Patient advocacy: a concept analysis


Abstract

Aim To clarify the ill-defined concept of patient advocacy and develop a model.

Method An eclectic concept analysis was used in the study.

Results Results of the analysis reveal that advocacy has three essential attributes: valuing, appraising and interceding. Antecedents to advocacy include a vulnerable population and a nurse willing to take on the responsibility for advocacy. The consequences of acting as a patient advocate can be potentially negative or positive for patient and nurse. On their own, the attributes are one of a number of helping strategies.

Conclusion Advocacy is a contemporary nursing issue comprising three essential attributes. Individually, each of the attributes is a helping strategy used in nursing. Only when all three attributes are present can advocacy be said to be realised.

T he term advocacy has appeared in nursing literature for almost two decades (Hewitt 2002, Mallik 1997). Much of the literature has attempted to legitimise and encompass patient advocacy in the role of the nurse. However, reservations about the suitability of the nurse to act as patient advocate have also been expressed (Allmark and Klarzynski 1992, Copp 1986, Walsh 1985).


Concepts are labels to describe phenomena that provide a ‘concise summary of thoughts’ (Meleis 1991). A problem with advocacy, however, is the myriad of definitions and explanations. Descriptions range from counsellor, watchdog and representative (Abrams 1978) to potential whistleblower (Ahern and McDonald 2002, Andersen 1990). There does appear to be a consensus that advocacy involves one person representing another (Allmark and Klarzynski 1992, Konke 1982a, 1982b, Morrison 1991). However, for Copp (1986), it means more than speaking for another as it involves intervention for ‘vulnerable’ people who require it.

There are a number of models of advocacy. Fowler (1989) has suggested four:

- Guardian of patients’ rights.
- Preservation of patient values.
- Champion of social justice in the provision of health care.
- Conservator of patients’ best interests.

The first and second models are concerned with patients’ legal rights to health care and treatment, with the second also encompassing individual values. The third model is based on inequalities and inconsistencies in healthcare provision. The final model demands that the nurse has autonomy to empower patients. It is with this model that the codes of professional conduct (NMC 2002, UKCC 1992) are concerned. Conservator of patients’ best interests is particularly evident in clause 2.4 of the NMC (2002) code, which states that the nurse ‘must promote the interests of patients and clients’.

Mallik (1997), however, states that advocacy models are inconclusive and that there is a need for clarification. Indeed, the increasing literature advancing...
advocacy as a nursing activity led Snowball (1996) to suggest that advocacy is just a buzzword: a ‘convenient label for diverse activities’ (Snowball 1996). Conceptual clarity is required to provide the evidence base for advocacy in nursing.

**Aim**

The aim of this research was to clarify the concept of advocacy and to develop a model of advocacy.

**Method**

Concept analysis is a method of enquiry that elicits clarification, identification and meaning of words (Norris 1982, Walker and Avant 1988, 1995). Several methods of concept analysis exist to aid clarification and there is considerable reference to Wilson’s logical positivist approach (1971). Logical positivism, in philosophy, is concerned with analysis of propositions in an attempt to show that it is possible to ‘know’ something for certain (Russell 1984). Walker and Avant (1983) adapted this method for the study of nursing concepts and much of the literature in which the purpose of the study is to examine a specific concept has used this approach. Burnside and Haight (1992) elucidated the difference between the concepts of reminiscence and life review. Gilje (1992) clarified the concept of ‘presence’ as a phenomenon in nursing, and Jacobs (1993) and Mairis (1994) clarified grief and dignity, respectively. Holcomb et al.’s (2002) report on the concept of nursing productivity used this method. Wilson’s (1971) and Walker and Avant’s (1983) approaches to conceptual analysis have been criticised, however, for simplifying complex concepts (Morse 1995). Rogers (1989) considered that Wilson’s (1971) method represented a static view of concepts and was a reductionist approach. Her philosophical examination of the foundations of concept analysis revealed two distinct views of concepts, namely entity and dispositional (Rogers 1989). The first focuses on the concept as an entity in itself, and therefore removes the meaning of the concept from context. Both Wilson’s (1971) and Walker and Avant’s (1983) approaches provide an entity view. In contrast the dispositional view emphasises an individual’s ability to perform specific behaviours as a result of being clear about the concept in question. Here the concern is with the use of concepts in reality and it can be seen to be relevant to exploration of concepts relating to the practice of nursing.

