes the central need of empowerment of the advocate (Hanks, 2007). “Nurses need to be empowered first, if they are to empower their patients” (Hewitt, 2002, p. 439). Empowerment can occur by providing knowledge, support and validation to nurses in regard to patient education and decision-making. Empowerment must also be given to other healthcare professionals, including physical therapists, who develop relationships with patients and have the responsibility of educating and providing care in various healthcare contexts.

Baldwin (2003), Bu and Jezewski (2006) and Hanks (2007) each discuss the need for advocacy in terms of antecedents. Baldwin (2003) presents antecedents related to the patient and the nurse advocate based on the nature of the situation. Antecedents of the patient may be in the context of vulnerability or conflicts and situations demanding decision-making. Antecedents of the nurse may be willingness and responsibility regarding the professional advocacy role. Bu and Jezewski (2006) provide similar antecedents, however, in the context of the micro social and macro social levels of the healthcare system. On the macro social level, health disparity and hospital environment are often complex contexts indicating the need for advocacy. On the micro social level, patient vulnerability often requires advocacy efforts. Patient vulnerability can occur due to poor medical status, illiteracy, and feelings of powerlessness or intimidation, which compromise a patients’ ability to self-determine their health care and protect their own best interests. Other attributes to consider at this level is that of education, time and threats of punishment for the advocate (Hanks, 2007)

The discussion of patients’ needs versus wants is also a consideration in patient advocacy due to various moral and ethical considerations. Professional codes of practice

often endorse advocacy for professionals (Doherty, 2005). “If the client seeks advocacy, health care professionals have a duty to respond to whatever the client wants” (Teasdale, 1998, p. 34). Conversely, the patient may not know to seek advocacy actions, and it is still within the professional’s responsibility to understand the patient’s wants and needs and then educate the patient or intervene to be sure they are protected.

Consequences or implications regarding patient advocacy are described in the literature as both positive and negative (Baldwin, 2003; Bu & Jezewski, 2006; Hanks, 2007; Huber et al., 2008; Sundin-Huard & Fahy, 1999; Teasdale, 1998). Positive consequences occur at multi systems levels in that patients’ rights, benefits, and values are preserved or promoted and professionals can increase their self-esteem, satisfaction and maintain personal integrity and moral principles. Autonomy and empowerment, for patients and professionals, are also a commonly noted as positive consequences of advocacy efforts (Baldwin, 2003; Bu & Jezewski, 2006; Estes, 1979; Huber et al., 2008, Teasdale, 1998).

Negative consequences, or risks, are also discussed in relation to patient advocacy (Baldwin, 2003, Bu & Jezewski, 2006, Hanks, 2010; Hewitt, 2002; Sundhin-Huard & Fahy, 1999; Teasdale, 1998). Because advocacy is about power, it has the potential for conflict that carries risks for all involved. Patient advocates are sometimes accused of insubordination, suffer loss of reputation, or labeled as troublemakers. Advocacy “is particularly risky for professionals, who are vulnerable to dismissal and who have very limited protection under employment law” (Teasdale, 1998, p. 20). Another negative consequence for patients is patient discomfort occurring when the patient is placed in an uncomfortable position when there is competition for the role of advocate between

professionals (Baldwin, 2003). Negative consequences also risk effective advocacy strategies if feelings of frustration and anger occur when advocacy attempts are unsuccessful (Hanks, 2010, Sundin-Huard & Fahy, 1999). Later in this chapter I present an advocacy model that I developed based on this literature of antecedents and consequences, and some of the literature discussed above.

Specific examples of advocacy. While patient advocacy in the nursing literature is discussed in broad conceptual terms, advocacy in the rehabilitation literature is presented via narrow descriptions of actions or situations that indicate the need for advocacy. Physical therapy and occupational therapy literature describe patient advocacy in terms of whistleblowing (Banja, 1985; Guccione, 1980, Mansbach, Bachner, & Melzer, 2010), constrained physical therapy (Guccione, 1980; Nalette, 2010, Triezenberg, 1996, 2005), advocating for specific causes (Doherty, 2005; Leong & Euller-Ziegler, 2004; Nelson, 2005; Sullivan & Main, 2007), and encouraging health care reform (Moore, 2010; Sullivan, 2009).

Whistleblowing, or the act of speaking up “in dealing with situations that may be ethically reprehensible or harmful to patients” (Banja, 1985), is discussed as a tool for advocacy and social intervention in qualitative physical therapy studies (Guccione, 1980; Mansbach et al., 2010). Mansbach et al. (2010) surveyed 227 physical therapy students and 126 physiotherapists regarding willingness to take action to prevent misconduct or protect a patient interest. The authors concluded that while both students and physiotherapists viewed acts that are detrimental and unjust to patients as being very serious, physiotherapists are more willing to take actions than students. Guccione (1980) surveyed 187 physical therapists in an attempt to identify ethical decisions frequently

encountered and determined respondents did not frequently make the decision to report questionable practices of another physical therapist, physician or other health professional.

Constrained physical therapist practice occurs when the clinician understands the patient legitimate needs and, while acting to meet those needs, may be compelled to provide less than necessary care (Nalette, 2010). This practice, highlighted as a situation where clinician or provider advocacy is needed, was documented in three empirical studies. Guccione (1980) surveyed physical therapists and Triezenberg (1996) questioned physical therapists using the Delphi technique and Nalette (2010) documented a case report each concluding that constrained clinical practice creates a moral dilemma for physical therapists. Nalette (2010) further proposes that the primary moral roles of the physical therapist are to be in relationship with the patient and advocate for that patient's best interest.

Advocacy is also discussed in conceptual physical therapy literature in relation to specific patient needs or causes. Doherty (2005) describes advocacy as a core value held by the rehabilitation practitioner and the need for strong patient advocates and resources for functional applications of technology. She argues for advocating for the patient who has no voice and for the technology that will allow patients greater control over their own health care. In a separate cause, Leong and Euler-Ziegler (2004), portray patient advocacy and empowerment as a pivotal role for arthritis patients and their families. The authors report personal advocacy enables patients with arthritis to make informed decisions about their disease and be responsible members of the healthcare team.

Nelson's (2005) conceptual article discusses the need for clinician advocacy for patients with lymphedema. The author presents the need for advocacy for "this under-recognized medical entity" (p. 107) and the issue of scarce resources and justice for chronic conditions requiring rehabilitation. Finally, Sullivan and Main (2007) discuss the conflicting role of advocacy for patients with chronic pain. These authors present the differences in the role of service provider and advocate, and while advocacy may be seen as a logical and legitimate extension of the provider role, the rehabilitation provider must bear in mind the negative impact of any form of protective behavior for patients with chronic pain.

A final situation of advocacy noted in the physical therapy literature is advocating for health care reform (Moore, 2012; Sullivan, 2009). Health care reform is a critical issue for physical therapy due to the inequalities in our health care system. "Many patients live in relative social isolation due to lack of transportation, receive inadequate long-term health care for routine medical conditions and require the assistance of overburdened family members to provide their daily care" (Sullivan, 2009, p. 171). The author argues for physical therapists to become politically active as a 'call to action for our patients'. Moore (2010) further supports legislative advocacy as a process articulated in the United States Constitution and its First Amendment as the right of individuals to bring issues before government. "Advocacy is the process to get a policy decision" (p. 591) and to achieve policy change, a well-conceived plan is needed. The author summarizes that it is essential regardless of setting of practice, political perspective, or policy expertise that physical therapists engage in the health policy and advocacy process.

Implications for Educating Physical Therapists for Patient Advocacy

The importance and complexity of effective patient advocacy can be seen from the above discussion. Education is needed for physical therapy students as well as seasoned professionals. Each of the reviewed empirical studies concluded that the need for education is important for physical therapy students to make ethical as well as clinical judgments. Guiccione (1980) stipulates that “to prepare future clinicians less adequately could jeopardize the integrity and the autonomy that physical therapy as a health profession has so arduously worked for” (p. 10). Entry-level academic programs for physical therapy students include advocacy as a Professional Core Ability that is embedded in ethics curriculum (Jensen, Paskhal & Shepard, 2013). However literature is limited in regard to specific methods or recommendations for physical therapy education. The literature is more scarce of resources regarding pedagogy for geriatric patient advocacy despite the fact that contextual and social factors of ill or disabled elderly place them in a critical role for the need for advocacy services (Huber et al., 2008). A review of the physical therapy literature yields advocacy education in physical therapy provided in two realms: generally as ensconced in ethics courses and specifically as part of service learning teaching methods.

Ethics coursework. While limited in scope, advocacy is recommended to part of the physical therapy curriculum via the general discussion of ethics in healthcare. “The goal of ethics education is to produce clinicians who value the importance of ethics and incorporate ethical decision making into every patient interaction” (Wharton, 2005). As advocacy is understood as a moral and ethical concept, literature on ethics becomes a prominent source of advocacy understanding and primary method for preparing students

to work with marginalized geriatric patients. The American Physical Therapy Association (APTA) and American Occupational Therapy Association (AOTA) each have ethics committees that endorse a code of ethics based on values of the profession and have a mechanism to hold professionals accountable. Ethics education has the potential to make a profound impact on enhancing professional accountability and facilitating the role of APTA and AOTA ethics committees (Wharton, 2005).

Three specific methods recommended for education of healthcare professionals regarding ethics of care were found in the literature, however, none empirically assessed. Gervais (2005) presents a model for ethical decision making to inform the ethics education of future care professionals. She proposes ethics education to include the critical examination of mindfulness to help students become self-aware, reflective and capable of understanding of his or her moral responsibility as a health professional. Another method recommended in ethics education of health professionals includes including reflections on spirituality and its concurrent importance in ethics education for facilitating moral responsibility, moral agency and moral courage in future practitioners (Gabriel, 2005). Finally, Davis (2005) recommends engaging students by addressing behaviors to enhance moral courage including fidelity, confidentiality and veracity. She notes that, in addition to teaching, behaviors must be modeled by educators, “we must commit not just to influencing our students to act with moral courage, we must inspire them to it” (p. 224).

Service learning. Service learning, as a teaching methodology, is the only noted teaching method utilized in academic programs to promote geriatric patient advocacy. The educational method of ‘service learning’ combines community service with explicit

academic learning objectives, preparation and reflection (Seifer, 1988) with the goals of providing service to the community along with the application of classroom knowledge in real-life settings (Beling, 2004). Kirkpatrick and Brown (2004) depict a geriatric nursing course that employs narrative pedagogy through stories and a service-learning project. The course is designed to allow critical and reflective thinking of the stories that will help the students engage with the older person in a therapeutic relationship. Karasik, Maddox, and Wallingford (2009) present three examples of service-learning in gerontology, occupational therapy and nursing disciplines along with student and program considerations to best incorporate real life experience with civic involvement. The authors feel to design effective experiences, it is important to be mindful of student's level of maturity, communities' service needs, students' time availability and selection of service parameters. A final model by Hamel (2001) uses service learning in physical and occupational therapy education to teach students about interdisciplinary collaboration, service, advocacy issues and social responsibility by using learning projects with formerly homeless older adults. The program reports that students learn about the importance of building rapport and trust with older adults along with the concepts of acceptance, awareness, empowerment and health promotion to break down the barriers and prejudices of marginalized elderly and plant the seeds of advocacy.

One empirical article reports the use of service learning in a geriatric setting to focus on the opportunity for advocacy. Michaels and Billek-Sawney (2006) studied 38 physical therapist students who were required to identify an older adult and determine that individual's fall risk and then generate a letter to the individual's physician regarding

findings and recommendations. The results indicated that the majority of students reported that the assignment allowed them to act as a patient/client advocate.

Insights from Critical Gerontology for Advocacy

“Prior to being effective advocates, we need to be aware of what issues exist for the elderly, where we can best serve them as advocates for these issues, and continually update ourselves as to the status and concerns of the elderly community” (Phillippi, 1997, p. 10). Also, the integrity and diligence with which a profession examines its unique ethical issues, understands its ethical interactions, and develops methods for educating its students will largely determine the moral position of that profession (Triezenberg, 1996). Each of these statements provides the foundation for the insights of critical gerontology to assist with physical therapy education in the area of patient advocacy, both for students in the classroom and professionals as part of life-long learning. The discussion of critical gerontology will assist in this education in three main ways: understanding the significance of critical reflection in everyday ethical decision making, understanding the humanities perspective of critical gerontology (Minkler, 1996, 1999) associated with the understanding of self-meaning and its relationship to advocacy, and understanding the political economy aspect of critical gerontology (Minkler 1996, 1999) and how this macro level thinking relates to advocacy.

The discussion of critical reflection stems from the critical theoretical perspectives founding critical gerontology. As healthcare providers, ethical education is important to “produce clinicians who value the importance of ethics and incorporate ethical decision making in every patient encounter” (Wharton, 2005). Effective ethical decision-making requires critical thinking and critical reflection. In the realm of critical

theory, this reflection should be a significant construct because, as healthcare providers, we are frequently in the center of power imbalances created by societal forces. Our patients can be considered marginalized in most instances, and geriatric patients with disabilities can be seen as truly oppressed. The ramifications of this imbalance and the societal norms surrounding it are important to understand and truly perform in the professional manner that is expected. Critical reflection as a component of ethical decision making in patient care is further delineated in individual, case instances and in macro level class instances. Each of these instances is further informed by the humanistic and political economy perspective of critical gerontology (Minkler, 1996, 1999).

The humanistic perspective of critical gerontology provides insight to healthcare providers in understanding the importance of self-meaning of our geriatric patients (Minkler, 1996, 1999). Professionals are trained to be patient centered and holistic, however, it is not understood that many of our attitudes and beliefs about older adults come from what society thinks they should look like, want and need. The humanistic pathway encourages critical reflection in each individual situation and encounter with a geriatric patient. As professionals we are obligated to look beyond hegemony and advocate for what the patient wants, based on their perceptions and beliefs.

The political economy perspective of critical gerontology provides insight to advocacy by understanding the global nature of power and inequity and the resulting ramifications on healthcare policy and practice (Minkler, 1996, 1999). Healthcare professionals are trained to understand general healthcare policies, however, require understanding of how political and market forces affect healthcare policy in both

governmental and institutional levels. Critical gerontology and its critical framework provides context for the decisions and advocacy efforts made in this regard. Advocating for societal disparities is an important role for healthcare providers for all patients and other persons of marginalized groups.

The political economy in critical gerontology and the humanistic path confront us with the disempowerment of the old – in the first instance, through structural constraints in which ageing takes place, and in the second, by casting into sharper relief questions about the loss of a sense of place and of meaning for the old in our societies (Minkler, 1996). Empowering, or advocating, for our patients is our professional duty. Critical gerontology offers insight to understand critical theory and the scope and breadth of advocacy needs for older persons with chronic health needs.

Current Practice of Geriatric Physical Therapy

While the role of patient advocate is embedded in the professional role of all physical therapists, this study focuses specifically on physical therapists working with geriatric or elderly patients. In recent years, changes in demographics of elderly patients, changes in health care economics, and the associated professional and ethical responsibilities provide challenges for physical therapists working in this realm. Each of these areas is discussed as they provide background and guidance to the current study.

Role of Geriatric Physical Therapist

The scope of practice for physical therapists working with older adults is large and increasing. Older adults comprise at least 40% of patients across physical therapy settings (Knapp, Russell, Byrum, and Waters, 2007), and the number of Americans age 65 years and older continues to grow at an unprecedented rate (Guccione, 2012).

Individuals born between 1946 and 1964 are frequently referred to as the ‘Baby Boomers’ and will be responsible for a sharp rise in the number of older people between 2010 and 2030, when the older population is predicted to account for nearly 20% of the total U.S. population (Federal Interagency on Aging, 2008). Due to the dramatic increases in older adults living in our society today, more entry-level physical therapists and physical therapist assistants are needed to care for patients across the continuum of care (Nalette, Dauenhauer, Frankel, Karuza & Katz, 2002). The Center for Health Workforce Studies of the University of Albany (2006) projects the growth in the number of physical therapists needed for geriatric settings to increase thirty-three percent in the next ten years. These clinicians are also being asked to work in a health care environment that is rapidly changing. Health care economics are requiring workers to provide high quality care in an increasingly demanding, productivity driven manner.

Changes in Healthcare with Increased Productivity Driven Practices

Changes in healthcare reimbursement have caused the delivery of physical therapy services to change in recent years. Changes in health care in the form of shrinking economic resources, managed competition, and managed care are mechanisms that function to varying degrees to limit patient access to rehabilitation (Lewis & Bottomly, 2008). The current reimbursement environment has dramatically altered the delivery of health care causing the length of stays (LOS) and subsequent number of rehabilitation treatment visits to be decreased in every level of health care (Mellion, 2001). The desire to reduce LOS cost shifting is often an issue. Cost shifting occurs when health providers reduce their length of stay by shifting the burden of expenses to a downstream provider. This has resulted with patients being discharged earlier and

shuffled down the line to the next level of care (Mellion, 2001). Hospital DRG (diagnostic related group) reimbursement has constrained hospital payments resulting in physical therapy services being limited to functional activities to allow the patient to be discharged to acute rehabilitation or skilled nursing units if they are unable to go home. Acute rehabilitation units are then required to provide 3 hours of therapy a day to justify admission and therapists are pressured not to miss time with little regard to patient's medical condition or complications. Current payment systems to skilled nursing facilities encourage over provision of therapy services (White, 2003) as skilled nursing units often rely on the provision of therapy services to boost their CMG's (case mix group) which subsequently increases the daily rate at which the facility is reimbursed. For patients residing at home or long-term residents of nursing homes, outpatient physical therapy services are often provided with the focus on utilizing interventions and treatment times that will maximize reimbursement of Medicare or other insurance dollars. Under the managed care reimbursement environment, there is "the potential for therapists to be 'double agents' with contractual obligations to the managed care plan and professional fiduciary responsibilities to the patient" (Lewis & Bottomly, 2008, p. 452). The 'business' of health care has caused physical therapy professionals to work in areas that espouse patient centeredness, however, are immersed in financially motivated procedural practices and treatment justifications. "The intersection of financial considerations and patient care is fraught with conflicts of interest and, frequently, with accompanying ethical dilemmas" (Stein, 2012, p. 86).

Professional and Ethical Responsibilities

Within the challenges of providing therapy services to geriatric patients in challenging health care settings, the professional role of the physical therapist is defined by several clinical and ethical responsibilities. The American Physical Therapy Association (APTA) has developed several documents that describe the behavior expected of its members including standards of practice, a code of ethics, and a guide for ethical conduct. Specifically, the APTA has identified seven core values of the profession: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility (Hack, 2005). While these values are defined in general terms regarding professional and ethical behaviors, sample indicators are provided to describe how the value should be modeled by physical therapy professional. Within the ethical values, patient advocacy described as a specific indicator for two core values and is implied in two other core values.

Being an advocate for patient's/client's needs is an indicator of the value of compassion/caring as it demonstrates the concern, empathy, and consideration for the needs and values of others. Advocating for the health and wellness needs of society, including access to health care and physical therapy services, is an indicator of social responsibility. It promotes the mutual trust between the profession and the larger public that necessitates responding to societal needs for health and wellness. Advocacy is also implied in the core value of integrity as this includes using power judiciously and in the core value of altruism as the general regard for devotion to the interest of patients/clients assuming the fiduciary responsibility of placing the needs of the patient/client ahead of the physical therapist's self-interest.

In general, clinicians must be knowledgeable about professional evidence based practices performed within the framework of ethical core values to improve patient function and maximize independence, while working within the framework of restrictive reimbursement practices. Patient advocacy in this realm is one aspect that can be examined as an example of this professional/ethical intersection.

Conclusion:

Toward a Gerontology Advocacy Model for Physical Therapists

Geriatric patients who become ill or disabled and subsequently enmeshed in the vast institution of healthcare often need help navigating the system. Healthcare professionals have a responsibility to assist these patients and help them understand where to obtain services, how to jump through the procedural hoops, and how to stand up for their own rights (Earp, et al., 2008). Patient advocacy is this process. Patient advocacy is “based on the premise that patients and their families can and should have a direct impact on the way healthcare is practiced” (Earp, et al., 2008 p. 59). Physical therapists are valuable members of the healthcare team and, due to professional role and close relationships with patients, are in primary positions to become advocates for those they serve. However, literature regarding physical therapists knowledge, understanding and practices of patient advocacy is minimal.

The lack of empirical literature on the important topic of patient advocacy clearly supports this study of physical therapists understanding of geriatric patient advocacy. Utilizing critical perspectives to frame the discussion geriatric patient advocacy is important for three reasons. First, it is important to put the true nature of critical

discourse into the discussions of critical thinking. As professionals, we are constantly instructed and encouraged to critically think in regard to patient situations in order to provide the optimal patient care. Imperative in the process is to carefully elaborate on the chief intellectual traditions that inform the discourse in order to relocate critical thinking and critical reflection squarely in the tradition of critical theory, with the explicit social and political critique and activism this implies (Brookfield, 2010). Second, physical therapist professionals play a role in adult education for their geriatric patients. As we consider how to assist learners to exert agency and realize collective interests in a world in which people live their life in which economic, social, and political forces are seen as being far removed from daily influence, critical theoretical frameworks help us penetrate hegemony, detect ideological manipulation, and realize when corporate agendas are displacing individual and social well-being (Brookfield, 2010). Finally, as required in all healthcare professions, true understanding and belief in social justice, as promoted in adult education critical discourses, is necessary for the moral and ethical expectations of practice. The overarching framework of social justice in adult education simultaneously explores multiple forms of oppression with the aim of eliminating societal-isms (Johnson-Bailey, Baumgartner, & Bowles, 2010). Understanding social justice practice and engaging in social justice programs allows students and practitioners “engage in participatory practices to the betterment of society” (p. 340).

CHAPTER 3

METHODOLOGY

The purpose of this mixed methods study is two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. In the analysis, particular attention is paid to critical assumptions by utilizing a critical gerontology theoretical framework. The research questions that guide this study are:

1. What are physical therapist professional's attitudes and beliefs regarding patient advocacy when working with the geriatric population in various healthcare settings based on four advocacy constructs of:
 - a. Safeguarding patients' autonomy?
 - b. Acting on behalf of patients?
 - c. Championing social justice in the provision of health care?
 - d. Understanding of past patient advocacy efforts/actions?
2. What are the perceived practices or actions for geriatric patient advocacy in various health care settings in regard to:
 - a. Experiences of patient advocacy performed within the framework of critical gerontology?
 - b. Types of antecedents, barriers and consequences experienced when providing advocacy efforts?

- c. Perceived meanings of patient advocacy for the practitioner, for the patient and for their families?

As stated in Chapter One, few studies have examined physical therapists' understanding of patient advocacy and none through the theoretical lens of critical gerontology. A review of the literature failed to identify a survey instrument that contained reliability and validity data and addressed the concepts important to the current study. Therefore, as the researcher, I modified a mid-range patient advocacy instrument developed by Bu and Wu (2008), drawing questions of advocacy efforts informed from other advocacy instruments, changing terminology that primarily referred to the nursing profession, as well as modifying questions from constructs from the field of critical gerontology to include in the survey.

The current study first makes use of a quantitative geriatric patient advocacy survey that, through a series of questions, quantifies factors that have been found to be pertinent to patient advocacy concepts (Bu & Jezewski, 2006) supplemented with questions pertinent to patient advocacy practices. I present a detailed discussion of the survey development process and the qualitative interview plan later in this chapter.

In particular, four hypotheses were examined:

H₁- Advocacy beliefs in regards to safeguarding patient autonomy will be positively correlated to social justice advocacy beliefs.

H₂- Advocacy beliefs in regards to acting on behalf of patients will be positively correlated to social justice advocacy beliefs.

H₃- Advocacy attitudes in regards to safeguarding patient autonomy, acting on behalf of patients and championing social justice in the provision of health care will correlate to micro-social advocacy behaviors relating to the individual geriatric patient.

H₄- Advocacy attitudes in regards to safeguarding patient autonomy, acting on behalf of patients and championing social justice in the provision of health care will correlate to macro-social advocacy behaviors relating to social justice.

The qualitative portion of this study includes interviews of physical therapists to obtain information regarding the contexts of patient advocacy efforts in geriatric settings including facilitators, antecedents, barriers, consequences and meanings for the practitioner, the patient and the patient's family.

This chapter begins first with my own background, partly as an explanation of why I am interested in the study, and then includes a rationale for the use of mixed methods including an overview of the theoretical underpinnings of quantitative and qualitative paradigms, participants, their selection process and a discussion of the data collection and analysis methods follows. Finally, the chapter concludes with approaches taken to ensure verification and trustworthiness.

Background of the Researcher

I am both a physical therapist (PT) with geriatric patients and an educator in a higher education setting of physical therapist students, and my desire to conduct this study is an outgrowth of my practice. As a practicing physical therapist working with geriatric patients and also as a physical therapist educator, I have a responsibility for direct professional care of geriatric patients and also for instruction of novice practitioners. In the clinic setting I am concerned with the recent and current changes in

healthcare reimbursement and patient access and corresponding changes in physical therapist practice requirements that focus on productivity and payment issues. In the classroom setting, I have had several students return from clinical assignments with ethical concerns regarding patient care and decisions that are made in the clinic that appear to be financially motivated rather than patient centered. These reflections have caused me to consider the ethical implications of the changes and current practice patterns for clinicians working with geriatric patients. Are we truly putting the patient first in our evaluation and treatment process? Exploring geriatric patient advocacy was a viable method to assess one aspect of ethical professional practice to better understand physical therapists attitudes, behaviors and actions regarding this important issue.

