Developing a mid-range theory of patient advocacy through concept analysis

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Abstract
Title. Developing a mid-range theory of patient advocacy through concept analysis
Aim. The aim of this paper is to clarify and refine the concept of patient advocacy through synthesizing the advocacy literature in nursing and to establish a theoretical basis for future studies on patient advocacy in nursing.
Background. Patient advocacy is an essential component of the Registered Nurse professional role. During the past 30 years, the patient advocacy role has become more important, but the concept of patient advocacy lacks a consistent definition and research into nurses’ patient advocacy roles is limited. There have been few quantitative empirical studies on patient advocacy in nursing.
Method. Walker and Avant’s method of concept analysis was used as a guideline in examining the concept of patient advocacy through synthesizing the advocacy literature in English (1974–2006).
Findings. A mid-range theory of patient advocacy emerges during the process of synthesizing and analysing the advocacy literature. Three core attributes of the concept of patient advocacy are identified: (1) safeguarding patients’ autonomy; (2) acting on behalf of patients; and (3) championing social justice in the provision of health care. They reflect nurses’ patient advocacy roles at both macro- and micro-social levels. Antecedents of patient advocacy occur at both macro- and micro-social levels and call for nurses’ advocacy roles in the healthcare system. Consequences produced by nurses’ patient advocacy behaviours are contextual. Nurses’ patient advocacy behaviours not only can positively influence the patients, other nurses and the nursing profession, but also can cause negative consequences for nurses who take action to advocate for patients.
Conclusion. The proposed mid-range theory may be useful in guiding advocacy practice in nursing and in guiding research in the advocacy area. The proposed theory needs to be furthered refined and tested in the future.

Keywords: concept analysis, ethics, nursing, patient advocacy, theory

Introduction
Since 1976, patient advocacy has been an essential component of Registered Nurses’ professional role. In today’s healthcare delivery system, patient advocacy is becoming increasingly

important. The public demands more information and control over their health care. Moreover, illness and limited knowledge about medicine, nursing and the healthcare system mean that patients are often vulnerable and powerless (Carpenter 1992). Furthermore, the development of medicine and

advanced technology has resulted in aggressive and swift use of technologies, which is becoming the norm in the contemporary hospital environment. In such a healthcare setting, patients’ quality of life and right to self-determination tend to be ignored. In addition, inequalities and inconsistencies exist in the provision of healthcare resources at all levels in the United States of America (USA). During the last 40 years, disparities in health status and access to health care between white and the minority populations (e.g., Hispanic and Black) has been recognized as a cause for concern throughout the USA (Tripp-Reimer 1999).

The philosophy of the nursing profession, nurses’ educational background, and the unique position of nurses in the healthcare system mean that they should be able to advocate effectively for patients. The American Nurses Association (ANA) (2001) Code of Ethics for Nurses with Interpretive Statements requires that nurses advocate for, and protect the health, well-being, safety, values, and rights of patients in the healthcare system. This advocacy role is also reflected in the principal elements of the International Council of Nurses (ICN) (2006) Code of Ethics for Nurses:

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The nurse ensures that the individual receives sufficient information on which to base consent for care and related treatment (p. 2).

The patient advocacy role has been emphasized in the nursing profession. However, in reality, nurses have not put it fully into practice in the healthcare system, even though they may support the concept (Millette 1993, Kieffer 2000, Nahigian 2003). The definition of patient advocacy is still confusing, and there is no consensus about its meaning among nurses and nurse authors. Neither the ANA (2001) Code of Ethics for Nurses nor the ICN (2006) Code of Ethics for Nurses contains a definition of patient advocacy for the nursing profession. In the nursing literature, there is still a lack of understanding about nurses’ views regarding advocating for patients and their actual performance of patient advocacy. Most empirical studies related to nurses’ patient advocacy roles are qualitative, descriptive studies (e.g., Mallik 1997, Chafey et al. 1998, Foley et al. 2000). Few quantitative studies on patient advocacy exist in the nursing literature. A clearly defined concept of patient advocacy is necessary to develop quantitative research on patient advocacy. Our study therefore aims to clarify and refine the concept of patient advocacy through synthesizing the advocacy literature, and to establish a theoretical basis for future studies on patient advocacy in nursing.