In an attempt to address her criticism of Wilson’s (1971) approach, Rodgers (1994) advanced an evolutionary cycle of concept development, which acknowledged that concepts are influenced by ‘significance’, ‘use’ and ‘application’. Her method brought about analysis that is practice related, as it focused on application of a concept in practice. This hybrid model, along with that of Wilson (1971) and that of Walker and Avant (1983), however, was rejected by Morse (1995) in favour of an alternative: an interpretative approach that used qualitative research methods to establish a concept’s maturity.

Using qualitative methodology and drawing on Bolton’s (1977) ‘rules of relation’, Morse (1995) proposed analysis of primary and secondary data to determine whether the object of enquiry could be considered a concept. The rules of relation are fivefold, concepts are:

**Table 1. The stages for concept analysis**

<table>
<thead>
<tr>
<th>Stages for concept analysis</th>
<th>Authors supporting</th>
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<tbody>
<tr>
<td>Identify the concept of interest</td>
<td>Walker and Avant (1983)</td>
</tr>
<tr>
<td>Determine the aims or purpose of the analysis</td>
<td>Rogers (1994)</td>
</tr>
<tr>
<td>Identify and select an appropriate realm or sample for data collection</td>
<td>(implied by Wilson 1971)</td>
</tr>
<tr>
<td>Identify attributes, antecedents and consequences of the concept</td>
<td>Walker and Avant (1983)</td>
</tr>
<tr>
<td>Identify a model case of the concept, if appropriate</td>
<td>Rodgers (1993)</td>
</tr>
<tr>
<td>Identify implications for further development of the concept</td>
<td>Rodgers (1993)</td>
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</table>

(Morse 1995)
The expressions of the ways in which an individual’s experience are organised.

The result of particular experiences becoming general.

The result of co-ordination of elements.

Used to organise events and must be capable of being applied to new ones.

Formed by examining the correlation between application of a rule to a particular situation and its results.

Having identified that a concept exists, application of the ‘rules of relation’ clarifies which of Morse’s (1995) six concept analysis approaches is the best framework for a particular concept analysis (Box 1).

While Morse’s (1995) approach is comprehensive, it is also more complex to a novice concept analyst. The method for the analysis and clarification of the concept advocacy used in the author’s study was an eclectic one based on Wilson’s (1971), Walker and Avant’s (1983) and Rodgers’s (1989) methods. Morse’s (1995) work on concept development and qualitative thematic analysis has also influenced the approach to this study. The stages and evidence to support their inclusion are shown in Table 1. Data sources include nursing, research and scholarly literature.

### Attributes of patient advocacy

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Valuing</th>
<th>Apprising</th>
<th>Interceding</th>
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<tbody>
<tr>
<td>Definition</td>
<td>A therapeutic relationship in which to secure patients’ freedom and self-determination</td>
<td>Promoting and protecting patients’ rights to be involved in decision-making and informed consent</td>
<td>Acting as an intermediary between patients and:</td>
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<td></td>
<td></td>
<td></td>
<td>– family</td>
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<td></td>
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<td>– significant others</td>
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<td></td>
<td></td>
<td></td>
<td>– healthcare providers</td>
</tr>
<tr>
<td></td>
<td>Gadow 1980</td>
<td>Chamorro and Applebaum 1988</td>
<td>Curtin 1979</td>
</tr>
<tr>
<td></td>
<td>Robinson 1985</td>
<td></td>
<td>Sines 1993</td>
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<tr>
<td></td>
<td>Salladay and McDonnell 1989</td>
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<td>Winslow 1984</td>
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<td>Smith 1979</td>
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#### Results

**Attributes of patient advocacy** The defining attributes, that is, those consistently occurring characteristics throughout the literature included the following:

- A therapeutic nurse-patient relationship in which to secure patients’ freedom and self-determination.
- Promoting and protecting patients’ rights to be involved in decision-making and informed consent.
- Acting as an intermediary between patients and their families or significant others, and between them and healthcare providers.

The attributes identified are summarised as valuing, appraising and interceding, and inherent in each is the nurse who is proactive as well as reactive. Evidence to support the defining attributes and their definition is shown in Table 2.