In this study I have not attempted to prove, nor do I believe, that physical therapy professionals overtly disregard the geriatric patient and their needs. Physical therapy is a wonderful profession and provides a valuable resource for geriatric patients to improve their abilities and quality of life. As a physical therapist, working with geriatric patients is a positive and rewarding experience and I encourage all of my students to consider geriatrics as a clinical specialty. However, with the changes in healthcare reimbursement and practice patterns the context in which care is provided is changing and therefore examining patient advocacy is important for current clinicians and for education of future clinicians. I believe that more research is needed dealing with physical therapists and their advocacy for geriatric population groups, in order to better both educate physical therapists, and to more effectively provide for the needs of geriatric populations.

Research Design

This study utilized a research paradigm that combined both quantitative and qualitative analysis that is commonly referred to as a mixed methods research paradigm. The design falls into the explanatory sequential type of mixed methods. In an explanatory sequential design the researcher starts with the collection and analysis of quantitative data, followed by the collection and analysis of qualitative data to help explain the initial quantitative results (Creswell & Plano Clark, 2011). Quantitative research allows researchers to test “objective theories by examining the relationship among variables” (Creswell, 2009, p. 4). Typically, this type of research measures observable and quantifiable data, which the researcher then analyzes. Qualitative research allows researchers to explore and understand “the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2009, p. 4). Researchers gather data with methods including observation, interviewing, and collecting artifacts. The researchers then make meaning from this data through interpretation.

Rationale for a Mixed Methods Research Approach

Mixed methods research has emerged in the last few years as a research approach popular in many disciplines and many countries, supported through diverse funding agencies (Creswell, 2011). Mixed methods research is becoming increasingly articulated, attached to research practice, and recognized as the third major research approach, or research paradigm, along with qualitative research and quantitative research (Johnson, Onwuegbuzie, & Turner, 2007). A fundamental assumption about mixed methods research in the social, behavioral, and health sciences is that it might potentially provide a better (broader, more credible) understanding of the phenomena under investigation

rather than a dichotomous qualitative or quantitative approach (Tashakkori & Teddlie (2010).

Johnson, et al, (2007) report that the concept of mixed methods research has been defined in many ways and therefore they analyzed definitions from leaders in the field in order to offer a general definition:

Mixed method research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration (p. 123).

Teddlie & Tashakkori (2011) support this definition because it includes what the authors believe to be an essential characteristic of mixed methods research: methodological eclecticism which involves “selecting and then synergistically integrating the most appropriate techniques from a myriad of QUAL, QUAN and mixed methods in order to more thoroughly investigate a phenomenon or interest” (p. 286).

Characteristics of Mixed Methods

Teddlie & Tashakkori (2011) delineate eight characteristics of contemporary mixed methods research, stating that mixed methods research incorporates:

- (a) Methodological eclecticism;
- (b) Paradigm pluralism or the belief that a variety of paradigms may serve as the underlying philosophy for the use of mixed methods;
- (c) A celebration of diversity at all levels of the research enterprise from the broader conceptual ones to the narrower more empirical ones;

- (d) An emphasis on a continua rather than a set of dichotomies, replacing the “either-or” with a range of options of integrated questions and innovative methods;
- (e) An iterative, cyclical approach to research to include deductive and inductive logic;
- (f) A focus on the research question (or research problem) in determining the methods/approaches employed within a given study;
- (g) A set of basic research designs and analytical processes that define mixed methods in relation to quantitative or qualitative methods, and
- (h) A tendency toward balance and compromise that is implicit within the “third methodological community” to create a balance of quantitative and qualitative orientations.

These characteristics of mixed methods research provide the backdrop for an inclusive view of geriatric patient advocacy using multiple lenses. Deductive and inductive methods support an explanatory method to obtain a holistic view of physical therapists beliefs and practices.

Quantitative and Qualitative Foundations

The goal of mixed methods research is not to replace quantitative or qualitative research approaches but rather to draw from the strengths and minimize the weaknesses of both in single research studies (Johnson & Onwuegbuzie, 2004). In order to mix research in an effective manner, researchers need to understand all of the relevant characteristics of quantitative and qualitative research. Sale, Lohfeld, and Brazil (2002) summarize the quantitative and qualitative paradigms and their assumptions. The

quantitative paradigm is based on positivism where empirical research includes phenomena that can be reduced to empirical indicators that represent a single truth. The ontological position is that there is only one correct answer to the research question, an objective reality that exists independent of human perception. Epistemologically, the investigator is capable of studying a phenomenon without influencing it or being influenced by it. Techniques in this method include randomization, highly structured protocols, and written or orally administered questionnaires with a limited range of predetermined responses.

In contrast, the authors describe the qualitative paradigm as based on interpretivism and constructivism where there are multiple realities or multiple truths based on one's construction of reality (Sale, Lohfeld, & Brazil, 2002). Typically the researcher is exploring issues of meaning and participants' perceptions of a phenomenon to understand the particular in depth (Merriam, 2009). The investigator and the object of study are interactively linked so that findings are mutually created within the context of the situation, which shapes the inquiry. The emphasis of qualitative research is on process and meanings, and techniques in this method include in-depth and focus group interviews and participant observation.

Understanding of the assumptions and differences in quantitative and qualitative paradigms informs mixed methods research and can enable researchers to account for those differences and to reject the dichotomy between approaches. If carefully designed, mixed methods researchers can provide a distinct nomenclature, methodology and utilization potential (Tashakkori, & Teddlie, 2010). Philosophically, mixed methods research can be viewed as the "third wave" or third research movement, a movement that

moves past the paradigm wars by offering a logical and practical alternative (Johnson & Onwuegbuzie, 2004).

Philosophy of Mixed Methods

Mixed methods research, as a third research paradigm, carries the label of “pragmatic” because its philosophical foundations can be found in the classic school of thought known as “pragmatism” (Johnson & Onwuegbuzie, 2004). Pragmatism, as a worldview, arises out of actions, situations, and consequences rather than antecedent conditions (as in postpositivism) (Creswell, 2009). Noted to be an eminently American philosophical movement, pragmatism proposes that “something is *true* only if it *works*” (Goodson, 2010, p. 172). As a philosophy, pragmatism has various dimensions: it accepts the methods of science for understanding human beings; accepts both the relativism and pluralism worldviews; and emphasizes the centrality of human experience and consequences of actions (Elias & Merriam, 2005). Johnson, et al (2007) note that pragmatism is a well-developed, attractive philosophy for integrating perspectives and offers an epistemological justification, logic for mixing approaches, and helps mixed research peacefully coexist with the philosophies of quantitative and qualitative research.

Johnson and Onwuegbuzie (2004) present characteristics of pragmatism in an effort to more completely delineate the tenets of this philosophy and how they relate to epistemological nature of mixed methods research. These characteristics include:

- (a) finding a middle ground between philosophical dogmatisms; recognizing the existence and importance of the natural world;
- (b) viewing knowledge as being both constructed and based on the reality of the world we experience;

- (c) placing high regard for the reality of and influence of the inner world of human experience in action and view current truth, meaning and knowledge as tentative and changing over time; and
- (d) considering capital “T” truth as what will be the “final opinion” perhaps at the end of history whereas lower case “t” truths are given through experience and experimenting.

Benefits of Mixed Methods

The pragmatic philosophical perspective underscores mixed methods researchers' attempts to legitimate multiple approaches in answering research questions, rather than restricting or constraining researchers' choices, by including expansive, creative, inclusive, pluralistic, and complementary approaches to research (Johnson & Onwuegbuzie, 2004). Support for mixed methods research presented by Sale, et al (2002) includes the ability to achieve cross-validation or triangulation by combining two or more theories or sources of data to study the same phenomenon to get a better understanding of it. Another argument for the application of mixed methods research is in the ability to collect multiple types of data using different strategies, approaches, and methods in such a way as to combine the strengths of quantitative and qualitative methods to create a product that might be superior to monomethod studies (Johnson & Onwuegbuzie, 2004; Sale, et al, 2002) and has the potential to generate more insights than would be possible with either method alone (O’Cathain & Thomas, 2006). Finally, Collins, Onwuegbuzie, and Sutton (2006) advocate for mixed methods research based on four rationales: (a) participant enrichment by mixing methods to optimize sample; (b) instrument fidelity by assessing creating, and monitoring instruments; (c) treatment

integrity by assessing fidelity of intervention, and (d) significance enhancement by facilitating thick rich data and augmenting interpretation and usefulness of findings.

Mixed methods research is an approach to knowledge (theory and practice) that attempts to consider multiple viewpoints, perspectives, positions and standpoints (Johnson, et al, 2007) and offers great promise for practicing researchers who would like to see methodologies that are closer to what researchers actually use in practice (Johnson & Onwuegbuzie, 2004). Tashakkori and Teddlie (2010) also note because of its potential for broader understanding of social issues, mixed methods may provide more robust opportunities for devising policies and practices to implement positive change.

Critiques of Mixed Methods

While Teddlie and Tashakkori (2011) support mixed methods research, they also examined the literature to present critiques regarding this paradigm. Concerns include logistic concerns, mixed methodologist's knowledgeability, quality of writing, and the direction of the field toward unity of approaches. Logistic concerns include cost and responsibility as mixed approaches typically are more expensive and take longer to conduct which may be a concern for doctoral students or those on stringent time frames. Mixed method designs often consist of complicated procedures and hence require team efforts (Charmaz, 2011). Mixed methodologists knowledgeability implies experience, knowledge and judgment developed across diverse methods and field experiences and also mentorship which is considered important for successful mixed method project completion. The concern regarding quality of writing stems from early developers in the field concluding that authors need to do a better job expressing and presenting their definition of mixed methods, explaining their mixing of methods and describing their

philosophy. In today's testing academic environment, quality of writing is often an issue with any form of research. However, there is a concern that mixed methods research is prematurely headed toward some "fixed" unity or consensus for social inquiry that will preclude the consideration and respect of multiple approaches.

Tashakkori and Teddlie (2010) also critique mixed methods research in the area of diversity noting that although diversity is a major strength of mixed methods, that diversity should be assessed in a reflective context to prevent the duplication of ideas, inconsistent terminology, chaotic classifications and burdensome pedagogy.

Further Issues in Mixed Method Research

One aspect of discussion regarding types of mixed methods research is paradigm emphasis or whether to give the quantitative or qualitative components of research equal status or give one paradigm the dominant status (Johnson & Onwuegbuzie, 2004). Creswell (2009) refers to this task as weighting. This can be understood by viewing the qualitative approaches and quantitative approaches as opposite ends of a continuum (Johnson et al, 2007). Mixed methods research is viewed as being in the center and incorporating both methods. The center of the continuum, considered 'equal status', is the home for the person that identifies as a mixed methods researcher and believes that qualitative and quantitative data and approaches will add insights to most, if not all research questions. As one moves from the center of the continuum, mixed methods research can be labeled qualitative dominant or quantitative dominant. Qualitative dominant mixed methods research is when one relies on a qualitative, constructivist view of the research process, while concurrently recognizing the addition of quantitative data and approaches will benefit the project. Quantitative dominant mixed methods research

is when one relies more heavily on a quantitative, postpositivist view of the research process, while concurrently recognizing that the addition of qualitative data will benefit most research projects.

Other issues to consider in mixed method research include timing, mixing and theorizing (Creswell, 2009). Timing of qualitative and quantitative data collection can be performed in phases (sequentially) or gathered at the same time (concurrently) depending on the intent of the researcher. Mixing means that the quantitative data and qualitative data are merged on one end of the continuum or combined in some way between the two extremes by connecting the data, integrating the data or embedding one form of data within a larger study. Theorizing involves considering whether a larger, theoretical perspective guides the study design, which may shape all phases of the research process.

This Mixed Method Research for Study on Advocacy

This study is a mixed method research study on geriatric patient advocacy. Research questions in healthcare fields are often multifaceted since the phenomena of interest are highly complex and intertwined. Researchers immersed in a topic area are typically not only interested in what has happened (causal effects) but also in how or why it has happened, or how patients make meaning of what happened indicating why mixed methods are often required in research in this area (Tashakkori, & Teddlie, 2010). The increasing recognition of the complexity of factors affecting health and health care, and the desire to answer a wider range of questions about them, have often supported the use of mixed methods research (O’Cathain & Thomas, 2006).

The multidimensional nature of health care provided insight to suggest using mixed methods research to study physical therapists understanding of patient advocacy

for geriatric patients. The concept of patient advocacy is a complex one and I was interested in examining it from a critical gerontology perspective. To that end I examined patient advocacy issues from both strands of critical gerontology viewpoints: advocating for the individual elder person meaning perspective as noted in the humanistic pathway and also advocacy efforts from the structural or institutional perspective as noted in the political economy pathway (Minkler, 1996).

Justification for Mixed Methodology

Justification for a mixed method approach to studying patient advocacy can be viewed from philosophical and logical standpoints. A mixed methods research approach to study this topic can be based on the three of the characteristics of pragmatic philosophical foundation noted by Johnson & Onwuegbuzie, (2004). Pragmatism considers knowledge as being both constructed and based on the reality of the world and we experience and live in. The understanding of patient advocacy practices is articulated in the professional role of the physical therapist; however it is constructed in the field based on many experiential, cultural and institutional contexts. Also pragmatism takes an explicitly value oriented approach to research that is derived from cultural values. Patient advocacy practices require values, ethics and morality to be considered for effective care. Finally, pragmatism endorses practical theory. Understanding patient advocacy from an ethical and critical perspective informs effective practice for betterment of clinicians, patients and their families.

A mixed method approach for studying patient advocacy can also be justified based on the logic of mixed method research design. The purpose of mixing methods is to address two linked and equally important questions (O’Cathain & Thomas, 2006) and

combining elements for “breadth and depth of understanding and corroboration” (Johnson, et al, 2007, p. 123). Understanding of patient advocacy issues in geriatric patients leads to two related but separate questions: What is physical therapist professionals understanding of patient advocacy when working with the geriatric population, its importance, and use in the clinical setting. Second, how are those advocacy efforts carried out and what do they mean for the practitioner, for the patient and for the patients’ family. The first of these questions was answered by using quantitative descriptive and inferential methods. The second of these questions was answered by obtaining rich descriptive data regarding meaning of experiences. It was hoped that by combining quantitative and qualitative measures for this topic allowed this research to inform the field in a comprehensive manner and improve the quality of practice and education in the physical therapy profession

An Explanatory Sequential Mixed Methods Research Design

Creswell (2003) discusses approaches for mixed methods that are organized based on timing of data collection, integration or mixing of the data for the analysis and framework. This study utilized an explanatory sequential research design. I began with a survey of physical therapists working in the area of geriatrics and then proceeded to conduct qualitative interviews with selective participants that fit particular criteria discussed later. Mixed methods research designs are similar to conducting a quantitative mini-study and a qualitative mini-study in one overall research study (Johnson & Owuegbuzie, 2004). A sequential explanatory strategy utilizes components of equal status for quantitative and qualitative methods and is typically used to explain and interpret quantitative results by collecting and analyzing follow-up qualitative data

(Creswell, 2009). A sequential approach, using the quantitative analysis first optimized the cases for qualitative analysis and provided insight into relevant research questions.

For the quantitative aspect, survey methods were used to examine physical therapy professionals understanding and use of patient advocacy practices when working with geriatric patients in a variety of healthcare settings. Survey design provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population (Creswell, 2009). A purposeful sample of physical therapists working in geriatric settings was obtained by using information from the geriatric section of the American Physical Therapy Association. An appropriate survey instrument was developed by adapting a survey developed by Bu and Wu (2008) based on concept analysis of patient advocacy. (See Bu & Wu's original instrument in Appendix A) The survey consists of three sections designed to obtain knowledge and attitudes of geriatric patient advocacy in three advocacy realms: protecting patients' rights, acting on behalf of patients, and championing social justice. As the original survey was developed for nurses in a general health care setting, the survey instrument was modified to include rehabilitative care along with the term health care and the term nursing was changed to physical therapy. A fourth section was added to include items specifically related to geriatric advocacy practice behaviors inclusive of critical gerontology concepts including micro and macro advocacy practices within the barriers of institutional, political and economic systems. Data analysis included descriptive and inferential statistics, which assisted to identify practitioners who understand and utilize patient advocacy practices with a geriatric population.

The qualitative aspect involved in-depth, semi-structured phone interviews of practitioners based on the results of the quantitative analysis. (Selection criteria will be discussed later.) Interviews are often the major source of qualitative data used to uncover the essence of an individual's experience (Merriam, 2009) and also allow the researcher to reach areas of reality that would otherwise remain inaccessible such as people's subjective experiences and attitudes (Perakyla & Ruusuvuori, 2011). Focused questions were utilized to understand participants' meanings, perspectives and experiences regarding patient advocacy in geriatric settings. Thematic data analysis was performed based on a basic qualitative research framework with the purpose to understand how professionals make sense of their lives and their experiences.

Sample Selection

The current study made use of survey research methodology, and included survey participants from which a subgroup of participants was chosen for qualitative in-depth interviews. The interview questions build on the survey results and included open-ended questions based on the survey and critical gerontology framework. A discussion of the qualitative sample selection and interview questions follows the survey discussion. The survey research focused on a modified Attitudes toward Patient Advocacy Scale designed to measure attitudes, beliefs and intentions toward patient advocacy (Bu & Wu, 2008). It is designed to measure 3 components of patient advocacy: (1) safeguarding patient autonomy; (2) acting on behalf of patients; and (3) championing social justice. The survey instrument and its modification for this study will be discussed in further detail after the next section that examines the selection of the survey sample.

Quantitative Survey Sample

Participants for this study were licensed physical therapists currently working with geriatric patients in a variety of healthcare settings. The Geriatric Section of the American Physical Therapist Association (APTA) includes approximately 4900 licensed physical therapists throughout the United States. Participants were obtained by posting an invitation to complete the survey on the announcements section of the Geriatric section web-site and also was emailed to members of the Geriatric section of the APTA listserv. In addition I contacted and emailed geriatric physical therapists known to me to ask them to participate in the survey. As will be discussed in more detail in Chapter Four, 138 physical therapists completed the survey.

Qualitative Interview Sample

The purposeful sample for the qualitative interviews included 10 physical therapists who were selected following an analysis of the quantitative data. For the interview portion of this research, I asked survey respondents to provide their contact information, if they would be willing to be interviewed. In order to encourage survey participants to provide their contact information, I allowed all who submitted their contact information to participate in a random drawing for a gift card.

The respondents who provided their contact information were arranged by order of their scores on the quantitative survey from the highest to the lowest. Higher scores indicated an increased level of patient advocacy understanding and behaviors. The survey consisted of 60 five-point Likert scale type questions. The highest possible score was 300. The top 14 volunteer participants' survey scores were contacted by email to request

a follow-up interview. Ten participants responded and agreed to phone interviews. The ten participants will be described more thoroughly in Chapter Five.

Data Collection

In mixed methods research, two types of data collection occur. In the current study, quantitative data was collected and analyzed first. The results of this analysis were used to inform the qualitative portion. The next section will discuss the procedures used in the quantitative instrument development and data collection followed by qualitative data collection.

Survey Development

The quantitative measures with licensed physical therapists was designed to understand the level of attitudes or beliefs regarding patient advocacy and advocacy behaviors performed in geriatric clinical settings. This information was gleaned by a quantitative survey instrument conducted online. The survey is a modification of the Attitude toward Patient Advocacy Scale (APAS) developed by Bu and Wu (2008). It is a 60 item questionnaire with 49 items from the APAS and 11 items added based on a scale to elicit information regarding past advocacy behavior. Responses are in a five point Likert scale format where 1=strongly agree; 2=disagree; 3=neither agree nor disagree; 4=agree; and 5=strongly agree.

The Attitude toward Patient Advocacy Scale (Bu & Wu, 2008) assesses attitudes toward advocating for patients which is reported to be a “predictor of behavior intention and actual performance of the behavior” (p. 64). The instrument was developed to examine the attitudes and behaviors of nurses toward patient advocacy based on three components: (1) safeguarding patients’ autonomy which represents actions that respect

and promote patients' self-determination under situations in which patients are competent and want to be involved in their own health care; (2) acting on behalf of patients which represents actions that preserve and represent patients' values, benefits, and rights in situations when patients are unable or do not wish to help and represent themselves; and (3) championing social justice in the provision of health care which refers to actions to strive for changes on behalf of individuals, communities, and society as a whole, so that inequalities and inconsistencies in the provision of health care are identified and corrected. The survey was modified because in its original state it is directed primarily toward the nursing profession and does not include items intended to measure history of advocacy behaviors.

A section of the survey was informed by Betts' (2013) survey on advocacy which included past advocacy behaviors. Eleven questions related to each of the three advocacy constructs were designed to obtain information from the participants on their past advocacy behaviors. Table 1 is a summary of each of the construct definitions and the corresponding item numbers, which relate to the hypothesis for this research.

Table 1
Construct Definitions and Corresponding Survey Items

Construct	Construct Definition	Survey Item
Safeguarding Autonomy	Beliefs regarding PT's duty to safeguard patients rights and wishes	Items 1-22
Acting for Patients	Beliefs regarding PT's duty to act for patients unable or unwilling to act for self	Items 22-35
Championing Social Justice	Beliefs regarding PT's duty to act for social justice in the provision of health care	Items 36-49
Micro Advocacy Practices	Actions performed on behalf of individual patients	Items 50-55
Macro Advocacy Practices	Actions performed to champion social justice	Items 56-60

A copy of the survey can be found in Appendix B. The survey was disseminated using Qualtrics with a custom template to design both the questions and the Likert scale responses. Qualtrics enables the researcher to use or obtain unlimited questions and responses, random assignment and Statistical Product and Service Solution (SPSS) integration.

Qualitative Data

The primary focus of qualitative data is to understand a particular point of view within a specified context (Merriam, 2002). As such it is important to understand the point of view of physical therapists working in geriatric clinical settings. To do this, it was necessary to interview those geriatric patient advocates to understand their advocacy experiences and contexts that influence their advocacy beliefs and behaviors.

The results of the survey were evaluated to determine which participants were further studied via semi-structured interviews. Survey participants were selected to be interviewed based on a selection criteria related to individual survey results. Those participants whose scores indicate the highest level of patient advocacy understanding and behaviors were invited to participate in the interview process. Interview questions were utilized to obtain greater depth of information related to specific advocacy practices, the context surrounding those practices and the perceptions of meaning of the practices for the therapist and patient. The interview guide can be found in Appendix C.

To explore each person's understanding, I obtained in-depth information regarding individual experiences and perspectives of advocacy behaviors. The interview questions in general were created to obtain qualitative data regarding experiences in the practices of the participants and key factors which contribute to understanding and performance of patient advocacy behaviors. Current physical therapy literature on patient advocacy includes narrow descriptions of actions or situations that indicate need for advocacy. Thus, the interviews for the study were designed to uncover specific advocacy efforts and the context in which advocacy actions occurred. In addition, interviewees were asked about personal and demographic information that influenced advocacy efforts including: (1) tenure in the field of physical therapy working with geriatric patients, (2) relevant accounts relating to individual advocacy efforts, (3) relevant accounts relating to social justice advocacy, (4) frequency of using advocacy skills or knowledge in the regular course of their job, and (5) how they obtained their advocacy skills and understanding.

Due to time and geographic distance, interviews were conducted over the phone. All interviews were digitally recorded using a digital recorder and a device attached to the phone, which allows the conversation to be subsequently transcribed. Additionally, I kept a notebook for observations during the interviews.

Data Analysis

In quantitative research, the reliability and validity of data collection instrument are key considerations. Reliability is whether an instrument can be interpreted consistently across a variety of situations (Field, 2009). Validity is a measure of how well an instrument actually measures what it sets out to measure. The survey was developed from the Attitude toward Patient Advocacy Scale (Bu & Wu, 2008). The scale was initially analyzed for scale reliability using Cronbach's alpha test. Cronbach's alpha test is a statistical test designed to determine if all of the questions in the survey are consistent with each other (Field, 2009). The Cronbach's alpha test for the original APAS was 0.97 (Bu & Wu, 2008).

The survey results were analyzed using SPSS statistical software to answer the hypotheses. This analysis included descriptive and inferential statistics to examine patterns in the responses including relationships (correlations) among demographic information and specific responses and response patterns.

The interviews were transcribed and the observation notebook was reviewed for additional data, and as a method to triangulate the data. Together these were analyzed using the constant comparison method. The constant comparison method is used when the researcher compares one segment of data with another to ascertain similarities and differences (Merriam, 2009). Merriam (2009) outlines this four-step process of analyzing

qualitative data. The first step is to construct categories as the interviews are read. Once all the interviews are read and all of the categories were constructed they were sorted to combine like categories and create subcategories. Once the category possibilities are exhausted, they were named. The categories must (1) be as sensitive to the data as possible, (2) be exhaustive, (3) be mutually exclusive, and (4) be conceptually congruent. Finally, the categories were organized in a descriptive manner that assists the reader to visualize how the categories work together.

Qualitative data analysis was an ongoing process during data collection. After each interview, I transcribed the data, referred to my field notes and reflected on the content. Any insights gained from this activity were recorded in my notes. Participants were provided with the transcripts to check that the content recorded corroborates with their intended meaning.

I began the coding process by carefully reading my transcribed data along with listening to recorded interviews and analyzing the data for meaningful concepts. I created a list of categories to help me analyze the transcripts based on three broad constructs of my research questions: attitudes and beliefs of geriatrics; attitudes and beliefs of patient advocacy; and defining actions and experiences with advocacy efforts. The data in each category was then coded in relation to these constructs. I continued to add and revise the codes in the process and review of previous transcripts for new concepts. Themes emerged in each category along with several corresponding sub themes.

Verification and Trustworthiness

Mixed methods research relies on standard strategies to verify the trustworthiness of data for the quantitative and qualitative methods as well as specific approaches that

enhance the congruency between methods. Inference transferability is considered an important to the validation of mixed methods research (Teddie & Tashakkori, 2009). This term was created to blend both quantitative (inference) and qualitative (transferability) to define the way to combine both methods of research. Inferences in mixed methods research are conclusions drawn from the quantitative and qualitative strands of study (Creswell & Clark, 2011). According to Creswell and Clark (2007) inference quality is enhanced when a subgroup of the survey participants are used for the interview portion of the research.