Methods

Walker and Avant’s (1995) method of concept analysis was applied to guide this analysis of the concept of patient advocacy. Concept analysis is a rigorous and precise procedure that yields a tentative meaning for a concept. It is often recommended as a way of starting to examine information in preparation for theory construction. We followed six steps of Walker and Avant’s concept analysis method: selecting a concept, determining the aims or purpose of analysis, identifying all uses of the concept that can be found, determining the defining attributes, identifying antecedents and consequences, and defining empirical referents (occurrences of the concept). Since the goal of our study was to develop a theory of patient advocacy for guiding nursing research and practice, we did not include steps to construct model, borderline, related, and contrary cases.

To conduct the concept analysis, we carried out an extensive literature search using electronic versions of CINAHL and MEDLINE for the years 1966–2006. We examined all relevant sources containing the search terms ‘advocacy’ and ‘patient advocacy’, limiting the search size by narrowing the focus to include primarily sources on patient advocacy in nursing. We then conducted a secondary literature search by examining the reference lists of published articles. Three unpublished dissertations (DiGaudio 1993, Kieffer 2000, Nahigian 2003) related to nurses’ patient advocacy roles were referred by nursing colleagues and obtained from the Health Science Library at the University at Buffalo. The three dissertations and another 217 published advocacy articles (1974–2006) were read in full and were synthesized according to the concept analysis approach (Walker & Avant 1995). The 220 articles and dissertations were written in English and involved nurses’ advocacy roles in the USA (e.g., Rushton 1994, Snowball 1996), the United Kingdom (UK) (e.g., Mallik 1997, Ambler et al. 1999), Sweden (e.g., Lindahl & Sandman 1998, Söderhamn & Idvall 2003), Australia (e.g., McKinley 1986, Breeding & Turner 2002), Canada (e.g., Romaniuk 1990, Edwards & Halbert 1992), Ireland (O’Connor & Kelly 2005), New Zealand (O’Connor 1996, Williamson 2003), Finland (Vaartio & Leino-Kilpi 2005), Turkey (Altun & Ersoy 2003) and Japan (Davis et al. 2003).

Findings

Definitions of the concept of advocacy in nursing literature

Merriam-Webster’s Collegiate Dictionary (1998) defines advocacy as ‘the act or process of advocating or supporting’,
and an advocate as ‘one that pleads the cause of another’ (p. 18). In the nursing literature, Florence Nightingale emphasized measures by which environmental factors can be manipulated to put patients in the best condition for nature to act upon them; this is considered an early example of advocacy in nursing (Bramlett et al. 1989). Historically, the ideal nurse has been defined variously as healer, champion of the sick poor, parent-surrogate, physician-surrogate, contracted clinician, personal counsellor and health educator (Gadow 1980). Since the 1970s, advocacy has increasingly been discussed as an essential component of nurses’ professional role and many definitions have been proposed in the nursing literature. The most frequently discussed advocacy models in the nursing literature are Curtin’s (1979) human advocacy model, Gadow’s (1980) theory of existential advocacy, and Kohnke’s (1982) functional model of patient advocacy. In 1989, Fowler added another model – social advocacy – to the advocacy literature. We found no systematic review of the concept of patient advocacy in the literature.

Two nurse philosophers, Gadow and Curtin, thought that nursing ought to be defined philosophically rather than sociologically, that is, defined by the ideal nature and purpose of the nurse–patient relation rather than by a specific set of behaviours. According to Curtin’s (1979) human advocacy model, healthcare professionals, patients or clients are all human beings, and it is this commonality that should form the basis of the relationship between nurses and patients/clients. In the field of human advocacy, nurses get to know patients and attend them as distinct and unique human beings. They must be sensitive to individuals and their reactions to those needs created by illness which may threaten the integrity of the person. Gadow’s (1980) theory of existential advocacy is based on the principle that freedom of self-determination is the most fundamental and valuable human right. According to Gadow, nurses should help patients become clear about what they want to do by helping them discern and clarify their values in a particular situation, based on the principle of self-determination, so that they reach decisions expressing their reaffirmed values.