**Valuing** Analysis of the literature demonstrates that valuing is one attribute of advocacy. It is an essential attribute of a therapeutic nurse-patient relationship that secures patients’ freedom and self-determination. Valuing is that which the advocate holds dear, prizes or cherishes. Valuing has two components: valuing patients’ individuality and valuing self. The patient advocate is one who, while providing expert care, maintains ‘individualization and humanity’ (Smith 1979). Gadow (1980) expressed valuing as: ‘the nurse is in the ideal position among healthcare providers to experience the patient as a unique human being with individual strengths and complexities’.

Similarly, Curtin’s (1979) concept of advocacy is based on the common humanity between nurse and patient for she maintained that: ‘we are human beings, our patients or clients are human beings, and it is this shared humanity that should form the basis of the relationship between us’.

Gadow (1980) placed valuing the patient’s individuality at the core of her philosophical foundation for nursing. She contended that the right to determine meaning for oneself was the most supreme human freedom, a freedom subsumed within the right to self-determination. Gadow (1980) wrote of the nurse advocate helping patients to ‘authentically’ exercise their freedom of self-determination. By this she meant a way in which one reaches decisions that are absolutely one’s own.

**Valuing self** - Konke (1982a) claimed that the advocacy role was action filled and suggested that it had risks. While supporting patients’ decisions the nurse risks being labelled an informer and precipitating anger in others. The best antidote to these risks and ‘hidden hazards’ was open-mindedness, which included knowledge of oneself and an
understanding of one’s own attitudes, values and beliefs. She believed that knowledge dispelled the myths of advocacy and, like advocacy, began with the self. Knowledge affords the advocate the information necessary to inform patients, and self-knowledge enables the advocate to support patients in their decisions.

Robinson (1985) argued that advocacy involved enabling patients to make decisions freely without pressure and encouraging patients to make informed decisions. The advocate takes responsibility for ensuring goals and priorities are client-centred. A successful patient advocate is a nurse ‘who is first able and willing to set aside personal agendas and unit politics’ (Salladay and McDonnell 1989). To do this the nurse needs to know his or her own values, beliefs and opinions.

**Apprising** The second attribute is apprising, which is a combination of informing, advising and educating. Konke (1982b) claimed that informing and supporting were at the heart of patient advocacy. Advocacy involves enabling patients to make their own decisions regarding health care, which will encourage the likelihood of them obtaining the health care of their choice. However, advocacy goes beyond merely assisting patients with their decisions. It involves helping them to reason and deliberate (Barton 1991). This requires that the patient is knowledgeable, before making the decision, about the implications, consequences and alternative options on offer. Thus the advocate acts as a ‘sounding board’ so that patients can arrive at the right decision aware of the ramifications of their decisions.

Chamorro and Applebaum (1988) enriched the apprising component by arguing that advocacy involved not only disclosing the consequences of proposed treatment plans but also the consequences of foregoing the treatment. This second attribute demands the skills of informing and advising so that the advocate can promote and protect patients’ rights to be involved in decision-making and informed consent.

**Interceding** The final attribute is interceding. It means coming between parties and intervening or mediating where necessary. Patient advocacy demands that the nurse helps patients to overcome barriers to meeting their needs (Curtin 1979, Winslow 1984). Reference to transcending barriers is supported in the literature, which recognises nursing’s role in re-humanising and re-personalising patients’ experiences of healthcare services.

Bureaucratic hospital systems and the power ascribed to healthcare professionals render the patient population vulnerable and impotent, as does the disease process (Curtin 1979). Kahn et al (1972) asserted that: ‘advocacy has existed for as long as there have been powerless groups in need of a champion’. In their position of powerlessness, patients require someone to speak for them, and in some cases mediate on their behalf. Interceding was identified by Marshall (1991) and Sines (1993) as an advocate’s role. Both authors included mediating between parties as one of the advocate’s functions. Copp (1986) identified interceding in respect of vulnerable people. As hospitalisation renders patients vulnerable, there is a need for an advocate who is able and willing to intercede on their behalf.

Most literature pertains to interceding between patients and healthcare providers. Some identifies that the patient’s advocate intercedes between patients and family or significant others (Conway-Rutkowski 1982).