The overall reliability of the Attitude toward Patient Advocacy Scale (Bu & Wu, 2008) is a reported Cronbach's alpha of 0.97 for the entire APAS and between 0.89 and 0.96 for each of the three subscales. Because the portion of the instrument based on history of advocacy behaviors was added to the modified APAS, rather than an actual reproducible instrument, the validity and reliability was constructed based on the results of a field test. Internal consistency is not required for the individual composites (3 advocacy attitudes and 1 advocacy action) because these subscales are not designed to be consistent with each other.

Dependability strategies are also important in qualitative research. Thus, three primary dependability strategies were used in the qualitative portion of the study. These include member checks, peer review and data triangulation. Member checks occurred throughout the process. Participants were asked to review interview transcripts. All participants reviewed the transcript from her interview and provided feedback. Each participants' input relating to their transcript interview was integrated into the final analysis.

Peer review also occurred in conjunction with the transcription, thematic analysis, data display, and findings. The peer review of the qualitative data was performed and reviewed with my advisor. Lastly, data triangulation was performed by reviewing the researcher notes and then compared to the thematic analysis and survey results.

Summary

The purpose of this chapter is to provide an overview of the methodology for the current research project. The chapter began with a rationale for the use of mixed methods. A discussion of the quantitative and qualitative phases of the research included identifying the sample population, sampling procedures for the quantitative survey and purposeful sampling criteria for the qualitative interviews. A discussion of the survey instrument included modification of Attitudes toward Patient Advocacy Scale for use with physical therapists with the addition of a history of advocacy behavior subscale. Questions for the semi-structured interviews came from the survey and modified to be open-ended. In addition, the data collection and analysis methods were presented. Finally, the chapter concluded with approaches to be taken to ensure verification and trustworthiness.

CHAPTER 4

QUANTITATIVE FINDINGS

The purpose of this mixed methods study is two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. This chapter focuses on the first of the purpose: to investigate physical therapists attitudes, beliefs and practices. The research questions that guide this study are:

1. What are physical therapist professional's attitudes and beliefs regarding patient advocacy when working with the geriatric population in various healthcare settings based on four advocacy constructs of:
 - a. Safeguarding patients' autonomy?
 - b. Acting on behalf of patients?
 - c. Championing social justice in the provision of health care?
 - d. Understanding of past patient advocacy efforts/actions?
2. What are the perceived practices or actions for geriatric patient advocacy in various health care settings in regard to:
 - a. Experiences of patient advocacy performed within the framework of critical gerontology?
 - b. Types of antecedents, barriers and consequences experienced when providing advocacy efforts?

- c. Perceived meanings of patient advocacy for the practitioner, for the patient and for their families?

A mixed methods research study was utilized, in order to gain a thorough knowledge of both the perceptions and the behaviors associated with geriatric physical therapist advocacy efforts.

The purpose of this chapter is to explore the quantitative data obtained from a patient advocacy survey designed for physical therapists who work with geriatric patients. The chapter will begin with a review of the construction of the advocacy survey utilized. Next, there will be a discussion of the demographic findings relating to patient advocacy beliefs and practices. The third section will explore the findings related to specific advocacy attitudes and tendencies. Finally, there will be a review of the hypothesis testing.

Review of the Construction of the Geriatric Patient Advocacy Survey

The quantitative data were collected by a patient advocacy survey administered to physical therapists who identified as working with geriatric patients in any healthcare setting. As discussed in Chapter Three, the survey was developed based on a modification of the Attitude toward Patient Advocacy Scale (APAS) (Bu & Wu, 2008) and a questionnaire that was created to obtain information on performance of activities or practices of advocacy efforts (Betts, 2014).

Survey Purposes

The Attitude toward Patient Advocacy Scale (Bu & Wu, 2008) assesses attitudes toward advocating for patients which is reported to be a “predictor of behavior intention and actual performance of the behavior” (p. 64). The instrument was developed to

examine the attitudes and behaviors of nurses toward patient advocacy based on three components: (1) safeguarding patients' autonomy which represents actions that respect and promote patients' self-determination under situations in which patients are competent and want to be involved in their own health care; (2) acting on behalf of patients which represents actions that preserve and represent patients' values, benefits, and rights in situations when patients are unable or do not wish to help and represent themselves; and (3) championing social justice in the provision of health care which refers to actions to strive for changes on behalf of individuals, communities, and society as a whole, so that inequalities and inconsistencies in the provision of health care are identified and corrected. The survey was modified because in its original state it is directed primarily toward the nursing profession. Additionally, survey items were deleted that appeared to reflect primarily nursing responsibilities in attempt to contain total survey length with the addition of the advocacy action/practice component that was added for this study.

The portion of the survey relating to advocacy behaviors and practices was created based on a survey of advocacy efforts developed and utilized by Betts (2014). The advocacy practices were determined based on individual advocacy efforts (micro social actions) or social justice advocacy efforts (macro social actions). The micro social actions were gleaned from the first two components of the APAS for actions that represent safeguarding individual patients' autonomy or acting on behalf of individual patients. The macro social actions were assembled based on the third section of the APAS which represents actions to promote social justice efforts.

The resulting combination of these surveys is the 60-item geriatric patient advocacy survey. The highest overall score is 300, by indicating a 5 of each of the Likert

scale items. The lowest score is 60, by indicating a score of 1 on each of the Likert scale items.

As discussed in Chapter Three, the survey link was initially posted on the website of the Academy of Geriatric Physical Therapists, which is a specialty section of the American Physical Therapy Association (APTA). The survey was subsequently emailed to current practicing physical therapists who belong to the Academy of Geriatric Physical Therapists via their listserv. The survey was also emailed to geriatric physical therapists known to the researcher and in each request for participation it was requested that the survey be shared with other geriatric physical therapists who may be interested on participating with the current research study. To provide further clarification for eligibility for participation, the survey was designed with an initial screener question. The initial question asked respondents if they were a physical therapist who worked with geriatric patients. A total of 157 respondents opened the survey. Of those, 153 participants responded that they were a physical therapist who worked with geriatric patients. Of the eligible participants, 121 completed all of the survey and 138 completed 70% or more of the survey. Some chose to complete all of the 60 items on the survey, however chose not to respond to some or all of the demographic questions.

Internal Consistency of the Instrument

Because the geriatric patient advocacy survey was created based on other survey instruments, it is important to examine the internal consistency of the instrument. The first 49 questions assess the attitudes and perceptions of geriatric patient advocacy based on three separate constructs: a) safeguarding patient autonomy, b) acting on behalf of

patients, and c) promoting social justice. The remaining 11 questions assessed the respondent's report of history of participation in advocacy practices or behaviors.

It is important to determine if items are sufficiently interrelated to justify their compilation into an index, measuring a unified construct. Cronbach's alpha was developed to measure if items on an instrument correlate well with each other to measure a similar construct (Cronbach, 1951). This relationship is called internal consistency. The indices were considered to have acceptable internal reliability if the Cronbach alpha was measured over .70 (George & Mallery, 2003). Cronbach alpha scores of over .90 are considered to have excellent internal consistency (George & Mallery, 2003). The results indicate the internal consistency for the geriatric patient advocacy survey and its individual components are excellent. Table 2 summarizes the internal consistency for the geriatric patient advocacy scale as a whole and the components that construct the overall instrument.

Table 2
Internal Consistency for Advocacy Survey

Item Scale	Item Numbers	Cronbach's Alpha
Overall Scale	1-60	.956
Patient autonomy	1-22	.929
Acting for patient	23-35	.912
Social Justice	36-49	.926
Advocacy actions/behaviors	50-60	.873

Demographics

It was the intent of this study to examine the attitudes and behaviors of geriatric physical therapists in all stages of their career and in a variety of healthcare settings. As such, it is important to examine the characteristics of the participants. In addition to advocacy survey items, the participants were asked to provide demographic information

including, age, gender, race, religion, years of practice, practice setting, educational degree, participation in student clinical education, specialist certification and formal advocacy training. The gender, age, and race/ethnicity characteristics are shown in Table 3.

Table 3
Characteristics of Respondents

Demographic	Number of Responses	Percent
Gender		
Female	117	85.4
Male	19	13.9
Age		
26-35	19	13.8
36-45	42	30.4
46-55	42	30.4
56-65	32	23.2
66-75	3	2.2
Race/Ethnicity		
White	129	93.5
Black/African American	1	.7
Latino	2	1.4
Asian	2	1.4
American Indian or Alaska Native	1	.7
Native Hawaiian	0	0
Other	3	2.1

Table 4 compares the demographics of the respondents to the demographics of the United States as reported by the 2010 U.S. Census (U.S. Census Bureau, 2010a) and more specifically, to the physical therapist members of the American Physical Therapy Association (APTA, 2013)

The field of physical therapy is largely a homogeneous group, when compared to the overall U.S. demographics. The field largely consists of white females, which is similar to the demographics of the geriatric advocacy survey respondents. While the survey respondents were largely homogeneous, tendencies in geriatric patient advocacy

perceptions and actions were explored. The demographic trends explored include age, gender, race, religion, years worked as a physical therapist, work setting. Each of these demographics is explored in detail.

Table 4
Comparisons among Survey Respondents, APTA, and 2010 Census Demographics

Demographic	Respondent	APTA	2010 Census
Average age	47.2	44.1	37.2(median)
Gender			
Female	85.4	69.9	50.8
Male	13.9	30.1	49.2
Race/Ethnicity			
White	93.5	91.7	83.6
Black/African American	.7	1.2	12.6
Latino	1.4	2.4	16.4
Asian	1.4	4.7	4.8
American Indian or Alaska Native	.7	.8	.9
Native Hawaiian	0	.3	.2
Other	2.1	n/a	6.2

Age

The advocacy survey respondents were between 26 and 75 years of age. The average age was 47.2 years. For statistical purposes, the respondents were grouped into five categories. Table 5 provides a summary of the age demographics for the current survey participants along with corresponding advocacy survey scores.

The majority of the respondents were equally distributed between the age groups of 36 and 45 years and 46 and 55 years. The largest advocacy scores were within the 66 to 75 age range, however, this was the smallest age interval. The results indicated that the lowest average advocacy scores fell within the 26 to 35 age range. A Oneway Between Subjects ANOVA was performed to determine if advocacy scores differed with each age interval. The overall results indicated that these differences were not statistically significant. As well, the differences in advocacy scores between any of the

age intervals were not found to be significant ($F_{(4,122)} = 1.01, p=.406$). Therefore, the age of the respondent did not appear to be significant in determining the advocacy survey scores.

Table 5
Age Differences between Advocacy Scores

Age Interval	N	Advocacy Survey M	Survey SD
26-35	19	239.00	22.91
36-45	42	244.18	23.81
46-55	42	244.95	23.93
56-65	32	251.96	22.94
66-75	3	257.50	33.23

Gender

There were 117 female and 19 male survey respondents. Table 6 provides a summary of the gender demographics of the advocacy survey respondents. The results indicate that females scored slightly higher than males. An Independent T-test was performed to determine if this difference was significant. The difference between female and male scores was not found to be significant ($t_{(119)} = -.473, p= .637$). Therefore, gender did not appear to be a significant predictor of advocacy scores.

Table 6
Gender Differences between Advocacy Scores

Gender	N	Advocacy Survey M	Survey SD
Female	117	245.88	23.56
Male	19	242.94	24.56

Race

The respondents were asked to identify their race. Table 1 indicates how the respondents identified their race of the geriatric advocacy survey. All of the identified categories were too small to run statistically sound analysis, with the exception of white. It was therefore necessary to combine all of the categories identified by respondents as

other than white to determine differences if identifying as a minority member. When examining advocacy scores, those who identified as non-white scored higher than those who identified as white. An Independent T-Test was performed to examine whether the difference was significant. This difference was found to be not significant ($t_{(119)} = -1.257$, $p=.211$). Therefore, race did not appear to be a significant predictor in geriatric advocacy scores. Table 7 summarizes these scores.

Table 7
Race Differences between Advocacy Survey Scores

Race	N	Advocacy Survey M	Survey SD
White	129	244.66	23.59
Non-white	9	258.20	23.00

Religion

Because religious beliefs may be an indicator of behavior, respondents were asked to identify their religion. The results indicate that most respondents reported to be of the Protestant faith (N=64) followed by the Catholic faith (N=37). Because some of the religious groups had very small respondents, it was not possible to determine the significance of the individual groups. To compare populations, it was necessary to combine groups into Christian and Non-Christian categories. The Christian group contained the respondents who identified as Protestant or Catholic.

The Non-Christian group consisted of all other reported religious affiliations. Table 8 provides a summary of advocacy scores for these two categories. The Christian subgroup had a lower average score when compared to the Non-Christian subgroup. An Independent T-Test was performed to examine whether the difference was significant. The difference was found to be not significant ($t_{(110)} = -1.148$, $p=.253$). Therefore, religion does not appear to be a significant predictor of advocacy scores.

Table 8
Religion Differences between Advocacy Scores

Religion	N	Advocacy Survey M	Survey SD
Christian	101	245.34	24.28
Non-Christian	25	251.86	21.96

Years of Practice

Years of experience working in a profession may also be an indicator of behavior, therefore, participants were asked to indicate the number of years they have worked as a physical therapist and more specifically, the number of years they have worked with geriatric patients. Table 9 provides a summary of the years of practice of the survey respondents.

The majority of respondents have worked greater than 21 years as a physical therapist and also worked greater than 21 years specifically with geriatric patients. The results indicate that the lowest advocacy scores were reported for physical therapists who have worked between 1 and 5 years of practice and between 1 and 5 years working with geriatric patients. The highest advocacy scores were reported for physical therapists who have worked between 11 and 15 years in the profession and also with geriatric patients. For each category a Oneway Between Subjects ANOVA was performed to determine if advocacy scores differed with years of practice. Results indicate no significant difference in advocacy scores based on overall years of practice working as a physical therapist ($F_{(5,111)} = 1.020, p. = .410$). Accordingly there was no significant difference in advocacy scores based on number of years practicing with geriatric patients ($F_{(5,110)} = 1.685, p. = .145$). Therefore, years of professional physical therapy practice does not appear to be a significant predictor of advocacy scores.

Table 9
Years of Practice Differences in Advocacy Scores

Years of practice	Overall practice		Geriatric practice	
	N	Mean (SD)	N	Mean(SD)
1 to 5	5	238.80 (28.69)	5	238.80 (28.69)
6 to 10	12	242.91(23.39)	13	245.67 (24.26)
11 to 15	18	257.56(26.63)	23	255.74 (27.08)
16 to 20	21	241.79(23.17)	30	237.71 (23.09)
21+	69	246.75(23.23)	54	249.91 (21.89)

Work Setting

In light of the different professional expectations required in different healthcare settings, respondents were asked to indicate their current work setting. Table 10 provides a summary of current work setting. When examining advocacy scores, those who work in ‘other’ settings scored the highest followed by those who worked in out patient settings, while those who worked in acute care hospital settings scored the lowest. Because the ‘other’ category did not provide the information to determine consistency of actual work settings for members of this group, this item group was removed from comparison data. A Oneway Between Subjects ANOVA was performed for all other groups to examine if the difference was significant. This difference was not found to be significant ($F_{(4,96)} = 2.47, p. = .053$). Therefore, work setting did not appear to be a significant predictor in advocacy scores.

Table 10
Work Setting Differences in Advocacy Scores

Setting	N	Advocacy Survey M	Survey SD
Acute Care Hospital	12	231.67	16.97
Subacute/SNF	36	236.84	24.72
Home Health	33	249.72	24.77
Acute Rehab Unit/Hosp.	10	250.78	25.57
Out Patient	13	254.17	21.64
Other	23	257.57	17.77

Educational Degree

The physical therapy profession has made a concerted effort to modify physical therapy education and advance the entry-level degree of its physical therapists. Initially, physical therapists were educated with via a Bachelor's degree or certificate post bachelor degree and in the 1990's the profession began to require physical therapists to receive a Master's degree (MS or MPT) in physical therapy. In the early 2000's the profession began the transition from Master's programs to Doctor of Physical Therapy (DPT). The progression in educational requirements reflect an advanced understanding in patient belief systems, community-based assessment and intervention and advocacy as required for excellence in practice (Threlkeld, Jensen, & Royeen, 1999). Due to changes in philosophy and curriculum, educational degree may be a predictor of beliefs and behaviors. Table 11 provides a summary of physical therapy degree. Results indicate the highest advocacy scores in those practicing with a certificate in physical therapy, however this was the lowest group of respondents. The lowest advocacy scores were noted in those physical therapists with a Master's degree. A Oneway Between Subjects Analysis of Variance was performed to determine if the difference in scores was significant. Results indicate no significant difference in score based on physical therapy degree ($F_{(3,111)} = 1.311, p=.340$). Therefore, physical therapy degree does not appear to be a predictor of advocacy attitudes and practices.

Table 11
Physical Therapy Degree Differences between Advocacy Scores

Degree	N	Advocacy Survey M	Survey SD
Certificate	4	251.50	35.54
Bachelor's	43	243.51	24.37
Master's	25	241.39	26.23
DPT	55	250.82	21.56

Clinical Education

Physical therapists working in various health care settings are often requested to participate in clinical education of physical therapist and physical therapist assistant students. As the entry-level physical therapy degree has advanced, so too has the amount of clinical education that students are expected to complete as part of their degree program. That being said, involvement in clinical education may have an effect on advocacy attitudes and practices and respondents were asked whether they participate in clinical education. Results indicate 58.3% (N=74) of respondents were involved in clinical education while 41.7% (N=53) were not involved in clinical education. While those involved in clinical education demonstrated higher advocacy scores ($m=250.38$, $sd=23.04$) than those not involved in clinical education ($m=241.43$, $sd=24.52$), results indicate that this difference was not significant ($t_{(110)} = 1.977$, $p=.052$). Therefore, involvement in clinical education does not appear to be a predictor of advocacy scores.

Specialist Certification

One method of pursuing professional development in the physical therapy profession is to obtain board certified specialization in a specific area of practice (geriatric, neurologic, pediatric, orthopedic, and cardiopulmonary, among others) by the American Board of Physical Therapy Specialists (ABPTS). In order to obtain specialist certification, a physical therapist must have completed a minimum of 2000 hours of direct patient care experience working in a certain area and then pass a national certification board exam. The process of pursuing and obtaining board certified specialist certification indicates advanced practice in the profession and may have an effect on advocacy beliefs and practices. Results indicate 42.5% (N=54) of respondents hold

specialist certification and 57.3% (N=73) do not hold specialist certification. Those who hold specialist certification (M=253.06, sd=21.43) scored higher on the advocacy survey than those without certification (M=241.44, sd=24.82). An Independent T-Test indicates that the difference in scores is significantly different ($t_{(110)} = 2.617, p=.011$) therefore, indicating that ABPTS certification does have an effect on advocacy attitudes and behaviors. Those with specialist certification have a more favorable attitude toward advocacy beliefs and practices.

Advocacy Training

Formal training in advocacy attributes or practices has not been found to be a part of typical entry-level physical therapist education, thus specific advocacy training may have an effect on patient advocacy beliefs and practices. The results indicate only 4.8% of respondents (N=6) have participated in formal advocacy training. Examples of formal training was reported be via the APTA (N=3), higher education coursework (N=2), or other continuing education (N=1). While advocacy scores of those with formal training in patient advocacy practices (M=261.17, sd=21.55) were higher than those without advocacy training (M=245.21, sd=23.72), an Independent T-Test indicated that these results were not significant ($t_{(108)} = 1.609, p=.111$). Therefore, the results of this survey indicate that there is no effect on advocacy attitudes and behaviors based on formal advocacy training.

Geriatric Advocacy Attitudes and Practices

The first 49 questions on the geriatric advocacy survey are a modified version of the APAS scale (Bu & Wu, 2008). The original APAS survey was developed to assess attitudes toward advocating for patients, which is reported to be “a predictor of behavior

intention and actual performance of the behavior” (Bu, & Wu, 2008, p. 64). The instrument examines the attitudes and behaviors toward patient advocacy based on three components: (1) safeguarding patients’ autonomy; (2) acting on behalf of patients; and (3) championing social justice in the provision of health care. Items 50 through 60 on the advocacy survey are questions related to past advocacy practices that would indicate actions of individual advocacy (micro social actions, items 50-55) society/social justice advocacy (macro social actions, items 56-60).

Safeguarding Patient Autonomy

The individual advocacy component of safeguarding patient autonomy represents actions that respect and promotes patients’ self-determination under situations in which patients are competent and want to be involved in their health and rehabilitative care. Bu and Wu (2008) consider this component consistent with micro-social behaviors. Items 1 through 22 on the advocacy survey assess physical therapist beliefs in safeguarding autonomy for their geriatric patients. These items ask respondents what they believe are important thoughts and actions when working with individual geriatric patients. More specifically, this section of the survey explores the belief that physical therapists should support the patients right to be involved in all aspects of their health care and be provided with the relevant information to be able to understand and make informed choices. This includes helping obtain health/medical information, helping weigh the risks and benefits of health care decisions, and supporting the patients’ right to refuse or make decisions that do not agree with their family or health care provider. This also includes reminding other health professionals of the patient’s rights, beliefs and decisions.

The average scores in these questions ranges from 3.98 to 4.71 which would indicate that the majority of the respondents believe that physical therapists at least agree or strongly agree to have favorable thoughts or beliefs regarding protecting patient autonomy. The belief question with the lowest average score was that physical therapists should respect the patient's wishes when they say they do not wish to know the truth about their health status and consequences (M=3.98). A similar low score was noted in the belief that physical therapists should support the patients' decisions even when patients' informed decisions regarding their care are incompatible with their physicians' plan of care (M=4.05). The highest average score in the safeguarding patient autonomy scale was the belief that physical therapists should make sure that the patients understand what is going to be done and what their experience will be like before performing any rehabilitative care (M=4.71). An equally high score was the belief that physical therapists should answer any questions in language they can understand when patients' have difficulty understanding instructions or treatment consent forms (M=4.71).

Acting on Behalf of Patients

The individual advocacy component of acting on behalf of patients represents actions that preserve and represent patients' values, beliefs, and rights in situations when patient are unable or do not wish to help or represent themselves. Bu and Wu (2008) also consider this component consistent with micro-social behaviors. Items 23 through 35 on the advocacy survey assess physical therapist beliefs in acting on behalf of their geriatric patients. These items ask respondents what they believe are important thoughts and actions when working with geriatric patients who are unable to help themselves or choose physical therapists to act for them for whatever reasons. More specifically, this section of

the survey explores the belief that physical therapists should examine, question and challenge decisions of providing or withdrawing medical or rehabilitative care when patients lack the capacity to decide for themselves. This includes working with patients' families and other health care professionals to facilitate collaboration regarding options that maximize the best care for patients who may be confused or unconscious.

The average scores in these items range from 4.03 to 4.83, which would indicate that respondents agree to strongly agree to having favorable thoughts or beliefs regarding physical therapists acting on behalf of their geriatric patients. The belief question with the lowest score was that physical therapists should question other health care providers' decisions when they believe health care decisions are not in the patients best interest (M=4.03). A similar low score was the belief that physical therapists should express patients' wishes for them if they know their values and wishes and they lack the capability to voice them (M=4.05). The highest average score in the acting on behalf of patients scale was the belief that physical therapists should act on behalf of patients when they ask the therapist to represent them (M=4.83).

Championing Social Justice

The advocacy survey component of social justice refers to actions that strive for changes on behalf of individuals, communities, and society as a whole, so that inequalities and inconsistencies in the provision of health care are identified and corrected. Bu and Wu (2008) consider this component consistent with macro-social behaviors. Items 36 through 49 on the advocacy survey assess physical therapist attitudes in championing social justice in the provision of health care. These items ask respondents what they believe are important thoughts and actions when working with

geriatric patients. More specifically, this section of the survey explores the belief that physical therapists should examine, critique, and participate in development of policies or projects that promote adequate health and rehabilitative care for disadvantaged populations. This includes items to question participation in institutional and political arenas and supporting legislation regarding policies that benefit people's health.

The average scores in these items range from 3.22 to 4.33, which would indicate that respondents range from neutrality to agree to having affirming thoughts or beliefs regarding physical therapists acting to champion social justice issues. The belief question with the lowest average score was that physical therapists should enter the political arena to represent physical therapy professionals in order to address problems existing in the health care system that negatively affect patient outcomes ($M=3.22$). The belief question with the highest score was the belief that physical therapists should strive to assure that health programs in the institution they work bring equally good health care to both advantaged and disadvantaged patients ($M=4.33$).

In general, the results of the attitudes and beliefs sections of the geriatric advocacy scale indicate that social justice scores were slightly lower than safeguarding patient autonomy scores or acting on behalf of patient scores.

Advocacy Practices and Actions

The advocacy survey component of practices and actions represents actual behaviors performed to promote individual or social justice advocacy. Survey items examine practices and actions performed in patient advocacy to safeguard geriatric patient autonomy, act on behalf of geriatric patients and champion social justice in the provision of health care. Items 50 through 60 on the advocacy survey assess physical

therapists' perception of actual actions performed in the past year. More specifically, this section of the survey explores the actions that physical therapists performed to ensure or assist individual geriatric patients receive optimal health and rehabilitative care (micro social actions, items 50-55) and also actions that physical therapists performed in regard to institutional or legislative policy examination, critique or development (macro social actions, items 56-60).

The average scores in these items range from 2.69 to 4.55, which would indicate a wide range of respondents' scores from disagree to strongly agree that they performed practices relating to patient advocacy. The advocacy action question with the lowest scores was physical therapists assisting in developing community services for homeless or disadvantaged geriatric patients ($M=2.69$). The advocacy action question with the highest scores was physical therapists ensured that patients understand what is going to be done and what the experience will be like prior to performing rehabilitative care ($M=4.55$).

Overall, the results of the action component of the advocacy survey demonstrated slightly higher scores for individual or micro-social actions (ranging from 3.33 to 4.55) than from scores for social justice or macro-social actions (ranging from 2.69 to 3.42).

In general, the majority of responses indicate that the advocacy survey respondents tended to have strongest attitudes and beliefs in the realm of safeguarding patients' autonomy and tended to have lower tendencies to performing social justice actions versus individual patient advocacy actions. Table 12 summarizes the survey findings for advocacy attitudes and practices.

Table 12
Summary of Advocacy Survey Components

Component	N	Median	SD
Safeguarding autonomy	138	4.41	
Acting on behalf of patients	138	4.27	
Social justice	138	3.87	
Advocacy actions	138	3.56(mean)	.655
Macro actions	138	3.96	
Micro actions	138	3.08	

*median score reported due to non-normal data distributions

Hypothesis Testing

The quantitative aspect of this study was designed to gather information regarding physical therapists attitudes, beliefs and practices regarding patient advocacy when working with geriatric patients. In order to fully understand individual advocacy constructs and beliefs, it is important to examine how well the individual components of advocacy correlate with each other and with practices performed in the realm of patient advocacy. In this section, the four hypotheses will be examined regarding physical therapists understanding of geriatric patient advocacy.

H₁

The first hypothesis is: Advocacy beliefs in regards to safeguarding patient autonomy will be positively correlated to social justice beliefs. To examine this hypothesis, it is necessary to determine if the questions on the advocacy survey relating to safeguarding patient autonomy are positively correlated with the questions relating to the social justice advocacy as defined in the APAS (Bu & Wu, 2008). Specifically, are questions 1 through 22 positively correlated with questions 36 to 49.

To determine if this hypothesis is supported, a Spearman Rho correlation test was performed. Spearman Rho correlation was chosen over the Pearson correlation test because the data in the data sets was found to not follow normal distribution patterns,

therefore non-parametric testing is preferable (Field, 2009). The results indicate that as the scores in safeguarding patient autonomy rise, there is a moderate significant correlation with social justice advocacy beliefs ($\rho=.419, p<.01$). For advocacy survey respondents, the higher the beliefs regarding safeguarding a geriatric patient's autonomy, the higher the social justice beliefs regarding geriatric patient care, thus H_1 was supported. Table 13 summarizes these findings.

H₂

The second hypothesis is: Advocacy beliefs in regards to acting on behalf of patients will be positively correlated to social justice beliefs. To examine this hypothesis, it is necessary to determine if the questions on the advocacy survey relating to acting on behalf of patients are positively correlated with the questions relating to the social justice advocacy as defined in the APAS (Bu & Wu, 2008). Specifically, are questions 23 through 35 positively correlated with questions 36 through 49.

To determine if this hypothesis is supported, a Spearman Rho correlation test was performed. Spearman Rho correlation was again chosen over the Pearson correlation test because the data in the data sets was found to not follow normal distribution patterns, therefore non-parametric testing is preferable (Field, 2009). The results indicate that as the scores in acting on behalf of patients rise, there is a large significant correlation with social justice advocacy beliefs ($\rho=.613, p<.01$). For advocacy survey respondents, the higher the beliefs regarding physical therapists acting on behalf of geriatric patients, the higher the social justice beliefs regarding to geriatric patient care, thus H_2 was supported. Table 13 summarizes these findings.

H₃

The third hypothesis is: Advocacy attitudes in regards to safeguarding patient autonomy, acting on behalf of patients and championing social justice in the provision of healthcare will be correlated with micro social advocacy practices relating to the individual geriatric patient. To examine this hypothesis, it is necessary to determine if the questions on the advocacy survey related to attitudes and beliefs are positively correlated with micro advocacy practices. Specifically, are questions 1 through 49 positively correlated with questions 50-55.

To determine if this hypothesis is supported, a Spearman Rho correlation test was performed. Spearman Rho correlation was chosen over the Pearson correlation test because the data in the data sets was found to not follow normal distribution patterns, therefore non-parametric testing is preferable (Field, 2009). The results indicate that as the scores general attitudes and beliefs in geriatric patient advocacy rise, there is a large significant correlation with micro social or individual advocacy practices ($\rho=.510$, $p<.01$). For advocacy survey respondents, the more favorable the attitudes and beliefs physical therapists reported regarding geriatric patient advocacy, the higher the individual advocacy practices relating to geriatric patient care, thus H₃ was supported. Table 13 summarizes these findings.

H₄

The fourth hypothesis is: Advocacy attitudes in regards to safeguarding patient autonomy, acting on behalf of patients and championing social justice in the provision of healthcare will be correlated with macro social advocacy practices relating to social justice. To examine this hypothesis, it is necessary to determine if the questions on the

advocacy survey related to attitudes and beliefs are positively correlated with micro advocacy practices. Specifically, are questions 1 through 49 positively correlated with questions 56-60.

To determine if this hypothesis is supported, a Spearman Rho correlation test was performed. Spearman Rho correlation was chosen over the Pearson correlation test because the data in the data sets was found to not follow normal distribution patterns, therefore non-parametric testing is preferable (Field, 2009). The results indicate that as the scores general attitudes and beliefs in geriatric patient advocacy rise, there is a large significant correlation with macro social advocacy practices ($\rho=.455, p<.01$). For advocacy survey respondents, the more favorable the attitudes and beliefs physical therapists reported regarding geriatric patient advocacy, the higher the institutional or political advocacy practices relating to geriatric patient care, thus H_4 was supported.

Table 13 summarizes these findings.

Table 13
Correlation Results for Hypothesis Testing

Hypothesis	Median	rho	Sig.
H ₁			
Safeguarding Autonomy Belief	97.00	.419	$p<.01$
Social Justice Belief	55.00		
H ₂			
Acting for Patient Belief	54.50	.613	$p<.01$
Social Justice Belief	55.00		
H ₃			
Advocacy Attitudes/Beliefs	205.50	.510	$p<.01$
Micro Social Practices	24.00		
H ₄			
Advocacy Attitudes/ Beliefs	205.50	.455	$p<.01$
Macro Social Practices	15.00		

Summary

The demographics of respondents completing the geriatric advocacy survey are similar to the demographics of physical therapist members of the American Physical Therapist Association (APTA). However, not all licensed physical therapists are members of the APTA. Therefore, while this may be that the current sample is representative of APTA members, it is unknown whether the current sample is representative of current practicing physical therapists in the United States. The advocacy survey and its individual components yielded Cronbach's alpha scores in the excellent range, indicating the instrument formed a unified construct. The results of the advocacy survey indicate that demographics of age, gender, race, religion, physical therapy degree, years of practice and formal advocacy training are not predictors of advocacy beliefs and practices. The only significant predictor of advocacy survey scores was physical therapists who have board certification in a physical therapy specialty area versus no certification.

When exploring the correlations between beliefs regarding individual micro social advocacy behaviors and macro social justice behaviors, the advocacy construct of acting for patients who are unwilling or unable to act for themselves was a higher correlation than safeguarding patient autonomy for patients competent and willing to act for themselves.

Finally, when exploring the results of advocacy beliefs and actions to history of advocacy practices, favorable advocacy attitudes and beliefs had a stronger correlation to micro social or individual advocacy practices than for macro social institutional or political practices.

The results of this survey data indicated overall favorable advocacy attitudes and beliefs and practices of physical therapists who work with geriatric patients. However, some items in each advocacy component area were less favorable than others, especially practices in the macro social or political arena. Qualitative interviews will now be utilized to explore these findings in greater depth. The goal of the qualitative interviews will be to gain a greater understanding of physical therapists' attitudes and experiences with performing advocacy practices in a variety of health care settings. Also to gain a greater understanding of the context of healthcare policy changes and beliefs regarding aging process and judgments based on these beliefs.

CHAPTER 5

QUALITATIVE FINDINGS

The purpose of this mixed methods study is two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. This chapter focuses on the second part of the purpose: to investigate the meaning and experiences physical therapists have with practices of geriatric patient advocacy. The research questions that guide this study are:

1. What are physical therapist professional's attitudes and beliefs regarding patient advocacy when working with the geriatric population in various healthcare settings based on four advocacy constructs of:
 - a. Safeguarding patients' autonomy?
 - b. Acting on behalf of patients?
 - c. Championing social justice in the provision of health care?
 - d. Understanding of past patient advocacy efforts/actions?
2. What are the perceived practices or actions for geriatric patient advocacy in various health care settings in regard to:
 - a. Experiences of patient advocacy performed within the framework of critical gerontology?
 - b. Types of antecedents, barriers and consequences experienced when providing advocacy efforts?

- c. Perceived meanings of patient advocacy for the practitioner, for the patient and for their families?

To investigate these questions, explanatory mixed-methods research was utilized in order to gain a thorough knowledge of both the perceptions and the behaviors associated with geriatric physical therapist advocacy efforts. The quantitative finding in the last chapter addressed the first research question. This chapter focuses on the findings related to the second research question. The methodology of the qualitative research process was discussed in Chapter 3. This chapter begins with a discussion of the qualitative participants' selection process and profiles of the participants including specific demographic information. Next, analysis of the interviews will be presented in terms of their emergent themes. Each of the themes will be discussed in terms of sub themes. Finally, a summary of the qualitative data findings will be provided.

Qualitative Participants and Data Display

The participants for the qualitative interview research process were selected based on the scores of the advocacy survey of attitudes, beliefs and actions of geriatric patient advocacy. The higher the score indicated the higher the participant's favored and participated in actions of geriatric patient advocacy. All survey participants were asked if they would be interested in participate in a follow up interview. All volunteer participants who scored higher than 272 (the 88th percentile) were contacted by email to request a follow up interview. A total of 15 persons qualified for interview selection based on survey score. Each was emailed with an interview request. A total of 10 persons responded with an agreement to be interviewed.

Participant Profiles

Each of the 10 interview participants in the study participated in digitally recorded telephone interviews, which were conducted and later transcribed. Brief profiles of the participants are included here.

Stephanie. Stephanie is a 39 year-old white female who reports to being of the Protestant Christian faith. She has been a practicing physical therapist for 15 years and worked primarily with geriatrics for 14 years. Stephanie is a Geriatric Clinical Specialist and works in a Critical Access Hospital which includes seeing patients in an inpatient, outpatient and skill nursing settings. Stephanie also is a faculty member in a Doctorate of Physical Therapy academic program.

Sarah. Sarah is a 61 year-old white female who reports to being of the Protestant Christian faith. She has been a practicing physical therapist for 40 years and worked with primarily geriatric patients for approximately 20 years. Sarah is a Geriatric Clinical Specialist and works in an acute care hospital.

Melissa. Melissa is a 47 year-old white female who reports to being of the Protestant Christian faith. She has been a practicing physical therapist for 14 years and worked with primarily geriatric patients for a reported 99% of her work post-graduation. Melissa is a Geriatric Clinical Specialist and works in private practice seeing patients primarily in their homes.

Rachel. Rachel is a 75 year-old white female who reports to being of the Protestant Christian faith. She has been a practicing physical therapist for 54 years and worked with primarily geriatric patients for approximately 6-7 years. Rachel works in both outpatient and home health care settings.

Donna. Donna is a 69 year-old white female who reports to being of the Protestant Christian faith. She has been a practicing physical therapist for 47 years and worked with primarily geriatric patients for approximately 14 years. Donna works in the home health care settings.

Diane. Diane is a 47 year-old Asian female who reports to having no religious affiliation. She has been a practicing physical therapist for 9 1/2 years and has had a caseload of 60-70% older adults for her entire career. Diane is a Geriatric Clinical Specialist and works in a large medical center and rotates in acute care and outpatient settings.

Olivia. Olivia is a 37 year-old white female who reports to being of the Catholic Christian faith. She has been a practicing physical therapist for 11 years and worked with primarily geriatric patients for most of that 11 years. Olivia is a Geriatric Clinical Specialist and works in outpatient and skilled nursing settings.

Karen. Karen is a 55 year-old white female who reports to being of the Protestant Christian faith. She has been a practicing physical therapist for 18 years and worked with primarily geriatric patients for approximately 11 years. Karen previously worked in a continuing care retirement community and recently began working in a rural outpatient setting.

Emily. Emily is a 56 year-old white female who reports to being of the Catholic Christian faith. She has been a practicing physical therapist for 34 years and worked with primarily geriatric patients for approximately 27 years. Emily works in a skilled nursing facility and is also a faculty member in a Physical Therapist Assistant program in a Community College setting.

Hannah. Hannah is a 58 year-old white female who reports to being of the Catholic Christian faith. She has been a practicing physical therapist for over 25 years and worked with aging adults for most of that time. Hannah is a Geriatric Clinical Specialist and has experience in all health care settings. Currently Hannah works in the outpatient setting and teaches in Academic and Continuing Education settings.

Summary of Participant Demographics

A summary of participants is presented in Table 14. Each of the ten interview participants was female. Nine of the ten interviewees were white, one was Asian and they ranged in age from 39 to 75 years. Participant work experience as a physical therapist ranged from 9 years to 54 years and their tenure of experience with aging adults ranged from 9 years to 27 years. Six of the interviewees were credentialed physical therapy specialists in geriatric care (GCS).

Table 14
Interviewee Demographic Information

Alias	Age	Race	Years as PT	Years with Geriatrics		Work Locale
Stephanie	39	White	15	14	GCS	Critical access hospital
Sarah	61	White	40	20	GCS	Acute Care
Melissa	14	White	14	13+	GCS	Private practice
Rachel	75	White	54	6-7		Outpatient and Home health
Donna	69	White	47	14		Home health
Diane	47	Asian	9 1/2	9	GCS	Acute and Outpatient
Olivia	37	White	11	11	GCS	Outpatient and Skilled nursing
Karen	55	White	18	11		Outpatient
Emily	34	White	34	27		Skilled nursing
Hannah	58	White	25+	25	GCS	Outpatient

GCS=Geriatric Clinical Specialist Certification

Analysis Summary and Data Display

Analysis of the interviews was conducted in light of the research questions and theoretical framework, and discussion of the data was organized in the categories of shaping the physical therapists attitudes and beliefs regarding *geriatrics*, constructing their attitudes and views regarding *patient advocacy*, and defining actions and experiences of advocacy efforts. Within each of these categories themes emerges with several corresponding subthemes. Table 15 outlines the categories, themes and sub-

themes, which emerged from the interviews. Each of the themes and subthemes are then discussed, followed by a summary of the chapter.

Table 15
Qualitative Data Display

Category	Themes	Sub-themes
Shaping Attitudes and Beliefs of <i>Geriatrics</i>	Becoming passionate about geriatrics	Falling into geriatric work Developing a passion
	Perceiving older adults as marginalized	Age bias Paternalistic care
	Embracing professional duty	Medical/social complexity Feeling positive about impact Significant relationships
Constructing Attitudes and Beliefs of <i>Patient Advocacy</i>	Traversing the bureaucracy of healthcare	Convoluting System Restricted practices Productivity demands
	Empowering voices	Patient's voice Therapist's voice
	Enabling individuals	Protecting rights Vicarious advocacy
	Championing community and political responsibility	Political obligation Community obligation Professional obligation
Defining Actions and Experiences of Advocacy efforts	Challenging limits	Challenging medical limits Challenging system limits Challenging personal limits Challenging attitudinal limits
	Seizing/Maximizing opportunities	Collaboration Tools Resources Personal fortitude Choices
	Preparing/Protecting the future	Education Mentors

Shaping Attitudes and Beliefs of Geriatrics

The first category of three themes that was gleaned from the interviews was the characteristics of shaping the general attitudes and beliefs of physical therapists regarding their work with geriatric patients. The three themes included the road that led the participants to become passionate about working with geriatric patients, the perception that older adults experience age bias and may be marginalized in the healthcare system and the features that cause physical therapists to embrace the challenge of working with older adults.

Becoming Passionate about Geriatrics through Happenstance

The interviewees were asked to share information regarding their history of deciding to focus their career efforts to work with geriatric patients. This first theme describes the path that led them to geriatrics and then the resultant passion that they feel toward working with aging adults.

Falling into geriatric work. Most interviewees reflected to not having a plan to work with geriatric patients early in their career and then a seemingly innocuous situation put them in contact with a geriatric patient or setting that instigated their interest and subsequent commitment to caring for these patients. Karen related her experience of taking a position in order to move from a staff position to gain management experience, which happened to be in a skilled nursing facility, stating “I just sort of fell into it. It wasn’t a conscious decision to move in to geriatrics. It just happened.” Olivia reported her interest came from working with one geriatric patient in an out-patient clinic, stating “a movement disorder specialist (physician) was looking to refer his Parkinson’s patient

somewhere. So that's where it started and as I grew in that experience, I became more interested in the older adult population.”

Hannah related her experience that led her to the commitment to aging adults came after an initial poor experience early in her career. She described how she then worked in several healthcare settings throughout the country (not with aging adults) and frequently became bored with her job. Ultimately she ended up rotating as needed between settings in a large healthcare organization and realized that her diverse experience with a lot of diagnosis was a perfect fit for the aging adult population and “this is what I loved to do, because I liked seeing people who had multiple different kinds of diagnosis...and from then on I gravitated toward that.”

Developing a passion. Ultimately all of the participants reported that working with geriatric patients has become a passion that allows much personal and professional satisfaction. Most interviewees relate how aging adults have so much to give and have stories to tell. Diane stated, “older folks have stories to tell you and I have a lot of learning experiences from them.” She goes on stating “I love to working with geriatrics and empowering them and showing them that there are actually a lot of things they can do.” Olivia concluded “I do not have a very specific path that led me to geriatrics, however now I cannot imagine not being a geriatric clinical specialist.” Hannah notes that when working with older adults “you are just in love with what you do, you just want to really do a good job every time, every patient...and your ability to think outside the box becomes strengthened, you become a much stronger clinician.”

Perceiving Older Adults as Marginalized

The second theme to emerge in this category relating to the shaping of their attitudes and beliefs is that participants described the need for quality patient care and advocacy efforts in the geriatric population due to the tendency of health care professionals to view and treat geriatric patients differently than younger patients. The interviewee's commonly described observing healthcare of older adults to be provided with an age bias and delivered in an authoritarian manner.

Age bias. Many interviewees reported that they see an age bias in many aspects of healthcare that was either reported by their older adult patients or personally observed in healthcare settings. Emily reported her patients have told her of their perception that they are treated a certain way because they are old and therefore deemed “never going to be independent again and thus feel like a burden.”

Participants also commonly believed that health professionals look at aging adults as a simplified diagnosis or a single problem defined by their age. Rachel describes this stating “I think we have put them on the shelf.” This view then becomes a bias in rationing of care with some patients considered too old for some medical procedures or providers being selective in who gets certain services or provisions. Melissa observes this bias in the inability to obtain the proper Durable Medical Equipment (DME) to help keep a patient functioning independently stating the provider “discriminated against my patients saying my patients were too old for their equipment.”

Hannah describes “just because they are medically complex and have co-morbidities, does not mean that they are destined not to be a contributing member of society.” And goes on to proclaim the importance of the need:

To eliminate age bias. And if we don't eliminate bias because they are too old to get the surgery; or they are not a working contributing member of society so they don't need that kind of care; then we are really going down an avenue that is scary, because we are starting to be selective with who gets services and who does not.

Paternalistic care. Many participants also described the authoritarian methods of providing care to aging adults in terms of negating the older adults own knowledge and ability to be an active participant in their own care.

Rachel noted that through her own personal experience (at 75 years of age) and observing her geriatric patients:

The experience I had with other people that I have been involved with, if you have grey hair and wrinkles, then you do not know anything. Doctors have a tendency and people have a tendency to dismiss the older patient, or the older person in the store. Disrespectful. You are too old to know anything.

Sarah goes on to note that older adults “may be slightly reluctant participants in medical care or are raised that the physician is an authority figure, and therefore is always right, and not to question authority” and ultimately “geriatric patients tend to be rushed through the system.” Donna agrees that for older adults “others are making decisions for them, they may be passive and therefore they get run over or passed by.”

Embracing the Professional Duty of Working with Aging Adults

The final theme in this category relating to the shaping of attitudes and beliefs is the fact that the interviewees come to see working with older adults as their professional duty. The emphasized that the love and commitment to working with older adults comes

from the opportunity of the therapist to see a wide variety of patient diagnoses and situations which presents a professional challenge and fosters their professional duty. This duty then allows the physical therapist the ability to have a significant impact on the lives of those they treat.

Medical and Social Complexity. Several of the participants shared the intellectual challenge of working with older adults includes medical and social complexity and the ability to see people of different physical therapy practice patterns. They noted the responsibility to look at all functional needs in multiple domains and look at the whole situation with consideration of context. By viewing the individual in a broad framework allows the physical therapist to identify things that might not otherwise be identified. Sarah reported her duty in the belief that aging adults have led complex lives up to this point and have multifaceted problems:

I've done a lot of home care in the last 20 years and so there is so many interesting social and ethical and pharmacologic as well as physiologic things that you need to just keep kind of swirling through your head as you are working with people. It just makes in more interesting.

Melissa describes the aging adult population to covers a large age span from young old to 'gero-geriatrics' and patients often become more complex with increasing age with more medical issues and impairments and functional limitations and disabilities than younger patients.

In addition to the complex medical issues in the care of older adults are the multi layered social factors that affect an older adult's health and healthcare. Sarah describes many elderly patients do not have others invested in their outcomes:

It's not always the case, but the elderly often have family or children who mean well, who want well, but are confused or have all this emotional stuff, baggage, from a lifetime with this person; and it's very interesting to watch how adult children cope because very often they are not ready to let that person stop being a parent.

Karen also relates embracing the challenge in the recognition that geriatric clients are different from younger clients:

We understand they are different and respect their needs. The thirty something patient who comes in because he's had his knee scoped and he just wants to get back to running or walking or whatever and that is a totally different animal than the 80 year-old who had a stroke, or he's had a knee replacement and we need to understand that they are very different. They want different things from us. That 80 year-old not only wants us to help us get his knee better but he also wants me to respect what his needs are...the 80 year-old more than likely wants me to be there a little bit more for him...they are going to take that extra five minutes at the end of the therapy session.

Feeling Positive about Professional Duty. The therapists interviewed reported that the large aging population and their multifaceted needs allows the physical therapist to have a significant positive impact on the lives of many aging adults. Each of the participants reported seeing aging adults in all areas of physical therapy practice.

Karen describes this impact of seeing geriatric patients in many practice settings and states aging adults:

Are getting their joint replaced, they are have surgeries to keep them alive longer, and medications to keep them alive longer. And we are going to have to take care of them. Even if students go into sports medicine, they will run into geriatrics.

Participants also describe the duty not only treat their impairments and functional limitations, but to give them the tools for future issues. Olivia describes helping “to manage the whole package and knowing that you do not have to wait until something happens to actually prevent it. Working to prevent the falls before there is a fractured hip.”

Finally this duty is seen as an obligation to support and promote quality of life. Emily refers to her position as “essential to the quality of life for my patients.” Hannah feels similar in that:

It is not only my role to help them get over whatever brought them in, but to give them the tools to take care of themselves for future issues. I truly believe that if I just help them over what caused them to come in, I am not doing them any service but am allowing them to be a revolving door.

Significant relationships. Most participants report embracing the duty of working with aging adults as it stems from the relationships that are developed and the support that becomes important to try to help their patient get better. Participants note physical therapists spend more time with patients than other health professionals and often becomes an important person in the patient’s life. Diane notes “I think a lot of times patients spend more time with us, they are more honest with us and they tell us what their wishes are and I stand firm on what the patient wants and needs...and when they open up more honestly so we can discuss more openly, that makes me a good

advocate because I know truly what is happening, what is truly going on in his or her environment and within themselves.”

Karen describes the relationship “so you can really become a very important person in your patient’s lives as a physical therapist. I’m not sure new grads learn that or understand the impact that they can make on the older patients lives. Because you’re touching them, talking to them, and engaging them, and sometimes you are their social outlet. Sometimes you are the only person in their lives that is showing them respect.”

Olivia describes a specific patient “who did very well with therapy and she has the capacity to leave her home, but can’t. And so she is depressed and definitely needs the social support and I started becoming that for her.”

Constructing Attitudes and Beliefs of Patient Advocacy

While the first category focused on physical therapists’ attitudes regarding *geriatrics*, the second category describing the interviews was constructing the physical therapists attitudes and beliefs regarding providing patient *advocacy*. As noted in the literature, advocacy is a broad topic with many ways to describe. Four themes emerged in regards to attitudes around patient advocacy including the many issues and forces in the business of healthcare, the concept of empowering voices, enabling individuals through patient advocacy and championing the social responsibility of patient advocacy when working with geriatric patients.

Traversing the Bureaucracy of Healthcare

The first theme in this category stems from each of the interviewees discussing advocacy as related to the restrictions and requirements of their work settings related to

the business aspects of healthcare. These issues are describes as a convoluted healthcare system, restricted healthcare practices and challenging productivity demands.

Convoluted system. Most participants discussed advocacy needs as mired in the complex financial, reimbursement, payment and other organizational factors that make up the United States public and private healthcare system. Interviewees describe the significant financial barriers that their patients endure along with Medicare and HMO restrictions that are constantly changing. Medicare was described specifically, since it is a primary payer for many aging adults, as a huge convoluted system that is not only big but hard to navigate. Sarah describes Medicare as “quite tricky, navigating a complex system that may be often uncomfortable for patients and families.”

Rachel describes the process of “tiptoeing through Medicare as carefully as I can...for whose benefit, for the patients benefit. It is a very complicated system and the patients do not understand and I really work very hard on helping them to understand Medicare and making sure they understand why and helping them be a part of process as much as possible.”

Donna discusses the healthcare system and the bureaucratic barriers along with “figuring out how to maneuver through them, around them, over them, break them down, or tear them down.”