### Antecedents and consequences

Antecedents and consequences are stages of concept analysis that are often ignored (Walker and Avant 1995), yet they enrich an analysis by placing the concept in context. The analysis reveals that there are two parties involved in patient advocacy – the nurse and the patient. Therefore, there are antecedents and consequences for both parties (Figure 1).

**Antecedents** Antecedents are events that must occur before the concept (Walker and Avant 1995). The analysis has shown that the nature of the situation preceding patient advocacy is twofold. First there is the context of vulnerability whereby the patient, simply by being a patient, is vulnerable. The patient in his or her vulnerable state might be facing conflict or in a situation that requires a decision. Second, there is a need for the nurse, who is to act as the patient’s advocate, to take responsibility for assisting the patient.

**Patient** – Much of the literature analysed referred to patient vulnerability. Abrams (1978) clearly described how on becoming a patient there was a need for an advocate. On entering hospital the patient experiences loss of control over his or her life, and loss of identity and initiative. Being hospitalised removes one from the family and the natural supportive network families provide. The patient faces a strange environment with potential worries about health problems as well as concerns about separation from family (Abrams 1978, Jenny 1979). Recent government publications provide evidence that patient vulnerability remains an issue in the 21st century, for example, publications guiding patients through the network of health services (DoH 2001).

In addition to being vulnerable, patients face conflicts and situations demanding decision-making. Barton (1991) identified this antecedent when she claimed that advocacy was a vehicle for enabling patients to refuse treatment. Citing a case study of a patient who refused chemotherapy twice, on the grounds of wishing to secure herself a ‘quality of life’, Barton (1991) demonstrated how a vulnerable patient faced conflict. The case study
demonstrated the first antecedent of vulnerability in that the patient (who had a cancer diagnosis) was experiencing a certain degree of persuasion from medical personnel as well as her family. There is evidence also that in this vulnerable state the patient was in a situation causing her conflict as she was refusing treatment. Brett (1998) likewise noted how conflict and vulnerability were inherent in the experience of the hospitalised older person. The strange environment and protocols may make older patients adopt a subordinate role where they find themselves agreeing with powerful healthcare professionals and feel a need to comply with rather than refuse treatment (Brett 1998).

Nurse – Willingness and responsibility are the two antecedents pertaining to the nurse. Fay (1978), recognising that education would promote the advocacy role, assigned students course work that explicitly encouraged them to take responsibility for, and to become, patient advocates during clinical experience. In Barton’s (1991) case study, the patient did not benefit from the services of an advocate. There was no nurse willing to take responsibility to continue to assist her with her decision and she was persuaded on the third occasion to consent to chemotherapy. Ahern and McDonald’s (2002) survey of nurses’ beliefs relating to whistleblowing and advocacy supported the existence of the two antecedents: nurses who reported misconduct believed in patient advocacy and felt they had a responsibility to patients.

Consequences

**Patient** – self-determination

**Nurse** – satisfaction

**Patient** – discomfort

**Nurse** – risk

The strange environment and protocols may make older patients adopt a subordinate role where they find themselves agreeing with powerful healthcare professionals and feel a need to comply with rather than refuse treatment (Brett 1998).
A 55-year-old woman with a diagnosis of inoperable pancreatic cancer was offered the opportunity of participating in a randomised controlled trial (RCT) involving cytotoxic chemotherapy. The patient confided to the nurse involved in her care that she was having difficulty deciding whether or not to participate in the trial. The GP and the patient's family were supportive of the trial. Participating in an RCT meant that she had no control over whether she would have to remain in hospital: one of the treatments involved being an inpatient. The patient asked the nurse to help her find out more information about the specific drug.

The nurse, with the support of the patient's family, contacted a national organisation's helpline and obtained written information about the nature of the cancer and the drug to be trialled. She also contacted the oncologist who provided additional information about the drug. Stating that the patient had a poor prognosis, the oncologist hoped that the trial might be able to offer some 'quality of life', although what this involved could not be specified.

The patient, in possession of the information the nurse had provided, decided not to enter the trial.