Restricted practices. All of the participants described the bureaucracy of healthcare in terms of the restricted practices that are constantly evolving in all areas of care. These practices include how facilities staff physical therapists, job related documentation and other duties required of professionals, and decision making for

physical therapy care, each of which stem from pressures to increase minutes of therapy that will increase reimbursement to facility.

Many of the interviewees described the changes in how healthcare institutions hire and staff their therapy departments. Therapists noted the increasing use of contract companies being brought in to manage therapy departments with the promise and goal to make money for the institution by ‘maximizing’ the provision of rehabilitation services. Companies are also using more PRN (as needed) therapists so there is a lack of consistency in care for patients. Melissa notes these changes cause “facilities do not have a good grasp on what is going on in the rehab department.”

The duties of the physical therapist also are changing and becoming restricted in the name of cost savings and maximizing reimbursement for facilities. Many responsibilities involved in comprehensive and best-practice patient care are not reimbursed and therefore not promoted by institutional management. These duties include phone calls to physicians, meeting time with families or other members of the health care team and documentation of patient care services. Many of these duties make up the foundation of advocacy efforts and therefore professionals are not paid for advocacy unless we are doing it in front of or directly with the patient. Diane describes “changes in healthcare documentation, specifically documentation for the Medicare system (the main insurance provider for aging adults), causes care to become more complicated.” And although documentation is critical for legal and financial reasons, it is allotted limited time in the physical therapists day to complete.”

The ultimate decision making capacity of physical therapists in regards to geriatric patient care is an alarming issues discussed by several participants. Interviewees

noted that administrators and directors of rehabilitation are making rehab decisions to have a patient receive therapy or remove them from therapy services and these decisions are made with regard to financial benefit overshadowing patient benefit. Also administrators making decisions regarding the frequency and duration of services that do not always directly correlate to the evaluating therapist's professional recommendation. Rachel refers to this model negatively as an "assembly line approached to patient care."

Participants also noted implicit and explicit demands for therapists to make decisions to move patients to lower levels of care which are less expensive for facilities to operate. For example, Sarah notes "pressures for patients seen in the emergency department to be sent home and not admitted. Also pressures for patients in 'observation status' to be sent home and not admitted" as it is deemed financially better for the institution. Donna also notes pressures from administrators of retirement communities to encourage clients into different living situations as "management of retirement communities wanting to move patients through the continuum of care because it increases payment to institution."

Olivia describes her advocacy role in this issue to stay firm in her own decisions for therapy to be provided or not. "Yes I advocate that patients are taken off therapy too. Sometimes they don't need therapy, they do not qualify...we need to take them off therapy, put them on restorative nursing (to continue with a maintenance program) or send them home. They don't need two more weeks of therapy because we can't document the skilled need and that it is reasonable and necessary."

Melissa succinctly describes these bureaucratic decisions as "the 'culture of practice' in doing what someone tells you based on financial practices; and the pressures

to see as many patients as possible and the rules and regulations of healthcare where people are like cattle and driven into a very defined scope of practice, very small compared to what is truly possible when working at the ‘top of your license’.”

Productivity demands. Similar but distinctly separate in the bureaucracy of healthcare was the discussion of productivity demands that were noted by most therapists to be permeating all areas of healthcare. Productivity demands in many healthcare settings includes a therapist being paid or compensated for only activities that involve direct, reimbursable patient care. These were noted to be increasing in size and scope.

The majority of participants described productivity restrictions along with noted changes in reimbursement acting to limit visits and change practice patterns to dramatically reduce the time therapists spent with patients. Rachel describes the struggle with:

The pressures and how you are supposed to do things, and a time element, and the productivity. The ‘P word’, and that was the hardest thing to deal with when I used to work in the acute hospital, the productivity. Because I am not a widget worker...these are human beings that we are working with and sometimes you can work quickly with one and sometimes you cannot.

Ultimately most interviewees describe the difficulty to challenge productivity constraints in their work setting as a requisite for advocacy practices. Karen further concludes that due to the recognition of financial implications of patient care, to change financial impact, the therapist must come out with “guns blazing and lots of resources”.

Empowering Voices

The second theme that emerged in this category on the therapist's attitudes about advocacy was that most of the participants interviewed used the term of supporting or promoting 'voice' when speaking of advocacy concepts and responsibilities, both in terms of the patient's voice and the therapist's voice.

Patient's voice. The participants often spoke in terms that describe how geriatric patients lack a voice and they need and deserve to have their 'voice' heard in regards to their health and health care needs and desires. This can include advocating for people who don't have a voice, when a patient needs someone to speak up for them, if they do not understand or are being treated poorly.

Encompassed in the discussion of voice, interviewees describe how it is very important to find out not just what you feel the aging adult needs, but find out what they actually need. This involves looking at patient as an entire person and the need to filter through the complexity of the situation to figure out the patient's individual needs. Stephanie describes how to find out what the patient states is their wants and needs "and that becomes my agenda."

Karen also describes the patient's voice and the need to "be able to help tell the patients story when it needs it, and be another voice or that hand on the shoulder, and that I'm there for you when you tell your story. And try to get the services you need." Diane further describes the importance of respecting the patient's voice and to "listen to the patient and they will tell you what their problem is and they will tell you how to solve that problem, and it is your listening skills that are most needed."

Therapist's voice. The theme of voice was also described by the participants in light of the therapist's voice and using that voice to empower and advocate for aging adults. Rachel describes the importance of "standing up for them (aging patients). It is being another voice of support and helping to ask questions...And also communicating with other healthcare providers, the doctor, the doctor's office" Olivia notes the need to "using your voice to initiate a co-advocate and get an ally in the advocacy process." And Hannah describes how she found her voice and is to using her voice to speak up on a national macro-social level "I found my voice, I started speaking up, I starting writing and responding and making posts on the APTA blogs."

Some participants discussed the difficulty in getting their voice heard due to where you are in the hierarchy of the organization and feeling a lack of power that limits their voice. Emily describes the importance of "getting across the idea... why I feel advocacy in this situation is important."

Sarah shares the importance of getting her voice heard in a situation where there is disagreement between the family and the patient:

They may not take the course that I want laid out but it's not through disregard. You know they'll say, well that might be a good point in whatever the situation is. So that's really what you want in advocacy, right, you want your point to be heard. It's not always important that you be the right point...but by getting the family on board in a non-threatening, non-patronizing way, then get the family to look at the client through different filters, different eyes, that is sometimes a challenge.

Enabling Individuals

All participants discussed the topic of geriatric patient advocacy in terms of their responsibility to enable each individual patient with which they work. Individual advocacy responsibility was presented in terms of protecting the patient's rights and also in the vicarious advocacy that often occurs when working with individual geriatric patients.

Protecting the patient's rights. All of the interviewee's had strong beliefs regarding their advocacy obligations to their individual geriatric clients. These attitudes revolve around providing support and assist when a patient needs their rights supported and also in providing support and assist when a patient may be unable to make their needs known.

Participants describe protecting a patient's expressed views as empowering the aging adult to promote and protect dignity. This may include advocating for those without access to services or those affected by socioeconomic status and culminates with getting the right resources to the right person at the right time or getting the patient in the right place to allow them to reach maximal functional capacity. This also includes helping someone help themselves and as Diane states not being "a fixer" but supporting their abilities.

The belief in advocating for right of patients to make their own decisions, Karen describes how physical therapists "can help families learn and educate them on how people can stay and age in place...giving them options...and see how they are coping, and maybe it does not look like what would be ideal for us, but they are clean, safe,

eating, and well maybe they are only living in three rooms of their 12 room house, but they are still okay, they are safe.”

Another example of empowering individual patients is speaking to the family or other health care providers on the patient behalf. Rachel describes supporting the patient rights with the family, “it’s working with the family members, and I’m helping or being a buffer. I am there and I tell them that I am an advocate and I’m there and I will do what I can to be of support to them because I am there for them. Because my primary concern is for them and how I can be of support and help and be a guidance.”

Protecting the individual patient’s rights also includes advocating for those who cannot advocate for themselves and helping the patient achieve the best life they can and be the most active that they can. Donna states “this involves looking out for the respect of patients we have in front of us, for example if a patient has dementia and is not making wise choices.” Emily reports this is “important because the patient may not have anybody else to do this, especially those with cognitive or speech issues.”

Hannah also exemplifies this need when they do not know what to ask. She describes an example of fighting for individual needs “I had a patient, a man who had fallen through the cracks with his prosthesis. And he couldn’t afford it, and there issues about what happened and where did the ball get dropped. And so I had to intervene to get the services he needed back involved to help him...to get him in touch with the right people.”

All of the participants also underscored the importance of the foundation of empowering and protecting individual patients is the full recognition of what is

motivating to our patient, what *their goals* are. This begins with understanding, before you can advocate *for*, you need to know what the *for* is.

Vicarious advocacy. Another component that emerged in the theme of empowering individual patients was in terms of vicarious advocacy. Several participants discuss the benefit of advocating for client interests also provides for advocacy for those persons who surround the client. Being positive, supportive, respectful and encouraging allows for patient and family appreciation and reinforcement of going the extra step.

Stephanie describes how advocating for geriatric individuals is also advocating for their family and grandchildren. She describes “we have seniors in our community that are also taking care of their grandchildren and so being an advocate for them is also being an advocate for their grandchildren, because if we keep them well and healthy then they can perform their duties and their abilities and they can perform everything they want to accomplish in life.”

Championing Community and Political Responsibilities

The final theme in this category is advocacy beliefs and attitudes in the broad macro social scale. Most participants interviewed discussed advocacy for geriatric patients in terms of social responsibility in terms of attitudes regarding advocating for social concerns and describing advocacy beliefs in the social realms including political, professional and communal. Olivia describes “if we don’t have a group voice, with concerns related to overall healthcare, related to reimbursement issues or related to other things, then we are doing our patients a disservice.”

Political obligation. The first sub-theme in the social advocacy realm is the belief that advocacy is important in the political arena to address political and policy

issues. Policy issues are described in relation to overall fairness of reimbursement in all aspects of health care for therapists to have equitable funding for the services they provide. Also policy changes are needed to allow changes in the increasing reliance of companies on strict productivity standards that are seen as directly impacting quality of care for aging adults.

Participants describe the need to be politically active in areas of payment reform which may include the need to contribute financially or write appropriate letters when urged to do so by the American Physical Therapy Association (APTA). Interviewee's agreed that the APTA is a strong leader and guider in political advocacy and sends a strong message to therapists along with suggestions and methods on how to advocate in the political arena effectively.

Olivia agrees to the importance of political advocacy but cautions "in the general physical therapy realm, advocacy means giving money but if you support the APTA Political Action Committee (PAC), it is sometimes without a clear understanding of what the money is for. Whether it is to lobby in Washington or in your state we need to know about what one person can do to advocate for one person versus how you can have an effect on a larger scale than that...so I think there is not enough understanding of what my donation might mean in terms of advocacy."

Emily notes:

If you were going to make a diagram of advocacy, your top is political advocacy and trying to get rid of therapy caps, trying to get the fairness in reimbursement between occupational therapy, speech therapy and physical therapy. We have had

walks on Capitol Hill in Washington and have made some improvements. But it is an uphill battle always.

Community obligation. The second sub-theme in the social advocacy realm is the belief that advocacy is important in the community arena including assessing and meeting individual community needs and addressing or fixing problems in the community from a prevention or wellness standpoint. Most participants reported the belief in this type of advocacy and provided examples including getting out in the community and doing community awareness or being a community, aging or disability resource. This includes being an advocate for issues prevalent in geriatric community and then go to where they are and meet those needs.

An example of community need provided by several interviewees is assessing community need and provide strategies to help with falls awareness. Stephanie provides another example of community outreach designed to provide services to frail aging adults without access to medical care for diabetes screens and teaching preventative strategies. Stephanie's example included a community health project that examined frailty indicators in a low-income area:

We went to local church-based organizations, because our community is primarily African-American and one of the centers for African-Americans is their faith and their church, so we created a sustainable project where individuals are still being screened for frailty at the churches. We also offer mobile vans for giving community-based exercise programs...and we are seeing quite nice improvements in several frailty factors.

Hannah notes that advocating and acting to meet community needs leads to “a healthier society, and paving the way for when I get old, that I will be taken care of.”

Professional obligation. The third sub-theme in the social advocacy realm is the belief that advocacy is important to support and promote the profession of physical therapy. Several participants conclude the need to advocate for our profession includes showing the value of physical therapy services and that advocating for the role of the physical therapist to help our patients. Interviewees provide one example of this belief is that all physical therapists should promote participation and support of the APTA. Another example commonly discussed is the importance of performing and utilizing research to describe positive outcomes and strategies physical therapists use when working with aging adults.

Stephanie suggests “supporting the APTA and the work they have done to get the research out there” while Olivia describes the need for “advocating for physical therapists and research in the areas of preventing injury and wellness.” Donna concludes “those who are more established within the profession should be giving of their time if they can, and if they cannot, then should give financially.”

In general, interviewees viewed advocacy as described by Emily as a “broad umbrella that may look different with different patients in different situations”. It is important to be comprehensive and creative to encompass individual advocacy efforts and needs and group advocacy efforts in order to give voice for issues for overall healthcare needs. As Olivia states advocacy includes “individual advocacy and group advocacy, we need a foot in both doors if we are really going to make a difference.”

Defining Advocacy Actions and Experiences

The third category that described the qualitative interviews was related to the advocacy practices and actions that physical therapists performed when working with older adults. This category consists of three themes to describes actions of advocacy in terms of challenging limits, seizing and maximizing opportunities for advocacy and preparing and protecting the future with regards to geriatric patient advocacy

Challenging Limits

The first theme in defining advocacy actions category revolves around challenging limits. Each of the interviewees discussed their experiences of advocacy practices in light of the general practice of challenging boundary limits for patient benefit and led the therapist to advocate for their geriatric patient. Challenges can be further described in terms of challenging medical limits, system limits, personal limits and attitudinal limits.

Challenging medical limits. The first sub-theme in challenging limits involves therapists actively challenging medical limits in their patient situations. Several participants provided examples of advocacy efforts that confronted the physicians or other medical professionals regarding recommended care that did not appear to be in the best interest of the patient from the physical therapist's perspective. These examples include general examples of questioning another healthcare professional's plan of care that appeared to be provide a decreased quality of care and also efforts to not provide physical therapy services to patient who did not appear to benefit from the service.

Examples also included specific efforts to advocate regarding medical issues. One example of advocating for medical issues comes from Karen who observes Parkinson's

patients in her rural area with poor medication dosage, stating “some of the farmers are stoic and they just say, ‘this is just the way it is’. And I have patients who come in and their medication is very poorly dosed, and I will ask the doctor about it, and they will say we don’t want to give them too much medication too soon because they will get used to it and then it won’t work. And that is not how those drugs work.”

Another example comes from Sarah who elected not to push aggressive program for a patient not medically stable as it is “a waste of, or not the best use of their Medicare dollars to really push through an aggressive rehab (program) if they are not really stable.” She provided a specific example of a patient who had a physical decline from an unknown reason. She pursued efforts to have the physician continue work with the patient to get an accurate diagnosis as the physician initially said pt. was just ‘getting old’ and had depression. The patient actually had normal pressure hydrocephalus. She describes “this was a person who is not a complainer, did not go to the doctor and was perceived by her family to be in good health and just stopped walking. So due to the dementia that starts to go along with the pressure, it went from them wanting to do a psychiatric placement at a psychiatric care facility but now she is getting a shunt today.”

Challenging system limits. The second sub-theme in challenging limits involve therapists actively challenging system or institutional limits that promote or encourage restricted practices in quality patient care. These instances include general advocacy efforts of challenging the system is described in methods to fight for reimbursement or against denial of payments. Participants have written letters to insurance companies to get more services and encouraged families and other health care providers to write letters.

Olivia states “I have actually gone in front of a (Federal) administrative law judge for patients whose therapy was denied, and I am like 95% successful.”

Several participants discussed efforts related to the pressures to choose between the institution and the patient in terms patient safety and provided examples of efforts to not have a patient discharged to home who may not be safe and would likely fall because of lack of support or resources. Sarah states “there’s lots of times when it’s kind of on the line, and that’s where advocacy comes in, you can look at this setting and say yeah, I can easily take Ethel home and we would be just fine, and it doesn’t require the skills of a therapist to get her better it just requires someone to be firm and consistent. But that’s different than looking the whole situation and saying Ethel needs a little special care for two weeks but Fred and Betty, her children, cannot financially or physically do it themselves. If we send her home she is likely to fail.”

Efforts were also described by many participants in relation to the pressures to be productive or to be complicit with institutional restrictive practices. Being caught between what the company wants you do and what you know you need to do for the patient. Karen feels “the line between advocacy and following facility and CMS (Centers for Medicare and Medicaid Services) policy and rules do not always match.” Hannah described not informing her institution that her patient was leaving their home while receiving home health services. This may have caused the patient not to be considered home bound and therefore not eligible for services. However, Hannah feels that leaving the house in certain circumstances, to go to church or to a family event, is important for patient’s emotional status and ultimately helpful to the rehabilitation program.

Another example includes therapist's conferencing with families or spending time sending emails or making phone calls to physicians, which in some facilities is considered non-productive time and limited in a therapist's day. Stephanie reported to being reprimanded and written up for low productivity due to talking to families, writing up many care plans or performing too many patient screens, and stated:

Screening patients is performed to determine if patients may need therapy services... and there are barriers to being good advocates because there is such a push for how much stuff can be billed and how much time you can spend with a patient...which is really impacting quality of care and payment.

Challenging personal limits. The third sub-theme in challenging limits involve therapists actively challenging their own personal limits when efforts to advocate are difficult and not supported by those around them. Many participants describe that advocacy efforts take a lot of time and energy and therefore challenge personal confidence and motivation that results in becoming tired and not engaged in patient care.

Participants describe advocacy situations often are situations that are good financially but not good ethically and they are being put in a position where they are compromising their beliefs. Donna describes the need for "finding a way to do what the facility wants and still be able to live with myself" and is described by many as stressful and frustrating. Frustration at not being able to provide care. Stephanie feels "there are a lot of therapists getting burned out by working in geriatric settings. They feel like this is all I do. I'm only valued for what I can produce and not what I do for the patient." Stephanie also reported seeing pressures of productivity "impact people's reputation and affect people's willingness to go out and treat people who are in need of service." Hannah

describes frustration at not being able to help patients can feel like “death by 1000 cuts...at some point you get stuck beating your head against the wall. You can walk away or you can tear down the wall and so I am trying to tear the wall down right now.”

Several interviewees also report advocacy efforts may also be challenging for those who do not agree and that may make people angry by advocacy actions. Offending some people or being torn between the patient and the family. Sarah notes that “from a personal level the biggest consequence is that people get angry. You lose points on patient satisfaction scales...and if the patient does not progress or gets dropped from therapy, you may feel the direction of the anger which may or may not be justified.”

Finally, many participants discuss personal challenges of efforts that cause them to separate from service and quitting or leaving their job. Karen reported challenging resulted in leaving her job.

One of the reasons I left because they started to become unethical in saying, okay we need to get so many minutes out of this person, because if they can be in the very high level. Or well since we're not going to make that level, we're going to push them down to the low category and put them with the rehab aide. I started to get pressure with that, and that is one of the reasons I stopped working there.

Because I was not going to play that game.”

Diane also left a job due to challenges to her personal beliefs “I decided to quit because the productivity expectations were too high, and my manager kept saying to co-treat...and the pressure was too much so I ended up quitting the job.” Similarly, Hannah left a position after being asked to treat in a way that was not in the best interests to her patients “over time I have really stuck to my guns on what I feel is ethically correct to do.

As well as legally correct. I won't work like that, I have to go home at night and face myself in the mirror and I can't do that if I violate what I believe in.”

Challenging attitudinal barriers. The final sub-theme in challenging limits involve therapists actively challenging attitude limits that limit advocacy awareness and efforts. These may include attitudes of patients, families or other health professionals. Some participants note that many physical therapists do not know about the options with geriatric patients. Sometimes it is difficult to recognize what needs to be done for each patient and advocating involves doing what the patient wants and knowing that it may not look like what would be ideal for us.

Challenging attitudes may occur when the family is not supportive of healthcare decisions and there are mixed messages from the family or patient. Stephanie describes this:

I feel it is really important to find out not just what you feel they need, but find out what they actually need. This can be a complicated process because if you're getting a lot of mixed messages from different sources, it can be complicated for advocacy for the best interest of the patient. The patient is saying one thing and the family is saying another and reconciling that can be a difficult process.

On a related note, Diane feels that she plays a role in helping patients see with a different perspective, and notes:

A lot of times, physical decline can make the walls smaller and smaller. Like with decreased mobility status, whether it be on foot or in a wheelchair, I think a lot of times that when patients see themselves as disabled, their community gets smaller. But if we can flip the coin and have them see from a different angle, and

say although I may be in a wheelchair...I can still function as a member of a community or society that I participate in.”

Participants also report challenging attitudes when administration is not supportive of professional decisions or there is apathy of other health professionals to certain care decisions. Sometimes this may be lack of recognition from others in the healthcare community. Karen describes:

I think sometimes the community not recognizing that there is a need, and when I say community I mean the medical community as well. The physicians not recognizing that there is a need, the aging and disability services not recognizing the problem, and that could be a real barrier.

Karen further describes an example of a family who believes:

It is not very important that we get dad a caregiver here in the morning to help him get dressed. He may not get dressed until noon, but he gets dressed. That may not help dad because he now cannot go out to breakfast with his buddies if he can't get dressed until noon. So sometimes the barrier is the other person's point of view.

Consistently most participants agree that challenging attitudes involves the need to help families and others to see the patient through different eyes, with different filters to truly act in the manner that the patient desires.

Seizing/Maximizing Opportunities

The second theme in the category of advocacy actions and experiences describes factors that facilitate advocacy practices. Each the interviewees discussed their experiences of advocacy practices in light of the elements that promote or assist them in

being good advocates. Seizing opportunities are further described in terms of the sub-themes of collaboration, utilizing necessary tools, accessing resources, employing personal fortitude and having the privilege of choice.

Finding your village with collaboration. Most of the participants described success with advocacy actions was promoted by collaboration with others who have the same goal. Working with others who support your views, especially those with an obvious love for the people you work with, may include colleagues, physicians, hospital or institutional administrators, directors of nursing, registered nurses, other healthcare professionals, social workers, discharge planners, case managers or families. Sarah notes that a “good case management person, social worker or discharge planner will be very helpful in fighting the fight with you.” Stephanie describes:

Calling on my colleagues that I have worked with has helped in the clinic setting, because if somebody else is saying ‘you know what, I don’t see Mr. Smith improving either’, and I’m wondering about that same thing too, or I’m thinking that we really need to think about this and what do you think about this has helped me to advocate in the past.

True collaboration and patient centered care was described by Melissa in that “egos need to be checked at the door and we must step up and work together.” Positive dialogue and communications were referenced along with the need to have back and forth dialogue that is respectful, may need to agree to disagree. Stephanie spoke to using “community partners to make activities sustainable and continue to carry it (the community program) forward...and trying to teach the community how to take care of their own.”

Finally, participants noted the need to seek our collaboration to help facilitate advocacy in order to create connections, a strong ally, and strong support. Karen describes support needed:

I think you need some support depending on where you are in the hierarchy of your organization, I think you need to have leadership support because if you are held to a certain standard of productivity and you want to do some advocacy, it is then taken away from that productive times. You need to have our leadership on board there.

Packing your toolbox. In being an effective advocate, the participants reflected that in order to be a comprehensive therapist, you need to use all of your tools. The toolbox of a physical therapist is a simple yet exhaustive compilation of knowledge and skills. Knowledge tools include understanding, reflecting and then utilizing the professional's expertise and knowledge. Sarah states:

In my mind advocacy begins with understanding, so before you can advocate for, you need to know what for is, so I guess I would say that advocacy is based on a comprehensive evaluation of the situation that includes physical examination of the client but it also has to include evaluation of the situation and the context in which they reside in that regard...and then it involves developing a plan to logically, economically, and possibly or feasibly state how to move the client from the path from A to B.

Knowledge also encompasses using data to support advocacy activities. Stephanie reports "if I feel like so-and-so needs therapy, I go back to that patient and I get good data as to why that patient is either appropriate or not appropriate and provide that information

back to the who has the question.” Olivia also references using research data to support her care “there a lots of times in my assessment part of my documentation I will cite articles and give a little synopsis of it...and whoever is reviewing that sees that there had been effort put into the justification.”

Sarah also stresses the use data, especially the specific research on gait speed, and states:

Thank God we know about gait speed. You can almost always write a little convincing thing about how you would predict a patient would be in a situation with using the bathroom, and one could not predict that she could reliably get to the bathroom in time to avoid an episode of incontinence, and incontinence increases the risk of falls. So gait speed and timed sit to stand are my best friend.

Skills tools referenced by participants include staying current in physical therapy skills and techniques and also demonstrating the professional tools of responsibility, integrity, promoting excellence and effective communication. Communication skills include being diplomatic in the approach toward advocacy actions and incorporating active listening. Diane stresses “listen to your patient...they will tell you what the problem is and how to solve the problem, they need you to listen. Being honest and upfront.”

Resources. The sub-theme of resources was portrayed by most participants in terms of time and others and also professional, community or local resources including specialists or community programs. Time was portrayed as a valuable resource. Rachel describes “the biggest barrier is time. Having enough time because there is the complexity of life and allowing the time or setting up situations where that can be done.”

Hannah reports the need to find and then utilize community resources

Whatever town you go into, find out what is around in that area, what community groups they have for aging adults. We cannot make change until we know what we have in the area. And the only way to get to know is to ask, go to the community centers and find out.

Stephanie reports supportive efforts include good “agencies on aging in our community and community resources in the YMCA that provides a wellness programs...and we train the wellness director... and provide the external supports”

Karen utilizes resources to obtain equipment for her patients

There are churches who have lending closets, we have our own lending closet, we go to Goodwill or to St. Vincent DePaul. We go to pick up equipment that is used and repair it and give it to a patient who does not qualify for a certain device, and we will supply that....When a patient already got a wheelchair and now they need a walker, but Medicare paid for the wheelchair and now will not pay for the walker. We scrounge around (to get it).

Several participants discussed utilizing appropriate professional resources, including professional associations. Interviewee’s noted the APTA along with its website, journals and communication methods were effective in many ways including: to provide the research for intervention decisions; to provide information regarding changes in policy, and to provide support in dealing with external agencies and regulatory bodies.

Personal Fortitude. The sub-theme of personal fortitude was described by many participants as necessary to being an effective advocate. Included in personal fortitude is being passionate, confident and courageous. Being passionate is being truly

vested in working with geriatrics and about the work that is done and the significant impact that is made on the lives of older adults. Hannah states “when you are passionate about something, your ability to think outside the box may be strengthened.” Being passionate about the profession is professed by Olivia as “being a PT and knowing that I have a responsibility to demonstrate ethics and integrity. And being an advocate and knowing what is right and what is wrong.”

Confidence is needed in the therapist’s skills and abilities. Karen describes her confidence via her experience “I guess, I have been in so many circumstances which would boil down to experience. And I know the resources I can call upon. And so I really do not fear repercussions from a family.” Confidence also includes knowing that you do not have to wait till something, like a fall, happens to prevent it and the determination to try again and knowing that it may require more than one attempt to be effective. Donna describes “when you get stuck beating your head against the wall, you can walk away or tear the wall down.”

Courage is the ability to stick your nose out every once in a while. And as Emily describes “we have people who are not strong enough to say no, I’m not doing that, it’s just not right.” Courage also includes standing firm on what the patient wants and needs and as Olivia describes “I am not afraid to be confrontational if it is for the benefit of the patient or myself or the profession or the program or the facility.”

The privilege of choice. The final sub-theme in advocacy actions is the ability of choosing optimal work settings and conditions. Many participants discussed the ability of being an effective patient advocate was a result as a personal decision to be in a place

that supported patient advocacy. Rachel describes having difficulty working in places that have an:

Assembly line approach...and I have a very hard time with that. And so therefore I pick and choose where I work, where I have a certain amount of autonomy and they understand the way I work and they are accepting of that.

Stephanie reported to choosing her setting because she knew the manager and what she was walking into “with a wide variety of patients and a wide variety of decisions that I would be able to make for my patients.” Similarly, Karen reports the ability to work in a place where:

They did not pay the highest salary, but I am pretty much allowed to do what I need to do. I see them doing a lot of things in the community that is really good. And I did make a choice to work for them...But not everybody has that ability and it's scary, very scary.

Preparing and Protecting the Future

The final theme to emerge from the many hours of participant interviews was the concern of the attitudes, abilities and opportunities to advocate by the new graduate or the young or novice physical therapist. Karen states:

These graduates are graduating with such huge dept. And so they are going to be pressured to say ‘okay well I’m just going to work in this place for five years, and this place will help pay my loans. And I’m going to just stick it out because you can do anything for five years. And there are developing very bad habits or just think well everybody is doing this so this is the way it is. And it is going to continue.

The concern regarding preparing and protecting the future geriatric physical therapist advocates is described in the sub-themes of education and mentors.

Education, education, education. Each of the participants discussed advocacy in terms of continued strong, repeated education of professionals in the classroom and clinic setting. Most participants noted the responsibility of faculty and universities to develop programs to put students in touch with aging adults to allow exposure and experience to work with aging adults while still in school. Rachel feels that DPT graduates “have basic knowledge but not advocacy awareness.” Hannah reports:

Reimbursement laws have changed and facilities have stopped taking students because they cannot get paid for what they do...therefore we need to help universities come up with free activities in nursing homes, in senior centers, in the community that would put the student in touch with the aging adult...I'm really worried that we are getting to the point that students will not get to touch an aging adult in college.

Olivia adds the importance of education in the clinical setting and to train our clinical instructors to have an understanding of showing students “how you can make changes on that level or educate others.” She goes on to explain “I think clinicians and faculty members and Clinical Instructors need to be open to the fact that you don't get the student just until they graduate, you need to be available if they need to bounce things off you.”

Mentors. Many participants also discussed the concern with novice professional's advocacy practices in terms of having good mentors. Most feel that new graduates need structure and protection and support from those already well established.

Novice practitioners are not as vocal, may be timid about their advocacy role. Sarah feels “younger colleagues seem reluctant to be the voice for this and are much more into being pleasers. To have things go smoothly than really take on a fight.” Karen states “we need to have some way of getting these other therapists involved so they can feel the support, so they can stand up to their employer and say, ‘you want me to be 90% productive, how do I do that?’”

Hannah reports new graduates need structure and have a need for protection in situations where there they are conflicted between what they feel is right for their patient versus what they are being asked to do by their institution. She states that new graduates:

Do not want to be too vocal and say things or do things that are going to have a negative consequence immediately or to your career. They need mentoring and to understand what it is they are doing and why they are doing and what would be the positive outcome and what would be the negative outcome.

Olivia specifically attributes her success as an advocate to having had good mentors, stating “And I became a good mentor, but people have to take the time to do these things.” Hannah feels that new grads coming out are often unsure of what the law says and what they believe in and what they stand for. Mentors can help them figure out how to help “them say it is okay and walk away from a job that is not ethically right.”

Participants also referenced mentors in terms of advising novice professionals in relation to life pressures. New graduates often have other responsibilities (kids, house, loans) and sometimes professional duty takes a back seat. These novice professionals with loans and life pressures may not be able to leave or choose positions based on productivity and advocacy. Many areas also offer a lack of choices for physical

therapists in job selection and even those who can choose to change jobs, this ability of convenient choice is not sustainable. Mentors can also help in stand-alone clinics with no other disciplines or support and help new grads who are nervous and wonder, do I really know the law? Do I know what I believe in? Do I know what I stand for?

Summary

The themes of the qualitative interviews demonstrate that the physical therapists interviewed were passionate and dedicated to providing comprehensive care for aging adults in order to promote the maximal quality of life. They recognize context, outside influences and marginalization that may occur in providing care in the vast bureaucracy of healthcare institutions.

These physical therapists also recognize very important issue of geriatric patient advocacy in all its forms including: the need for advocacy on individual and social levels for themselves as professionals, for their profession and for their community needs which ultimately affects their ability to advocate for their patients.

Finally, the physical therapists interviewed described specific and relevant actions and experiences related to geriatric patient advocacy along with the many factors that challenge their abilities, facilitate their efforts, and cause them concern with regard to advocacy to be provided collectively to benefit the entire profession and generations within the profession. As stated succinctly by Stephanie:

Advocacy becomes a careful balance between competing priorities. What does my employer want versus what does the patient need and who wins. And I say the patient wins because that is ultimately who we are serving. I mean we have to serve both interests. But I think the patient has the priority in those situations.

Physical therapists who act as geriatric patient advocates identify this balance, prioritize the patient's needs and strive to meet those needs in the most efficient manner to ensure the patient, the professional and those around them triumph in all complex situations.

CHAPTER 6

DISCUSSION

The purpose of this mixed methods study is two-fold: a) to investigate physical therapy professionals' understanding/perspectives of patient advocacy for geriatric patients in healthcare settings; and b) to explore physical therapists' experiences of geriatric patient advocacy including advocacy actions, the context of advocacy efforts, and the perceptions of meaning these efforts have for practitioners, patients and patients' families. The research questions that guide this study are:

1. What are physical therapist professional's attitudes and beliefs regarding patient advocacy when working with the geriatric population in various healthcare settings based on four advocacy constructs of:
 - a. Safeguarding patients' autonomy?
 - b. Acting on behalf of patients?
 - c. Championing social justice in the provision of health care?
 - d. Understanding of past patient advocacy efforts/actions?
2. What are the perceived practices or actions for geriatric patient advocacy in various health care settings in regard to:
 - a. Experiences of patient advocacy performed within the framework of critical gerontology?
 - b. Types of antecedents, barriers and consequences experienced when providing advocacy efforts?
 - c. Perceived meanings of patient advocacy for the practitioner, for the patient and for their families?

To investigate these questions, an explanatory mixed-methods research methodology was utilized in order to gain a thorough knowledge of both the perceptions and the behaviors associated with geriatric physical therapist advocacy efforts. The purpose of this chapter is to integrate the quantitative and qualitative findings and explore the implications of these findings. The chapter will begin with a discussion of the integration of the qualitative and quantitative findings in light of the research questions. Next will be a discussion of some of the findings in light of the literature and the theoretical framework of the study. Third is a consideration for disciplines, and practice. The chapter will end with a brief consideration of the limitations, suggestions for further research, and conclusions.

Integration of Quantitative and Qualitative Findings

The purpose of this research project was to answer two broad research questions. While the quantitative findings were discussed in Chapter Four and the qualitative findings were discussed in Chapter Five, this section will attempt to integrate and discuss how an integrated view of the findings answer the research questions. The discussion of this section will be presented in light of the two research questions.

Attitudes and Beliefs

The first research question was: *What are physical therapist professionals' attitudes and beliefs regarding patient advocacy with the geriatric population in various healthcare settings?* Physical therapists who work with geriatric patients are committed to providing the best care for maximal rehabilitative and quality of life benefits. The results of the geriatric patient advocacy survey indicate an average total of 245 out of 300

points on an advocacy scale, where each of the 60 Likert-type responses had a possible total of five points. The range of total responses was between 194 and 300, indicating a wide breadth of geriatric patient advocacy beliefs and practices. These beliefs can be further described in terms of micro social individual beliefs, macro social communal beliefs, and report of past patient advocacy efforts or actions.

Micro social attitudes and beliefs. As reported in Chapter Four, micro social individual beliefs are further described in terms of safeguarding patient autonomy and acting on behalf of patients. When asked about the individual advocacy component of safeguarding patient autonomy, the average scores ranged from 3.98 to 4.75 for each of the patient autonomy questions indicating that the majority of the respondents believe that physical therapists at least agree or strongly agree to have favorable beliefs regarding protecting patient autonomy. When asked about acting on behalf of patients, the average scores on these questions range from 4.03 to 4.83 indicating that the respondents agree to strongly agree to have favorable thoughts and beliefs regarding physical therapists acting on behalf of their geriatric patients. The results tell us that the respondents had favorable attitudes, however there were a range in different individual advocacy beliefs.

The interviewees expressed strong beliefs regarding their advocacy responsibility to their individual geriatric patients. Physical therapists believe in the need to advocate for those without access to services or those affected by socioeconomic status in order to allow their geriatric patients to reach their maximal functional capacity. They believe in supporting the right for patients to make their own decisions, noting the need to educate, to provide options and support the patient's decision, even if it is not the decision that the therapist or family feel would be ideal. They also believe in empowering individual

patients by speaking to the family or other health care professionals on the patient behalf and asking questions even if the patient does not know what to ask. Most importantly physical therapists underscored the importance of empowering and protecting individual patients with full recognition to what is motivating and important to the patient, for what *their goals* are; and the understanding that before you can advocate *for*, you need to know what the *for* is.

Macro social attitudes and beliefs. Macro social advocacy beliefs include social justice and actions that strive for changes on behalf of individuals, communities, and society as a whole to identify and correct inequalities and inconsistencies in the provision of health care. When asked about macro social beliefs, the average scores were lower than those of individual beliefs and ranged from 3.22 to 4.33, indicating that respondents range from neutrality to agree to having affirming thoughts and beliefs regarding physical therapists acting to champion social justice issues.

The participants who demonstrate beliefs as social justice advocates recognize their social responsibility in community, professional and political realms. They believe it is important to assess and meet individual community needs, address problems from a prevention or wellness standpoint and be a resource or advocate for issues prevalent in the geriatric community including falls awareness. They also believe it is necessary to advocate for and support professional associations that promote the profession of physical therapy and the physical therapist as a healthcare provider. These associations provide data, research and best-practice guidelines to positively impact the lives of geriatric patients. Finally, physical therapists believe that advocacy is important in the political arena to address political and policy issues related to fairness of reimbursement

issues, payment reform and productivity standards that are seen as directly impacting the quality of care for aging adults.

Past advocacy efforts or actions. Chapter Four also reported behaviors therapists' performed in the name of individual or social justice advocacy. When asked about advocacy practices, the average scores ranged from 2.69 to 4.55, indicating the widest range of scores and indicating respondents disagree to strongly agree that they performed practices related to patient advocacy in the past year. The results indicate slightly higher scores for micro social (individual) actions, with scores ranging from 3.33 to 4.55 than for macro social (social justice actions) ranging from 2.69 to 3.42.

Interviewees recognized the need and concurrently acted as a resource for geriatric patients, families and the geriatric community. On an individual basis, they reported actions to challenge medical and system restrictions by confronting physicians, families or other medical professionals regarding care that did not appear to be in the best interest of their patient. They also personally contacted insurance companies to obtain more rehabilitative services and represented patients when services were denied to promote optimal care. On a community basis, physical therapists were actively involved in community awareness programs to prevent falls, mitigate frailty and screen for diabetes, all of which are prevalent issues in many geriatric communities. They also donated time and money to political campaigns and political action committees in order to facilitate policy decisions that directly impact aging adults.

When integrating quantitative and qualitative data, a picture emerges of physical therapists who generally have favorable attitudes and beliefs of geriatric patient advocacy

for individual and community needs of aging adults. The majority display favorable advocacy behaviors and actions in support of individual geriatric patients and their families. Some inconsistency occurs in the area of social justice advocacy actions. This inconsistency can be explained in the time and skills needed to advocate on a social level. Social justice advocacy occurs outside of typical job responsibilities and includes interacting with those not involved in direct patient care. Therapists' consistently performing macro social advocacy actions are often involved with institutions whose mission and responsibilities include social and community efforts.

Perception of Experiences

The second research question was: *What are physical therapist perceptions surrounding practices or actions for geriatric patient advocacy in various health care settings?* To examine physical therapist perceptions of advocacy actions, antecedents, barriers and consequences are assessed to provide meaning to the behaviors in relation the patient, family, practitioner and other health care providers. This examination begins with examination of the demographic information from the geriatric patient advocacy survey. When examining the demographics of the respondents with the highest geriatric patient advocacy survey scores, Chapter Four reports age, gender, religion, professional experience, work setting and prior advocacy training are not significant factors in overall survey scores. The only personal element that appeared to influence advocacy survey scores was the possession of a specialized certification in geriatric physical therapy (GCS). Physical therapists who had a GCS had significantly higher survey scores than physical therapists without this certification.

To examine other factors that appear to influence physical therapists' perception of advocacy actions, it is necessary to examine the data from the qualitative interviews. Many of the participants reported having a work history that evolved into a passion for working with aging adults. This passion then became the foundation of the physical therapists' professional duty to provide the best care and services to ensure optimal quality of life for aging adults despite barriers and challenges inherent in the health care system and attitudes of others. The therapists voiced the need to utilize all available opportunities and resources to promote successful advocacy experiences. These resources include collaboration with other health care professionals and community agencies and staying abreast of current knowledge and skills to obtain and maintain expertise in working with aging adults. Respondents also expressed the personal fortitude needed to be a successful advocate including having passion, confidence and courage to stand firm on what the patient wants and needs notwithstanding beliefs of others. Finally, respondents described the privilege of choosing ideal work settings and conditions that allow for effective advocacy actions along with the perception that novice and future therapists may not have this luxury given the current climate of health care.

Ultimately, physical therapists reported the satisfaction of professional duty when working with aging adults is augmented with successful advocacy practices. By being a successful advocate, the patient receives the right care at the right place at the right time to allow maximal benefit for themselves and their family or others around them. Participants also noted some trepidation in the attitudes and abilities to advocate by new graduates or young professionals with the recommendation to encourage better academic and clinical education to promote advocacy concepts and mentors.

The Findings in Light of the Literature and Theoretical Framework

Chapter Four provides a comprehensive review of the quantitative findings. Chapter Five provides a comprehensive review of the qualitative findings. It is important to merge these findings to provide a complete picture of the significance of this data particularly in light of the literature and theoretical framework. To discuss this integration of the findings this section of discussion will be organized in light of three topics: (1) the physical therapist as provider advocate, (2) limitations to advocacy practice and (3) the novice versus expert practitioner.

Physical Therapist as Provider Advocate

As described in Chapter Two, the type of advocacy performed by the physical therapist can be defined as provider advocacy (Huber, et al., 2008; Teasdale, 1998). Provider advocates are professionals in which advocacy is just one aspect of their professional role. This type of advocacy is intrinsically complex due to “the central defining characteristic of provider advocates-inherent role conflicts between professional/occupational roles and their advocacy roles” (Huber et al., 2008, p. 40). As noted in Chapter Four, the results of the geriatric advocacy survey indicated that the majority of the respondents had favorable beliefs about the physical therapists responsibility toward geriatric patient advocacy. Survey items highlight the complexity and possible role conflict of the physical therapist advocate by noting generally favorable results for beliefs that encompass the patient’s rehabilitative care and also the general healthcare needs that extend beyond rehabilitation.

Role Complexity. As noted in Chapter Five, qualitative discussions by the

interviewees support the complexity and possible conflicts undertaken in the role of physical therapists as provider advocates. The complexity of the role was portrayed in two ways. First, is the medical and social intricacy involved when working with aging adults. This complexity requires the therapist to have knowledge and skills in many areas including the medical and rehabilitative arenas along with the contextual factors such as emotional, psychological, financial and environmental constraints. This is consistent in the healthcare literature, particularly in relation to the discussion advocacy in the professional roles of nurses. Lindahl and Per-Olof (1998) and Negarandeh Oskouie, Ahmade and Nikraves (2008) conducted qualitative studies of the nurse's role of advocacy in relation to patients, which indicates their role is: to build a caring relationship, gathering information from a holistic perspective, to carryout commitment and to empower (Lindahl &Per-Olof, 1998) with specific responsibilities including informing and educating, valuing and respecting, supporting physically, emotionally, and financially, protecting and representing and promoting continuity of care (Negarandeh, et al., 2008).

Secondly, the qualitative interviewees portrayed the complexity of the role of the provider advocate in the variety of advocacy responsibilities of the physical therapist. These include obligations to advocate for individual patients along with obligations in the community, political and professional realms. While the overall physical therapy literature on patient advocacy is sparse, a few authors report individual advocacy obligations in various circumstances. Doherty (2005) describes advocacy as a core value along with the need for strong patient advocates and resources for functional applications of technology. Leong and Euller-Ziegler (2004) portray advocacy and empowerment as a

pivotal role for arthritis patients and their families. Finally, Nelson (2005) discusses the need for clinician advocacy for patients with lymphedema due to scarce resources.

Two authors denote the responsibility of physical therapists to advocate in the political realm (Moore, 2012; Sullivan, 2009). Each author discusses the need for advocacy for health care reform due to the inequalities in our health care system. Sullivan (2009) argues for physical therapists to become politically active as a “call to action for our patients” (p. 171). Moore (2010) further supports legislative advocacy as a practice articulated in the United States Constitution as a manner to obtain a policy decision and achieve policy change. While several participants noted the belief in provider advocacy in the community and in professional organizations, these discussions were absent in the physical therapy literature.

My study on patient advocacy allows the discussion of role complexity of the physical therapist be validated and expanded for micro social and macro social responsibilities. The literature on individual advocacy responsibilities is confirmed by the obligation the physical therapist has in situations where patients have limited resources. This study adds to the current literature by broadening the financial implications to truly include all psychosocial issues that must be considered. The literature on macro responsibilities is confirmed in the responsibility physical therapists should play in political activism. This study adds to the current literature by expanding the macro obligations to include community and professional responsibilities. Ultimately, this study goes beyond isolated advocacy obligations described in the literature to describe the many realms and complex situations that must be considered by the physical therapist in order to successfully perform in their professional role.

Role Conflict. Provider advocate role conflicts were discussed by the participants in light of patients' advocacy needs as mired in the convoluted healthcare system that includes restricted healthcare practices and challenging productivity demands. Several examples were provided by participants of institutions and employers pressuring physical therapists to provide or modify treatment decisions based primarily on financial factors and less on individual patient needs. Nalette (2010) describes this issue as constrained physical therapist practice, where the clinician understands the patient legitimate needs and, while acting to meet those needs, may be compelled to provide less than necessary care. Role conflict is also noted by Sullivan and Main (2007) who present the differences in the role of service provider and advocate that occur when working with patients who have chronic pain; and while advocacy can be seen as a logical and legitimate extension of the provider role, the rehabilitation provider must bear in mind the negative impact of any form of protective behavior for these patients.

The results of my study confirms and expands the limited research regarding conflict physical therapists experience as part of their professional role. Results confirm the general experience of constrained physical therapy practice and provides specific examples that occur in all areas of healthcare where professional judgment is being questioned or molded to meet institutional constraints. Specifically, noted are the many situations where decisions are made for aging adults primarily based on their age and absent of holistic consideration. While ideally we would like to think ageism is not a factor in healthcare, this study provides examples of this issue and the conflict that physical therapists experience in countering this practice.

Limitations to Advocacy Practice

A second consideration that emerges from the quantitative and qualitative data relates to the barriers that exist to limit advocacy actions despite advocacy beliefs. Quantitative survey results reported in Chapter Four were based on modification of the Attitude toward Patient Advocacy Scale (APAS) developed by Bu and Wu (2008). The APAS was designed to assess attitudes toward advocating for patients that are reported to be a “predictor of behavior intention and actual performance of the behavior” (p. 64). The APAS was modified to remove some items for brevity and modify nursing language to represent rehabilitative needs. Eleven items were also added to allow measurement of performance of advocacy behaviors. While hypothesis testing confirmed each of the four stated hypothesis and positive correlations were noted between advocacy beliefs and practices, it can be noted that average scores were higher when measuring advocacy beliefs versus advocacy actions. Also it can be noted that micro social advocacy actions were slightly more favorable than macro advocacy actions.

The qualitative data in Chapter Five helps explain the discrepancy between advocacy beliefs and behaviors. In general, participants reported a strong belief in their professional duty to be an advocate for their geriatric patients. This responsibility was depicted in the need to protect patients’ rights, act on behalf of patients and overall empower aging adults in the provision of health care. Participants also noted many challenges that limit the physical therapist’s ability to be an effective advocate. These limitations were noted in the literature in terms of negative consequences or risks to patient advocacy (Baldwin, 2003; Bu & Jezewski, 2006; Hanks, 2010; Hewitt, 2002; Sundhin-Huard & Fahy, 1999; Teasdale, 1998). The main limitation or barrier that was

reported by the interviewees was time. The majority of physical therapists reported time as a valuable resource frequently scarce in the current proliferation of productivity driven practices of health care. Concurrently, time was not mentioned in any of the physical therapy literature related to patient advocacy; this may be due to the relatively recent emergence of productivity driven practices that have limited reference in the literature. While the barrier of limited time might be obvious in current healthcare practice, it will be interesting to see if other studies document this as an issue as well in this fairly new productivity driven age.

Other factors reported by physical therapists were the personal challenges associated with patient advocacy. Many participants' described that advocacy efforts take a lot of time and energy and therefore challenge personal confidence and motivation and results in becoming tired and not engaged in patient care. Physical therapists also reported to feelings of frustration at not being able to provide quality care consistent with research by Hanks (2010) and Sundin-Huard & Fahy (1999). These authors report negative consequences risk effective advocacy strategies if feelings of frustration or anger occur when advocacy attempts are unsuccessful. Finally, many participants discussed their frustration in light of ultimately separating from service and quitting or leaving their job. These consequences were similarly described in nursing literature. Because advocacy is about power, it has the potential for conflict that carries risks for all involved. Patient advocates are sometimes accused of insubordination, suffer loss of reputation, or labeled as troublemakers. Advocacy "is particularly risky for professionals, who are vulnerable to dismissal and who have very limited protection under employment law" (Teasdale, 1998, p. 20).

The barriers that limit physical therapy advocacy efforts can also be viewed in relation to the literature and framework of critical gerontology. Interviewees reported the issue of restricted practices in all aspects of geriatric care and the paternalistic practices of physicians and other health care providers. This is in line with Minkler's (1999) discussion of the aging enterprise and her belief: "among the greatest challenges of our aging societies are those concerned with the provision of humane and affordable health and social services in ways that empower, rather than disempower" (p. 6). The current institutional practices experienced by interviewees were also consistent with Este (1979) critical report of the biomedical model and the vast array of bureaucracies, interest groups, providers and programs that have contributed to the commodification and treatment of the needs of the elderly in ways that often work to benefit professionals and organizations more than they do the aging adult.

The attitudinal barriers reported by participants can also be viewed from a critical gerontology perspective. Interviewees described the difficulty encountered when challenging others to provide for what the patient wants and not what may be ideal for others. This was also described in terms of challenging others to see a patient through different eyes, through different filters to truly act in the manner that the patient desires. Minkler (1996) defines this need as putting "a human face, a human body and spirit, on aging and growing old" (p. 470).

Expert vs. Novice Practitioner

The final reflection that emerges from the quantitative and qualitative data relates to the discussion of expert and novice practitioners. Expert practitioners are discussed

relative to physical therapists who hold specialist certification in geriatric care. Novice practitioners are discussed in terms of education and resources needed to assist them in advocacy skills and practices. As noted in Chapter Four the majority of demographic information including age, years of physical therapy practice, years of experience working with aging adults, and work setting did not present any statistical differences in the geriatric advocacy survey scores. However, those physical therapists that reported to having specialized certification in geriatric care (GCS) had significantly higher scores on the geriatric advocacy survey than those without specialist certification. Obtaining a GCS is one method of pursuing professional development and is noted as the path to clinical excellence and expert practice in the physical therapy profession. The American Board of Physical Therapy Specialists (ABPTS) recognizes clinicians who have completed a minimum of 2000 hours of direct patient care experience working with aging adults and subsequent passing of a national certification board exam. The process of pursuing and obtaining board certification indicates advanced practice in the profession and appears to have an effect on advocacy beliefs and practices.