**Table 3. Advocacy**

<table>
<thead>
<tr>
<th>Implications for practice</th>
<th>Antecedents</th>
<th>Consequences</th>
<th>Own advocacy skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
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<tr>
<td>Planning</td>
<td></td>
<td>Patient participation</td>
<td>Decision-making strategies</td>
</tr>
<tr>
<td>Advocating</td>
<td></td>
<td>Using relationship building skills</td>
<td>Promoting and protecting patients’ rights to be involved in decision-making and informed consent</td>
</tr>
<tr>
<td>Evaluating</td>
<td></td>
<td>Criteria of effectiveness – consequences</td>
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</tbody>
</table>

A negative consequence that was implied in the literature, however, is patient discomfort. Discomfort appears more apparent when there is competition for the role of advocacy between professionals (Copp 1986). Konke (1982b) provided the most tangible evidence for the less desirable aspect of advocacy from the patient's perspective. She claimed that it was a human trait to want to blame others in situations where the decision made turns out not to be the best one.

**Nurse** – A positive consequence for the nurse is job satisfaction; however, the negative aspect relates to perceived and actual risk in terms of career.

Literature pertaining to the nurse’s role clearly identifies advocacy as an ideal which, in turn, is a means to self-actualisation and a positive consequence of advocacy (Henderson 1961, NMC 2002). From Henderson’s early writing to current codes of professional conduct, being an advocate can help the nurse to fulfil his or her role and is thus a positive influence. It is grounded in the caring ethic (Curtin 1979).

A negative consequence, however, is advanced explicitly by Andersen (1990), namely whistleblowing. Other authors less forthright than Andersen (1990) also support the notion that advocacy is a risky business (Abrams 1978, Copp 1986, Fay 1978). Graham Pink was a charge nurse working in care of the older person’s wards on night duty at Stockport. After unsuccessfully raising concerns with his managers over a period of two years, he decided to publicly report how understaffing was causing inadequate care. Pink was dismissed. However, his employers said that it was not because of whistleblowing. They took action when a patient's relatives complained that the information supplied to the press had been sufficient for them to identify who was being written about and this had caused them distress. Further examples of these risks are evident in Hunt’s (1995) whistleblowing survey results.

**Discussion**

The attributes of advocacy elicited from analysis of nursing, research and scholarly literature are valuing, apprising and interceding. While each has been addressed individually, in reality they overlap. Concept analysis reveals that patient advocacy is a combination of three essential helping strategies. Only when all three attributes are combined is advocacy realised.

The deliberate, logical and systematic approach of assessment (Table 3) is required to determine those situations in which advocacy is appropriate and possible. Identifying patients who are vulnerable and who require an advocate is essential. Additionally the potential advocate needs to observe for other situations in which to advocate for patients. The advocate needs to be aware of the antecedents so as not to miss opportunities that may be less apparent than merely being a member of, or stereotyped into, a vulnerable group. While assessing for situations of advocacy the advocate needs also to consider the consequences.
This will include weighing the benefits against the costs to the nurse and patient. It is possible following one negative experience that an advocate may assess the consequences in novel situations to be too great to implement advocacy.

Patient participation is required. The fact that the antecedents for advocacy include vulnerable patients who may also be experiencing conflict in making decisions serves to illustrate the importance of their involvement in the process. As the purpose of advocating has been demonstrated as enabling patients to exercise their right to freedom and self-determination, their active involvement is fundamental.

Instruments of evaluation are not readily available for advocacy, however, the author suggests that the consequences of advocacy may be useful criteria to determine effectiveness.

Nurses should be aware that valuing, apprising and interceding are required if they are to engage in patient advocacy. There will be situations in which nurses practise all of the skills noted as attributes, but not necessarily simultaneously. On their own the attributes are one of a number of helping strategies. Advocacy is possible only when all three attributes are present.

**References**


**Implications of practice**

- Patient advocacy is a combination of valuing, apprising and interceding
- Antecedents to advocacy include a vulnerable population and a nurse willing to take on the responsibility for advocacy
- The consequences of acting as a patient advocate can be potentially negative or positive for both patient and nurse

**Conclusion**

The results from the analysis of the concept of advocacy reveal that it is a combination of three essential helping strategies. Only when valuing, apprising and interceding are combined can advocacy be realised. From the discussion, exploring implications for practice, along with the identification of antecedents and consequences, it can be concluded that advocacy is an essential and necessary requisite of nursing.