As noted in Chapter Five, not all of the physical therapists interviewed held specialist certification. However, each of the interviewees, who scored in the top 88th percentile of advocacy survey scores, demonstrated having the initial qualifications for this certification: significant experience as a physical therapist, specific experience with geriatric patients and the passion to go above and beyond to have and maintain up-to-date knowledge and skills as a clinician. Most participants reported to utilizing the latest data and research in their care of aging adults, which augmented their advocacy practices. Therapists also emphasized the importance of continuing education for themselves and

quality formative and continuing education for new graduate or novice practitioners in the area of advocacy concepts and practices. Having a GCS or not, participants reported qualifications consistent with the theory of expert practice in physical therapy as reported in the literature. Jensen (1999) and Resnik & Jensen (2003) report therapists classified as expert demonstrate a patient-centered approach to care, characterized by collaborative clinical reasoning and promotion of patient empowerment. Participants in the qualitative interviews demonstrated each of these characteristics.

Physical therapists discussed novice practitioners in the final theme of Chapter Five's qualitative data results. Participants reported concern of the attitudes, abilities, and opportunities to advocate by the new graduate or the young or novice physical therapist. Physical therapy literature supports this concern. Empirical studies conclude the need for education is important for physical therapy students to make ethical as well as clinical judgments. Guiccione (1980) stipulates, "to prepare future clinicians less adequately could jeopardize the integrity and the autonomy that physical therapy as a health profession has so arduously worked for" (p.10). Entry-level academic programs for physical therapy students include advocacy as a Professional Core Ability that is embedded in ethics curriculum (Jensen, Paskhal & Shepard, 2013). However literature is limited in regard to specific advocacy definitions, methods or recommendations for physical therapy education. Most participants reported it is the responsibility of faculty and universities to develop programs to put students in touch with aging adults to allow exposure and experiences to work with aging adults. Current physical therapy education literature provides limited support for these beliefs, noting advocacy education for rehabilitation professionals is provided in two realms: generally ensconced in ethics

courses (Davis, 2005; Gabriel, 2005; Gervais, 2005; Wharton, 2005) and/or specifically as a part of service learning coursework (Hamel, 2001; Karasik, Maddox, & Wallingford, 2009; Kirkpatrick & Brown, 2004). The physical therapy literature on advocacy education can be augmented by adding the constructs noted in adult education critical pedagogy literature. Advocacy is frequently about power and protecting or promoting rights of those who lack power. Adult education pedagogy recognizes the issues of dominant ideology and hegemonic forces that often perpetuate many healthcare decisions. Physical therapy education would benefit from the discussion of practice patterns in relation to critical theory along with critical thinking in order go beyond anatomy and physiology to enforce holistic, context based care decisions.

Many participants also discussed the concern with novice professional's advocacy practices in terms of needing good mentors. Most feel that new graduates need the structure and protection and support from those already established. Novice professionals may not be as vocal and need support and advice in relation to life pressures. Participants feel mentors are needed to advise novice therapists in relation to real life pressures and help them understand professional and ethical dilemmas and how professional duty and advocacy intersect. While no literature was found to directly support mentoring in physical therapy education in relation to patient advocacy, mentoring is discussed as a method of promoting professional ethical behaviors.

Several authors endorse mentoring as a method of demonstrating and supporting ethical practices (Black, et al., 2010; Ingram, D. et al., 2013; MacDonald, et al., 2002). Clinical mentors can assist in distinguishing the ethical dimensions of a case from other dimensions and assist in developing morally acceptable options (Doherty, 2005).

Kornblau and Burkhardt (2012) list mentorship as one manner to help clinicians avoid ethical dilemmas noting “mentors can provide invaluable advice and support to rehabilitation professionals...may provide additional information...or a different perspective on a situation. Further, mentors can help by raising questions and issues not yet considered” (p. 92). Barr and Tichenor (2013) advise utilizing expert clinicians as clinical mentors for novice clinicians in clinical residency programs which will allow for help when facing a complex decision-making process. Interviewees noted the complex situations that often invoke the need for geriatric patient advocacy. Mentors in academic and clinical settings can assist novice professionals traverse the complex and often opaque areas and issues that arise in providing care for aging adults.

Insights for Theory and Practice

The results of this research also have important implications for the theory building in regard to the theoretical frameworks, which guided this study. This research may allow us to view some of the components of Critical Gerontology in relation to geriatric patient advocacy. It also may allow room for critical perspectives of adult education to play a more significant role in the formal education process for physical therapists.

Critical Gerontology

As noted in Chapter Two, the primary framework informing this research study is critical gerontology. Critical gerontology is described as “a more value-committed approach to social gerontology- a commitment not to just understand the social construction of aging but to change it” (Phillipson & Walker, 1987, p. 12) and also casts a “critical eye on society and the field of gerontology itself” (Ray, 2008, p.97). Informed

and inspired by the tradition of critical theory associated with such figures as Adorno, Horkheimer, Marcuse and Habermas (Brookfield, 2005), critical gerontology is concerned with the problem of emancipation of older people from all forms of domination (Moody, 1993) and stands in opposition to the conventional positivism and empiricism long dominant in gerontology (Moody, 1992).

As a field, Minkler (1996, 1999) notes that critical gerontology has evolved along two paths. The first path embraces a broad political economy of aging framework. In this sense, critical gerontology views the ‘problem’ of aging in structural rather than individual terms. The second path in critical gerontology emerges from a humanistic orientation and provides a supplement to the political economy perspectives by putting a “human face- a human body and spirit-on aging and growing old” (Minkler, 1996, p. 470). In applying the theory of critical gerontology to the current study, patient advocacy can be discussed in three main ways: (1) understanding the significance of critical reflection in everyday ethical decision making; (2) understanding the humanities perspective of critical gerontology associated with the understanding of self-meaning and its relationship to advocacy; and (3) understanding the political economy perspective of critical gerontology to provide insight to advocacy by understanding the global nature of power and structural implications in healthcare.

The discussion of critical reflection stems from the critical theoretical perspectives founding critical gerontology. As healthcare providers, ethical considerations occur with most health care decisions and it is important to have “clinicians who value the importance of ethics and incorporate ethical decision making in every patient encounter” (Wharton, 2005, p. 142). Effective ethical decision-making

requires critical thinking and critical reflection. In the realm of critical theory, this reflection should be a significant construct because, as healthcare providers, physical therapists are frequently at the center of power imbalances created by societal forces. Patients can be considered marginalized in most instances, and geriatric patients with disabilities can be seen as truly oppressed. The ramifications of this imbalance and the societal norms surrounding it are important to understand and truly perform in the professional manner that is expected, including advocacy.

The current study supports the construct of critical reflection in advocacy beliefs and behaviors. The results of the geriatric advocacy survey indicated overall favorable attitudes, beliefs and actions for individual and social advocacy practices. The participants voiced several challenges to effective advocacy, however were able to consistently recount successful advocacy behaviors despite these barriers. Therapists were able to critically assess the context of their patients and filter and focus on the patients' wants and needs that were often mired in institutional regulations and guidelines.

The humanistic perspective of critical gerontology provides insight to patient advocacy in understanding the self-meaning of our geriatric patients (Minkler, 1996, 1999). Physical therapists are trained to be patient-centered and holistic, however it is not understood that many of our attitudes and beliefs about older adults come from what society thinks they should look like, want, and need. The humanistic pathway encourages critical reflection in each individual situation and encounter with a geriatric patient. As professionals, we are obligated to look beyond hegemony and advocate for what the patient wants, based on their perceptions and beliefs. Interviewees clearly

persisted in their advocacy practices with the ultimate guide being what the individual patients' wanted. Several therapists reported that actions often did not look like what the therapist or family prioritized but rather focused on empowering the aging adult to promote and protect dignity and respect. All of the participants also underscored the importance of the foundation of empowering and protecting individual patients as the full recognition of what is motivating to the patient, what *their* goals are.

The political economy perspective of critical gerontology provides insight to advocacy by understanding the global nature of power and inequity and the resulting ramifications on healthcare policy and practice (Minkler 1996, 1999). Physical therapists are trained with knowledge of general health care policies; however, they require understanding of how political and market forces affect health care policy in both governmental and institutional levels. Critical gerontology and its critical framework provide context for the decisions and advocacy efforts made in this regard.

The current study suggests physical therapists are aware of power imbalances and often find themselves at the center with the need to choose between the institution and the patient. Therapists' report that these institutional pressures are rapidly increasing in all aspects of healthcare practice as healthcare reimbursement is decreasing and productivity demands are increasing. While the geriatric advocacy survey scores for macro advocacy practices were lower than for individual practices, most therapists interviewed at least agreed to advocating the in the political and social realms. Several participants reported to giving of their time or money to advocate for health care reform and political policy changes. Participants also reported to providing education and services to promote specific concerns of geriatric patients, including falls awareness, frailty interventions and

diabetic screens. The current study promotes advocating for societal disparities as an important role for health care providers for all patients and other persons of marginalized groups.

The current study tells us physical therapists, who are effective geriatric patient advocates, hold a dedicated belief in the equality of quality health care for all persons, with a special concern for aging adults. While they understand that this belief is part of their professional duty and is embedded in the Code of Ethics for physical therapists, they view their role as geriatric patient advocate as important to the services they provide on an individual and societal basis.

Critical Perspectives of Adult Education

While critical gerontology provides a framework for the individual and societal components of geriatric patient advocacy, critical perspectives of adult education provide an essential lens for the need for geriatric patient advocacy. “Critical theory assumes that inequality is a permanent structural reality and is accepted without complaint because dominant ideology has convinced the majority that inequity is normal and predictable” (Brookfield, 2010, p. 72). As presented in Chapter Two, the concepts of critical theory, hegemony, repressive tolerance, and power relations provide the foundation for critical pedagogy.

Critical theory and critical pedagogy inform the current research in several ways. Critical theory provides a framework to view the healthcare system. When a person becomes ill or disabled, accessing healthcare can be an overwhelming process. All aspects of care have different financial reimbursement mechanisms and requirements and the current healthcare economy has created vast disparities in access to comprehensive

healthcare insurance. Physical therapists who are effective advocates successfully traverse the bureaucracy of health care and understand the restricted practices that must be accounted for and overcome to provide quality care for all aging adults. They also continuously educate older adult patients and their families to help them navigate and obtain the maximal benefit from health care services.

Once in the system, patients become dependent on physicians and other health care professionals to make decisions regarding diagnostic and treatment options that often fosters dominant or paternalistic attitudes. Geriatric patients easily become marginalized in their ability to be active and informed members of their own healthcare process. This research demonstrated physical therapists recognize the authoritarian methods of providing care to aging adults and actively seek to promote patient autonomy and mitigate paternalistic practices. They seek to empower and actively give a voice to aging adults.

Critical pedagogy offers methods for healthcare professionals to become informed regarding marginalization and oppression and the impact the system has on patients in their care. The role of the physical therapist is to provide education and treatment to empower and maximize the quality of life for geriatric patients. Critical pedagogy is a method to facilitate understanding of marginalizing practices and allow discussion for advocacy or other avenues to support geriatric patients in a complex system. Based on the work of Paulo Friere (2000) critical pedagogy is described by Brookfield (2005) who proposes the core of adult learning should allow society to see their individual well-being as integrally bound up with that of the collective, act toward each other with generosity and compassion, and be ever alert to the presence of injustice, inequity, and oppression.

Specifically, Brookfield (2005) proposes seven interrelated “learning tasks” embedded in critical learning theory that need to be included in adult education practice: (1) challenging ideology; (2) contesting hegemony; (3) unmasking power; (4) overcoming alienation; (5) learning liberation; (6) reclaiming reason; and (7) practicing democracy. Physical therapists primarily work as clinicians and secondarily as educators and the results of this study were informed by some of these tasks but not all. Physical therapists, who are advocates and adult educators did describe methods to challenge ideology of aging and ageism. They also demonstrated contesting the hegemonic practices and power structures of healthcare institutions that enforce and perpetuate financially driven health care practices. The remaining tasks were lesser noted however still remain pertinent for consideration in physical therapy education.

Understanding the theoretical assumptions of critical theory in regards to adult learning provides the foundation for pedagogy of teaching physical therapists in this framework. This is important because all physical therapists have the professional duty to educate their patients and, as the qualitative participants exemplify, many physical therapists educate on a formal level in academic and to a greater extent for students in clinical settings. Brookfield (2005) proposes pedagogical suggestions to integrate into critical practice. First, to teach critically is not just a question of how we teach, but also about what we teach. Physical therapists need to be prepared to encounter an ever-changing convoluted health care system that is increasingly driven by financially motivated practices. All participants interviewed noted the vast changes in practice in all areas of health care. They also pointed out that students need to be prepared to consistently question the context of their decisions and be prepared to advocate against

financially driven forces. Second, specific methodological approaches emerge from critical theory's analysis. Brookfield (2005) stipulates, "critical teaching begins with developing students' powers of critical thinking so that they can critique the interlocking systems of oppression embedded in contemporary society" (p. 350). This is an important distinction for physical therapist education, both in formative areas of academia and clinical education and in continuing education. Currently, academics in healthcare use the term critical thinking to describe cognitive or clinical reasoning. The true nature of critical reflection, as noted in adult education critical pedagogy, becomes lost in translation.

Teaching becomes inherently political as critical thinking is not just a cognitive process but is bound up in realizing and emphasizing common interests, rejecting the privatized, competitive ethic of capitalism, and preventing the emergence of inherited privilege (Brookfield & Holst, 2011). Interviewees actively worked against productivity driven practices and challenged medical, system and personal limits to be effective advocates for geriatric patients. The assumption that advocacy is required in healthcare implies that the process of becoming a patient results in the reduction of autonomy and the patient rights may not be respected (Willard, 1996). Ultimately, advocacy is about power and influencing those who have power on behalf of those who do not (Teasdale, 1998). Freedom, fairness, equity, liberation, the ethical use of power are all ideas central to teaching in the critical tradition that intends to help people learn how to replace the exchange economy of capitalism with truly democratic socialism (Brookfield, 2005). These concepts need to be purposefully portrayed in education of physical therapists at all levels of education.

Feminist theory and pedagogy provide a lens for this research in the observation of patriarchal practices that occur in healthcare settings. Post structural feminist theory is described in relation to teaching pedagogy in themes of positionality, construction of knowledge, and giving voice (Tisdell, 2000). Interviewees specifically describe the concept of giving voice in relation to empowering the therapist's voice and the patient's voice. Empowering the therapist's voice was noted as important in the hierarchy of the organization where their lack of power may limit their voice. The participants strongly described that geriatric patients often lack a voice and that they need and deserve to have their voice heard in regards to their health and health care needs and desires.

The concept of positionality was also described by participants, while not in terms of race, gender or class, but in relation to the therapist, patient, doctor, and administrator relationship. Physical therapists interviewed described their responsibility in helping patients, physicians and administrators construct new knowledge regarding individual patient care and the decisions and treatment options that need to be considered and employed for aging adults. While these practices may be more easily identified due to the predominance of female physical therapists and female geriatric patients, the education, treatment and advocacy efforts needed in healthcare apply to males as well because they espouse patient-centered practices.

The demographics of the current study involved primarily female survey respondents and all female interview participants', and feminist themes including general patriarchal practices, positionality and the concept of voice were noted in the findings. Feminist pedagogy affords healthcare providers understanding of giving geriatric patients a voice in their care and also for perspective on the value of life experiences in regard to

the choices they make, both of which were discussed by interviewees. With this lens, physical therapists provide education, treatment and advocacy efforts specific to the individual needs of geriatric patients.

Finally, critical disability theory also informs the current study. Similar to other critical pedagogies, people with disabilities can be understood as an oppressed group struggling for civil rights as people with disabilities constitute possibly the largest marginalized group whose access to public places, education and the political sphere has been limited (Rocco & Fornes, 2010). The field of disability studies informs this study as it provides the location for the deconstruction of disability and an examination of the cultural, political and social ramifications of disability in society (Rocco & Fornes, 2010). Effective physical therapist advocates recognize cultural context and its influence on adults with disabilities. They also are actively involved in political and social advocacy efforts to maximize patient access in areas that are important to them. Clark (2006) provides the distinction between disease and disability: Diseases or illnesses are related to biological processes and follow a course of progression that can proceed through recovery, whereas disability defies recovery, and as such cannot be healed to allow a disabled body to function as a nondisabled body. Disability can be considered a social construct and therefore provide insight to adult education regarding pedagogy for teaching and learning. The foundational principles of critical disability theory further outline the marginalization of patients in healthcare systems and hegemonic practices that occur that point to the need for a firm understanding of patient advocacy.

Implications for Disciplines and Practice

The current study spans the disciplines of adult education, patient advocacy and physical therapist education and practice. The primary focus of this study was to examine the intersection of adult education and physical therapist practice. The following section of this chapter will discuss the implication of this research for adult education and the field of physical therapy.

Adult Education

The current study has implications for several aspects of adult education, including continuing education and the critical perspectives of adult education. Physical therapists require state licensure to practice and in most states, therapists are required to complete continuing education coursework to maintain licensure. In states where continuing coursework is not mandated, the professional duty of the physical therapist includes the importance of lifelong learning to maintain excellence in practice. While in many states the topics of continuing education are not mandated, several states, including Pennsylvania, require some course work in legal and ethical issues.

The results of the geriatric patient advocacy survey suggest that advocacy is a vast topic that incorporates many individual, professional, political and community factors. Continuing education programs need to differentiate education on patient advocacy responsibilities from the general discussion on professional duty and ethics. Survey results also suggest that continuing education programs related to advocacy should consider that favorable advocacy attitudes and beliefs do not equal effective advocacy practices. Physical therapists report that even with positive intentions, challenges and barriers occur, which prevent successful advocacy behaviors. The results of this study

indicate that successful provider advocates rise to the challenges of system, attitudinal and personal barriers and use a variety of resources to provide effective advocacy practices.

The results of this study also highlight the importance of critical pedagogy in adult education in two areas with limited information in the literature. Age and disability are examples of 'isms' that create marginalization and power imbalances similar to gender and race. Age, and corresponding ageism, was identified by all interviewees as a factor that is currently being utilized to determine who is provided access to certain health care services and interventions. A few participants referred to these decisions as methods as rationing of healthcare based on age. Critical pedagogy is needed on the context of formative academic and clinical education of physical therapy students and also in continuing education of physical therapy professionals. While age inequalities may not be as overtly obvious as gender and race inequalities, ageism is an issue that should be important for all adult educators when discussing critical discourses. As noted by one participant, old age, different from race and gender, is a marginalized group to which will all eventually belong (hopefully), therefore the better we educate health care professionals today, the better we will be treated and provided for in the future.

Disability should also be an important concern for adult education and adult educators for three reasons: (1) the process of becoming disabled provides opportunities for the person and his/her family to learn about the disability; (2) increasing numbers of students with disabilities enroll in formal education programs, and (3) disability is an identity marker that diminishes opportunities for work, education and leisure (Rocco & Delgado, 2011).

Adult education pedagogy can be informed by critical disability studies, for as Rocco and Delgado (2011) note “just as some in adult education have invited and made space for African American and feminist scholars, we need to make space for disability so that students feel comfortable with exploring research agendas centered on disability and adult education” (p.9). The authors also recommend disabled people be included when discussing multicultural issues, and disability be integrated into the stream of research on power and privilege. The critical perspective acknowledges “the field of adult education maintains this asymmetrical power relationship with people with disabilities by centering on issues of disease and health and not on the experience of adults with disabilities as a social justice issue (Rocco, & Fornes, 2010, p. 385). Results of this study suggest physical therapists recognize these disparities and provide advocacy practices to ensure equality and maximal access to services and technologies despite level of ability. Critical disability theory and pedagogy provide a lens for research on advocacy to allow the patient with disabilities to be viewed and understood as an individual first and foremost with wants and needs that need to be respected, valued and protected.

Physical therapists act as adult educators in multiple contexts, including with students in academic and clinical settings and with patients and patients’ families in all healthcare settings. These contexts of adult and continuing education in relation to physical therapists along with the critical perspectives of adult education provide a method to merge theory and practice. Critical perspectives are integral to be included in advocacy education as they form the foundation of advocacy need. Aging adult patients

in the healthcare system need to be recognized as marginalized and the physical therapist provider has the duty and responsibility to advocate for individual and societal needs.

Physical Therapy

The field of physical therapy has basic guidelines for education and practice created by the Commission on Accreditation of Physical Therapy Education (CAPTE) and the American Physical Therapy Association (APTA). While these guidelines include general statements involving professional behaviors and the physical therapist Code of Ethics, each institution creates its own curriculum, which may but frequently does not include specific advocacy training. Also physical therapist education involves significant exposure to clinical instructors who may or may not possess favorable advocacy attitudes or demonstrate advocacy behaviors. The current study suggests changes to formative physical therapist education to emphasize the foundational constructs of advocacy along with methods to model and foster advocacy practices for students, new graduates and novice practitioners. Respondents also voiced the need for specific advocacy education based on significant concerns regarding the rapid changes in health care practice that may limit choices and restrict practices of physical therapists; each of which may impede effective advocacy.

Formative academic programs in physical therapist education take place at a post baccalaureate level. These programs espouse the use of andragogy and adult education methods in teaching. However, the literature in physical therapist education and this author's experiences yield therapy programs notably absent of critical pedagogies. This research suggests these foundational topics are important for the discussion of patient advocacy. The relevant components of critical perspective of adult education were

discussed earlier in this chapter. They include Brookfield's (2005) recommended tasks involved in learning with critical theory along with his suggestions to integrate theory into critical practice. These components need to be routinely integrated into all levels of physical therapy curriculum and taught along with specific recommendations on how to critically reflect and advocate for the best care for the geriatric patient.

In the field of physical therapy, the knowledge of the breadth of advocacy practices is limited. Advocacy is represented on the APTA website as solely political advocacy along with methods of writing letters and contacting the legislature in relation to policy change. This research identifies the vast demands of patient advocacy required in geriatric clinical practice. Physical therapists relate the complex interaction of individual and social advocacy responsibilities. This research also suggests that educational methods should include factors to facilitate effective advocacy including personal and professional collaboration, identification of community resources, effective use of knowledge and skills and developing personal fortitude to advocate in complex situations.

The current study suggests several implications for both adult education and the field of physical therapy. In addition, there are implications for further research, to continue to expand the knowledge base for geriatric patient advocacy.

Limitations, Implications for Future Research and Conclusion

The results of the geriatric advocacy survey and the qualitative interviews provide a wealth of new information regarding how physical therapists understand and practice patient advocacy with their geriatric patients. However, there are limitations to the study and several implications for future research.

Limitations

One of the main limitations of the study overall was the inability to access average physical therapists practicing in geriatric settings nationally. Each state individually has demographic information on practicing physical therapists based on licensure. However, there is no national database to access a cross section of practicing physical therapists. Therapists in this study were all members of the APTA, which is not mandated for all physical therapists; in fact there is a significant cost to be a member and many physical therapists do not belong to this organization. Based on 2012 data, approximately 21% of licensed physical therapists were members of the APTA (APTA, 2012). By limiting participants to APTA members, perceptions may not be representative and therefore results not generalizable to average practicing therapists.

Another limitation is that while the study's sample size is statistically sound, the sample size was too small for certain statistical analysis. Specifically, the sample of participants who identified as other than white race or Christian religion was too small to determine significant differences. Also, due to the sample size, a factor analysis was not appropriate to determine the interaction of factors on geriatric advocacy attitudes or behaviors.

A final limitation is the overall lack of racial and ethnic diversity noted in the survey sample responses and interview participants. While the field of physical therapy is generally homogenous in terms of race, ethnicity, and gender this was exacerbated by homogeneous responses and contributes to a lack of racial and ethnic voice in the current study.

Implications for Future Research

The limitations of the study have implications for future research, which will accomplish three goals. The first is that it will continue to add to the limited body of knowledge of physical therapists' beliefs and behaviors regarding advocacy practices when working with aging adults. Second it will continue to highlight the rapidly changing policy changes, restricted physical therapy practices and financially motivated institutional pressures that affect quality of care provided by therapists in all work settings. Finally, it will continue to espouse the importance of critical theory in the current discussions of critical thinking that occur in physical therapist education and practice.

The current study suggests several areas on which to concentrate for future research. These areas include further assessment of average, non-APTA member, clinical practitioners' beliefs and practices of patient advocacy in geriatric patient settings, assessment of student perception and understanding of geriatric advocacy practices in clinical settings, defining resources and tools needed for effective patient advocacy along with methods for incorporating these tools into academic and clinical education, and the impact of financially motivated pressures on physical therapy treatment provision and quality of care for aging adults.

Interviewees, as effective patient advocates, frequently mentioned the importance of belonging to the APTA and specifically the subsection of the Academy of Geriatrics. This membership provides information and resources on physical therapy best practices and research data for knowledge and skills along with new and changing service

recommendations. However, as noted above, only 21% of practicing physical therapists are members of the APTA, therefore research should continue to determine further advocacy beliefs and practices along with methods these non-APTA members are using to understand and practice advocacy behaviors with aging adults.

Clinical education was recommended as an appropriate space for student education regarding advocacy practices. Assessment of student views of advocacy practices and use of modeling and mentors in clinical settings would provide an alternate lens of advocacy practices to inform academic and clinical instructor education. Within this context, examining the uncertainty that goes along with the difficult decisions to provide advocacy in some patient situations would help better describe the individual challenges and support needed to be successful healthcare provider advocates.

Utilization of tools and resources to facilitate advocacy practices was emphasized by all interviewees. Research to further delineate essential tools needed for effective advocacy practices along with barriers to advocacy practices will help bridge the gap between favorable advocacy beliefs and effective advocacy behaviors. This includes examining what is missing in current education and practice to promote successful advocacy.

Lastly, all of the interviewees stated the need for advocacy practices are currently exacerbated by the rapid changes in health care policy and systems and subsequent restricted therapy practices in many areas of care. Qualitative research in the area of policy changes and concurrent practice changes would shine a light on resultant changes in patient care and perceptions on quality of life for clinicians and patients in this new era of health care. Action research, utilizing qualitative participants who are actively

providing patient advocacy, would also help understand effective methods of advocacy and strategies utilized for patients and in education of others to be successful advocates.

While the current study has some limitations and implications for further research, the current study has made strides in adding the breadth of knowledge in physical therapists' advocacy knowledge and practices. The knowledge provides a framework to create improved formative and continuing education programs for physical therapists in the care of aging adults utilizing and emphasizing critical perspectives of adult education. This study also adds to the critical gerontology framework by asking a new question in an area that has had limited recent focus and provides a new social context for the foundational beliefs of critical gerontology to be examined and portrayed.

The findings indicate complex nature of advocacy practices in all health care settings and the challenges and barriers that must be overcome to provide effective advocacy. The findings also yield factors that facilitate successful advocacy including having a passion toward working with older adults, accessing resources, demonstrating excellence in clinical practice and have the personal fortitude to buck the system when needed. Lastly, the current findings describe and exemplify how patients in the institution of health care, especially aging adults, frequently experience bias and marginalization. Physical therapists recognize these challenges, develop significant relationships and trust, and proceed to embrace the role of provider advocate.

Conclusions

The current study provides a framework for the discussion of physical therapist beliefs and practices of geriatric patient advocacy. While physical therapists have always been educated to provide patient-centered care, it is only recently that personal

experience and student questions regarding experiences in clinical education, caused me to wonder ‘where is the patient in all this?’

This question is what provided the impetus to researching the topic of patient advocacy and provided an important question to consider in relation to the rapid changes in health care that are changing how physical therapists, and other health care providers practice. These changes include limiting time and efforts to providing direct patient care services and the associated ancillary practices needed to be comprehensive in nature.

These changes are only recently being documented in the literature and formally recognized as problematic by regulating bodies. In October, 2014, American Physical Therapy Association along with the American Occupational Therapy Association and the American Speech-Language-Hearing Association published a consensus statement regarding ethical service delivery and integrity of practice due to changes in clinical practice that appear to limit therapist decisions and clinical judgment in healthcare settings.

The results of the current study are clear and there is consensus among physical therapists that it is our role to provide patient advocacy for geriatric patients’ rehabilitative and medical needs. It is our duty to empower aging adults, protect their rights, speak for them if indicated and champion social policies to ensure equal access and attention to needs of the geriatric community. It is also imperative to educate student and novice physical therapists in the constructs and practices of effective patient advocacy.

The current study has valuable lessons for both the fields of adult education and physical therapy, but it also inspired personal growth. In reflecting on my own practice

in the clinic and in academia, I realize how advocacy practices have become nebulous and implicit in nature. It is now my role to shine a light on advocacy responsibilities with specific and explicit definitions and practice standards. My goal is for each of my students' to want to work with geriatric patients and develop a passion for providing quality care. It is also my goal to bring the theoretical constructs of critical theory and critical pedagogy into the discussion of critical thinking in professional studies. These are the first steps to becoming an effective advocate and provide the foundation to the practice of lifelong learning in order to obtain and maintain excellence in clinical practice.

Final Thoughts

I entered this doctoral program based on the observation that while I had been teaching in academia for several years, I had no formal training in education and had a genuine desire to improve my knowledge and skills. Little did I know that I would be enlightened in ways far beyond mastering how to write test questions or how to organize a lecture presentation. This program put me in the midst of a cohort of students, faculty and mentors that constantly challenged my beliefs and thinking and expectations of myself and of my students. I read and wrote about things far beyond my current knowledge and comfort zone. I learned that you truly do not know what you don't know and one of the most important questions that needs to be asked is why? I also learned that it is much more important to listen than to speak.

This current research study has reinforced my passion toward working with older adults and the significant impact that physical therapists can make in the quality of life for an older adult. Therapists are truly privileged to be able to develop close

relationships, provide care and advocate for aging adults. The physical therapists whom I spoke to for the qualitative interviews were truly inspiring in their efforts and also validating of my efforts to better understand the concepts of patient advocacy. This research also inspired my goals in the classroom to share my knowledge and beliefs with my students and help them recognize their privilege and discover their passion to become professional clinicians. While I am acutely aware of how my work has already changed and refined as a result of my tenure and responsibilities as an adult education doctoral student, I am looking forward to seeing how my work as a physical therapist, adult educator and researcher continues to inform my passion and practice focused on aging adults.

APPENDIX A: Attitudes toward Patient Advocacy Survey Items (Bu & Wu, 2008)

SECTION 1 examines your attitudes regarding safeguarding patients' autonomy in situations in which patients are competent and want to be involved in their health care.

1. I should find out the extent to which my patients want to be involved in planning their health care.
2. When assisting patients to make decisions regarding their health care, I should assess patients' decision-making capabilities related to their particular clinical situations.
3. I should periodically assess patients' beliefs and wishes regarding their health situation.
4. I should be sensitive to and respectful of patients' views regarding their health care even if I do not share their views.
5. I should review with patients their rights to refuse when they do not want the medical procedures.
6. If patients are not well informed regarding their diagnosis and medical treatment, I should help them to obtain adequate relevant information.
7. If I find that other members of the health care team withhold information from patients about their health status, I should remind them that patients have the right to know that information.
8. If I find that patients enroll in an experimental treatment without fully understanding the treatment, I should advise patients not to participate in the experimental treatment until being fully informed.
9. I should continually provide patients with information and knowledge about the health care that they are receiving.
10. Before performing any health care, I should make sure that patients understand what is going to be done and what their experience will be like.
11. When patients have difficulty understanding instructions on the treatment consent forms, I should answer any questions in language that they can understand.
12. I should help patients weigh the benefits and risks of each health care option available when they make health care decisions.

13. Before implementing patients' decisions, I should make sure that patients' decisions are really what they desire.

14. If it seems that patients make decisions to please others, I should remind them that they have the right to make decisions based on their own wishes.

15. I should help patients clarify relevant values, beliefs, and goals to decide what they really want to do regarding their health care.

16. I should assist patients in documenting their values and preferences relating to their health care.

17. I should encourage patients to complete advance directive documents regarding their health care.

18. I should assist patients to communicate their health care preferences to physicians and other health care providers.

19. When patients' families disagree with the patients' informed decision regarding their own health care, I should support the patients' decisions over their families' wishes.

20. When, according to my professional judgment, patients' informed decisions are not in their best interests, I should discuss with them the consequences of their decisions and then support their final decisions.

21. Even when patients' informed decisions regarding their health care are incompatible with their physicians' plan of care, I should support the patients' decisions.

22. When patients say that they do not wish to know the truth about their health status and consequences, I should respect their wishes.

23. I should respect patients' wishes if they do not want to make their own decisions regarding their health care.

24. I should respect patients' decision that they want other people, such as family members and health care providers, to make health care decisions for them.

25. I should assist patients to gain control over their health care if they want control.

26. I should promote patients' efforts to overcome obstacles that prevent them from responding capably to their health care situation.

27. I should encourage patients to participate in decisions affecting their health and welfare.

28. I should help patients gain control in situations in which, for any reasons, they may feel a lack of control.

SECTION 2 examines your attitudes regarding acting on behalf of patients under situations in which patients are unable to help themselves or choose nurses to act for them for whatever reasons

29. I should raise questions regarding medical orders that may cause harm to patients.

30. I should carefully examine each decision of withdrawing medical care, particularly when the patients lack the capacity to decide for themselves.

31. If I witness patients undergoing inappropriate treatments, I should intervene on their behalf.

32. I should help patients access the health care services that they need.

33. If I witness patients being treated unethically by any member of the health care team, I should challenge the unethical treatment.

34. If I believe that patients' prescribed treatments are incompatible with their best interests, I should consult other resources, such as a supervisor or ethics consultant.

35. I should access institutional resources, such as a patient representative, legal nurse, or risk management person, to help support patients' wishes or best interests.

36. If I witness patients being treated incompetently by any member of the health care team, I should challenge the incompetent treatment.

37. When patients lack the capability to voice their wishes, I should express their wishes for them if I know their values and wishes.

38. I should act on behalf of patients when they ask me to represent them.

39. When patients' legal advance directives are ignored by the health care team, I should make efforts to lead the team to honor the patients' wishes.

40. If I find that physicians implement medical treatments on unconscious patients who violate their documented wishes, I should remind the

physicians what the patients' wishes are.

41. When patients' needs are neglected by health team members, I should remind them of the patients' specific needs.

42. When patients' families challenge patients' legal advance directives, I should make efforts to preserve the patients' wishes.

43. When health care providers are making health care decisions for patients who I believe are not in the patients' best interests, I should question the health care providers' decisions.

44. If unconscious patients' health care preferences are not known, I should work with their families and other health professionals to determine the options that maximize the best care for the patients.

45. When there are differences regarding the unconscious patients' health care among family members, I should facilitate communication and collaboration among the family members to achieve a consensus that will benefit the patients.

SECTION 3 examines your attitudes regarding championing social justice in the provision of health care

46. If I find that patients' utilization rate of health risk screening service is low, I should work with other professionals to develop a new patient education program to promote screening behavior.

47. I should examine the health care institution's rules or policies to identify whether or not any interfere with meeting patients' needs.

48. If I find that certain rules or policies of an institution often interfere with meeting patients' needs, I should try to change them through the institution's usual organizational procedures for policy change.

49. If the rules or policies interfering with meeting patients' needs cannot be changed through the usual organizational procedures, I should directly bring the problem to the attention of upper level management.

50. If directly bringing the problem to the attention of upper level management does not result in changes in the rules or policies that interfere with meeting patients' needs, I should try other means, such as getting support from other colleagues or informing the press, of making necessary changes.

51. I should try to participate in shaping policies and rules that provide equally

good care for both advantaged and disadvantaged patients.

52. If I find that disadvantaged patients in my facility lack adequate and consistent health care, I should work with other professionals to assure that adequate and consistent health care is available to them.

53. I should examine institutional rules and policies to identify any that interfere with bringing equally good health care to both advantaged and disadvantaged patients.

54. I should strive to assure that health programs in the institution bring equally good health care to both advantaged and disadvantaged patients.

55. If I find that the disadvantaged population in the community has difficulty accessing health care, I should try to help resolve this problem.

56. I should participate in developing projects in the community, such as establishing health services for homeless populations, to promote equality of health care to disadvantaged populations.

57. I should participate in developing health policies that are sensitive to patients' health care needs.

58. If I find that existing policies interfere with health care delivery, I should collaborate with other professionals, such as physicians, social workers, lawyers, and community representatives, to change those policies.

59. I should step out of traditional nursing settings to participate in developing policies that affect patients' health care.

60. I should participate in shaping health care policies that promote the wellbeing of individuals and communities.

61. I should engage in supporting the legislation that will benefit people's health.

62. I should enter the political arena to represent nursing manpower in order to address problems existing in the health care system that negatively affect patients' outcomes.

63. I should use evidence from the literature to influence health care policy change.

64. I should participate in research that can influence health care policy change.

Sections 1, 2, and 3 – Items 1-64: Copyright 2005 by Xiaoyan Bu. All rights reserved.

Appendix B: Karnish Advocacy Survey

Background and Consent Information:

The topic of ethics in physical therapy practice is receiving increased attention on a regional and national basis. A component of ethical behavior that is embedded in the physical therapy code of ethics is providing patient advocacy.

As a physical therapist you may be involved in patient advocacy practices in any setting of health care. I am specifically interested in advocacy knowledge and behaviors when working with geriatric patients. I am inviting **all physical therapists who work with geriatric patients** to participate in a research study designed **to describe the knowledge, attitudes and practice behaviors of patient advocacy** in geriatric settings.

This study is being conducted by Kristen Karnish, a doctoral candidate from The Pennsylvania State University, under the supervision of Dr. Elizabeth J. Tisdell. We are asking you to complete a web-based questionnaire, which will take approximately 15 minutes of your time. By choosing to participate, you will help to expand the knowledge about the attitudes and behaviors of geriatric patient advocacy and add to the current body of research related to geriatric physical therapy.

You must be 21 years of age or older to participate in this research. Your decision to participate is strictly voluntary, and there are no risks to survey participants. You are free to answer all, some, or none of the questions on the questionnaire. You may withdraw from participating at any time. Refusal to participate will involve no penalty to you.

You will be given the opportunity at the end of this online survey to participate in a follow-up one-on-one interview via phone for a more in-depth interview of geriatric advocacy practices. If you would like to participate in a follow-up interview, you will be asked for your name, telephone number, and email address. If you choose to provide your contact information, you will be entered into a drawing for an Amazon gift card of \$50. Once the follow-up interview process is complete, your name, telephone number, and email address will be removed from the dataset. Once this information is removed, it will no longer be linked with your survey responses. If this research is published, no information that will identify you will be included, since your name will not be linked to your responses.

Only project investigators will have access to study data. Data will be stored on a secure server and on researchers' computers, which are accessible only by password. Your confidentiality will be kept to the degree permitted by the technology used. Although reasonable efforts are made to protect responses, no guarantees can be made regarding the interception of data sent via the Internet by any third parties. Completion of this web survey implies your consent to participate in this research. Please print a copy of the informed consent form for your records.

You can ask questions about the research by contacting Kristen Karnish (kmk36@psu.edu) or her dissertation supervisor Dr. Elizabeth J. Tisdell, Penn State University Harrisburg (ejt11@psu.edu).

Are you a physical therapist who works with geriatric patients?

Yes No

Please rate how strongly you agree or disagree with each statement on the following scale between 1 and 5. One (1) indicates strong disagreement and five (5) indicates strong agreement; more specifically:

1= Strongly disagree; 2= Disagree; 3= Neither agree nor disagree; 4 = Agree; 5= Strongly agree

Items 1-22 examine your attitudes regarding safeguarding patients' autonomy under situations in which geriatric patients are competent and want to be involved in their health and rehabilitative care.

As a physical therapist, when working with geriatric patients, I should:		Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree
1	Find out the extent to which my patients want to be involved in their health care	1	2	3	4	5
2	Assess patients' decision-making capabilities relating to their particular clinical situations when assisting them to make decisions regarding their health care	1	2	3	4	5
3	Periodically assess patients' beliefs and wishes regarding their health situation	1	2	3	4	5
4	Be sensitive to and respectful of patients' views regarding their health care even if I do not share their views	1	2	3	4	5
5	Review with patients their rights to refuse when they do not want medical or rehabilitative procedures	1	2	3	4	5
6	Help patients obtain adequate relevant information regarding their diagnosis and treatment if they are not well informed.	1	2	3	4	5
7	Remind other members of the health care team that patients have the right to know information, if I find that information has been withheld from patients about their health status	1	2	3	4	5
8	Continually provide patients with information and knowledge about health care they are receiving	1	2	3	4	5
9	Make sure that the patients understand what is going to be done and what their experience will be like before performing any rehabilitative care	1	2	3	4	5
10	Answer any questions in language they can understand when patients have difficulty understanding instructions on treatment consent forms	1	2	3	4	5
11	Help patients weigh the benefits and risks of each health care option available when they make health care decisions	1	2	3	4	5
12	Make sure that patients' decisions are really what they desire before implementing patients' decisions	1	2	3	4	5

13	Remind patients that they have the right to make decisions based on their own wishes if it seems that patients make decisions to please others	1	2	3	4	5
14	Encourage patients to complete advance directive documents regarding their health care	1	2	3	4	5
15	Assist patients to communicate their health care preferences to physicians and other health care providers	1	2	3	4	5
16	Support the patient's decisions over the families wishes when families disagree with a patients' informed decision regarding their rehabilitative care	1	2	3	4	5
17	Discuss with patients the consequences of their decisions and then support their final decisions when, according to my professional judgment, patients' informed decisions are not in their best interest	1	2	3	4	5
18	Support the patients' decisions even when patients' informed decisions regarding their health care are incompatible with their physicians' plan of care	1	2	3	4	5
19	Respect patient wishes when they say they do not wish to know the truth about their health status and consequences	1	2	3	4	5
20	Respect patients' decision that they want other people, such as family members and health care providers, to make health care decisions for them	1	2	3	4	5
21	Encourage patients to participate in decisions affecting their health and welfare	1	2	3	4	5
22	Help patients gain control in situations in which, for any reasons, they may feel lack of control	1	2	3	4	5

Items 23-36 examine your attitudes regarding acting on behalf of patients under situations in which geriatric patients are unable to help themselves or choose physical therapists to act for them for whatever reasons.

As a physical therapist I should:		Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree
23	Carefully examine each decision of withdrawing medical or rehabilitative care particularly when the patients lack the capacity to decide for themselves	1	2	3	4	5
24	Intervene on patients' behalf if I witness patients undergoing inappropriate treatments	1	2	3	4	5
25	Help patients access the health care services that they need	1	2	3	4	5

26	Challenge unethical treatment by any member if the health care team if I witness patients being treated unethically	1	2	3	4	5
27	Consult other resources, such as a supervisor or ethics consultant, if I believe that patients' prescribed treatments are incompatible with their best interest	1	2	3	4	5
28	Access institutional resources, such as a patient representative or risk management person to help support patients' wishes or best interests	1	2	3	4	5
29	Express patients' wishes for them if I know their values and wishes and they lack the capability to voice them	1	2	3	4	5
30	Act on behalf of patients when they ask me to represent them	1	2	3	4	5
31	Remind the physicians what the patients' wishes are if I find that physicians implement medical treatment on unconscious or confused patients that violate the patients documented wishes	1	2	3	4	5
32	Remind health care team members of the patients' specific needs if they are neglected by team members	1	2	3	4	5
33	Question other health care providers decisions when I believe health care decisions are not in the patients best interests	1	2	3	4	5
34	Work with patients' families and other health care professionals to determine the options that maximize the best care for their patients if an unconscious or confused patients' decisions are not known	1	2	3	4	5
35	Facilitate communication and collaboration among family members to achieve consensus that will benefit unconscious or confused patients	1	2	3	4	5

Items 36-49 examine your attitudes regarding championing social justice issues in the provision of health care.

As a physical therapist:		Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree
36	If I find that certain rules or policies of an institution often interfere with meeting patients' needs, I should try to change them through the institution's usual organizational procedures for policy change	1	2	3	4	5
37	If directly bringing the problem to the attention of upper level management does not result in changes in the rules or policies that interfere with meeting patients' needs, I should try other means, such as getting	1	2	3	4	5

	support from other colleagues or informing the press, of making necessary changes					
38	I should try to participate in shaping policies and rules that provide equally good care for both advantaged and disadvantaged patients	1	2	3	4	5
39	If I find that disadvantaged patients in my facility lack adequate and consistent health care, I should work with other professionals to assure that adequate and consistent health care is available to them	1	2	3	4	5
40	I should strive to assure that health programs in the institution bring equally good health care to both advantaged and disadvantaged patients	1	2	3	4	5
41	If I find that the disadvantaged population in the community has difficulty accessing health care, I should try to help resolve the problem	1	2	3	4	5
42	I should participate in developing projects in the community, such as establishing health services for homeless populations, to promote equality of health care to disadvantaged populations	1	2	3	4	5
43	If I find that existing policies interfere with health care delivery, I should collaborate with other professionals, such as physician, social workers, lawyers, and community representatives, to change those policies	1	2	3	4	5
44	I should step out of traditional physical therapy settings to participate in developing policies that affect patients' health care	1	2	3	4	5
45	I should participate in shaping health care policies that promote the wellbeing of individuals and communities	1	2	3	4	5
46	I should engage in supporting the legislation that will benefit people's health	1	2	3	4	5
47	I should enter the political arena to represent physical therapy professionals in order to address problems existing in the health care system that negatively affect patient's outcomes	1	2	3	4	5
48	I should use evidence from the literature to influence health care policy change	1	2	3	4	5
49	I should participate in research that can influence health care policy change.	1	2	3	4	5

Sections, 1, 2, and 3—Items 1-49: Adapted from survey developed 2005 by Xiaoyan Bu. Permission granted. All rights reserved

Items 50-60 examine practices and actions performed in patient advocacy to safeguard geriatric patient autonomy, act on behalf of geriatric patients and champion social justice issues in the provision of health care.

Within the past year, as a physical therapist I have:		Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree
50	Ensured that patients understand what is going to be done and what the experience will be like prior to performing rehabilitative care	1	2	3	4	5
51	Reviewed with patients their right to refuse when they do not want health or rehabilitative procedures	1	2	3	4	5
52	Assisted geriatric patients to access health or rehabilitative services they need	1	2	3	4	5
53	Questioned health or rehabilitative care providers decisions which I believe are not in the patients best interests	1	2	3	4	5
54	Provided PT services despite institutional pressure to reduce or withdraw physical therapy procedures which I felt were against the patients' best interests	1	2	3	4	5
55	Reduced or withdrew PT services despite institutional pressure to provide physical therapy procedures that may be incompatible to the patients' best interests	1	2	3	4	5
56	Advocated for policy change or policy development to address physical therapy professional concerns for geriatric patients in health/rehabilitation settings	1	2	3	4	5
57	Assisted with policy change or policy development to provide equally good care for advantaged or disadvantaged geriatric patients	1	2	3	4	5
58	Questioned institutional rules or policies that interfere with bringing good health or rehabilitative care to both advantaged or disadvantaged geriatric patients	1	2	3	4	5
59	Assisted in developing community services for homeless or disadvantaged geriatric patients	1	2	3	4	5
60	Engaged in political/ legislative arenas to support legislation to address health care concerns that negatively affect the geriatric population	1	2	3	4	5

Section 4, items 50-60 adapted from Betts, 2013

Demographic Information

Please complete the demographic information. Those who complete all of the demographic information will be entered into a drawing for an Amazon gift card worth \$50. Also indicate if you would be willing to be contacted for a follow up interview lasting approximately 45 minutes. Thank you so much for participating in this survey.

1. What is your age?

2. What is your gender?
 - a. Female
 - b. Male
 - c. Other

3. Are you Hispanic or Latino?
 - a. Yes
 - b. No

4. Please identify your race/ethnicity

<ol style="list-style-type: none"> a. White Islander b. Black or African American c. American Indian or Alaska Native d. Asian 	<ol style="list-style-type: none"> e. Native Hawaiian or Other Pacific f. Other g. Two or more races
--	---

5. Please indicate your religious preference
 - a. Protestant/other Christian
 - b. Catholic
 - c. Muslim
 - d. Jewish
 - e. Mormon
 - f. Other non-Christian
 - g. None

6. Please indicate the number of years you have practiced as a physical therapist?
 - a. Less than 1 year
 - b. 1-5 years
 - c. 6-10 years
 - d. 11-15 years
 - e. 16-20 years
 - f. 21+ years

7. Please indicated the number of years you have worked with geriatric patients?
 - a. Less than 1 year
 - b. 1-5 years
 - c. 6-10 years
 - d. 11-15 years

- e. 16-20 years
 - f. 21+ years
8. Please indicate what type of setting in which you currently work
- a. Acute Care Hospital
 - b. Acute Rehabilitation Unit/Hospital
 - c. SubAcute/Skilled Nursing Facility
 - d. Home Health
 - e. Out-Patient Center
 - f. Other:_____
9. Please indicate your highest physical therapy degree
- a. Certificate level
 - b. Bachelors
 - c. Masters
 - d. DPT
10. Please indicate your highest academic degree
- a. Bachelors
 - b. Masters
 - c. DPT
 - d. PhD, EdD or other terminal degree
11. Are you involved in clinical education of physical therapist or physical therapist assistant students?
- a. Yes
 - b. No
12. Do you hold specialist certification?
- a. Yes
 - b. No
 - c. If yes, what type_____
13. Do you have any formal training in patient advocacy practices?
- a. Yes
 - b. No
 - c. If yes, what type_____

Interview Contact Information:

Last, First Name:_____

E-mail Address:_____

Phone Number:_____ Best day/time to call:_____

Appendix C: Interview Guide

Research is confidential. No names or other specific identifiers will be use in any research. This interview is being recorded to be transcribed and coded later.

Purpose: To investigate physical therapist attitudes and beliefs regarding patient advocacy when working with geriatric patients, and what are physical therapist practices or actions of geriatric patient advocacy including experiences, antecedents, barriers, consequences, meanings for patients, PT and family.

1. How many years have you been a practicing physical therapist?
2. How many years have you worked with geriatric patients?
3. What setting do you primarily work in?
4. Why geriatric physical therapy?
5. Please describe your role in the services you provide to your patients?
6. In general, how would you define patient advocacy? (individual-protecting pt. rights or acting for patients vs. social justice)
7. What role does patient advocacy play in your interaction with geriatric patients?
 - a) What patients need advocacy?
 - b) Specific needs of geriatric patients?
8. Can you describe situations that you have provided patient advocacy?
 - a. Individual advocacy practices
 - b. Social advocacy practices
9. Interested in the pressures to choose between the patient and the institution (specific or general healthcare business)
 - a. Please discuss any institutional pressures you have had to provide or increase physical therapy services.
 - b. Please discuss any institutional pressures you have had to decrease or withdraw physical therapy services.
10. Describe your experience /interaction when interacting with patients, physicians, other health care professionals and/or families?
11. Please discuss structures or factors that facilitate effective advocacy.

12. Please discuss structures or factors that are barriers to effective advocacy.

13. Please discuss any consequences or results of advocacy efforts.

- a. Ethical considerations
- b. Moral distress

14. Do you have other information that you wish to share on the topic?

In order to validate this qualitative data, I will transcribe this interview and send you to review to be sure the information is accurate. If you have any changes or corrections you can let me know.

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