Kohnke (1982) proposed a functional model of patient advocacy, which is simpler and more pragmatic. Kohnke’s central belief is that individuals have a right to self-determination. According to this model, advocacy involves informing patients and then supporting the decisions they make along with their right to make that decision. Informing means supplying the patient with the information needed to make informed choices.

Curtin’s (1979), Gadow’s (1980) and Kohnke’s (1982) advocacy models have the same basis in a belief in personal autonomy that means individuals are permitted personal liberty and freedom to determine their own actions. The philosophical basis for the advocacy concept in the nursing literature reflects the dominant values (e.g. humanity, individualism, freedom and autonomy) of US society. However, each of the three advocacy models has its own connotation and emphasis. Curtin’s model is considered a humanistic model that emphasizes patients’ benefits and nurses’ humanity. Gadow’s existential advocacy model and Kohnke’s functional advocacy model both emphasize patients’ self-determination and incline towards a legal advocacy model, although there are some differences between the two. Gadow stresses that nurses should help patients discern their own values and that the decisions made by patients should truly reflect those values. Nurses are more personally involved with patients’ decisions. According to Kohnke, nurses should provide patients with information that is adequate to help them make their own decisions. What nurses need to do is to inform patients and support whatever decisions they make. Nurses are less personally involved with patients’ decisions.

Fowler (1989) proposed the social advocacy model. This model retains nurses’ concerns about individual patients, yet advances them beyond institutional walls, and calls for participation in social criticism and social change. Social advocacy calls attention to inequalities and inconsistencies in the provision of care at both the micro- and macro-allocation levels, and it insists on change. Social advocacy is rooted in the concept of social justice. Applied to health care, social advocacy means there should be equitable access to adequate nursing and care for all. This concept of social advocacy attempts to bring ‘what is’ into conformity with ‘what should be’. It tries to correct both clinical and social injustices that fail to respect patients as persons, their rights, their values, or their dignity. As a model, this form of advocacy encompasses the values that the three advocacy models described above contain, yet surpasses them by broadening the concerns of nurses beyond those of the immediate bedside.

Although the four advocacy models described above are frequently discussed in the nursing literature, each of them reflects solely on one aspect of patient advocacy. Moreover, all the four advocacy models fail to point out that nurses’ patient advocacy behaviours are context-based: that is, nurses take different actions to advocate for patients in different clinical situations.

A mid-range theory of patient advocacy

advocacy model. A mid-range theory of patient advocacy emerges from synthesizing and analyzing the advocacy literature. It contains the same philosophical ideas (i.e., humanity, freedom and justice) as those encompassed within the four advocacy models proposed by Curtin (1979), Gadow (1980), Kohnke (1982), and Fowler (1989).

According to our proposed theory, patient advocacy is viewed 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. Based on our concept analysis, patient advocacy includes three broad core attributes: (1) safeguarding patients’ autonomy; (2) acting on behalf of patients; and (3) championing social justice in the provision of health care. The number of citations where core attributes are discussed in the literature is presented in Table 1. The three broad core attributes occur explicitly or implicitly in the advocacy literature and reflect underlying meanings of almost all the empirical referents of patient advocacy or the specific patient advocacy actions identified from the literature.

**Safeguarding patients’ autonomy**

The first core attribute represents a series of specific 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. There are two assumptions in this meaning. The first is that individuals have primary responsibility for their own health and healthcare professionals have a responsibility to respect and/or promote patients’ health. Second, it is assumed that individuals are competent to make their own decisions and act on their own behalf though they may need information and assistance to do so. This core attribute emphasizes patients’ legal rights in the healthcare system and reflects the implications of Gadow (1980) theory of existential advocacy and Kohnke’s (1982) functional model of patient advocacy.

**Acting on behalf of patients**

The second core attribute represents a series of specific actions that preserve and represent patients’ values, benefits and rights in situations where patients are unable or do not wish to help and represent themselves. These situations may include unconsciousness, or choosing to have nurses act on their behalf. In such situations, advocacy means that nurses need to represent and defend patients when their rights and benefits are jeopardised. Advocates act as representatives, protectors, surrogates and delegates. This core attribute reflects the implication of Curtin’s (1979) human advocacy model.

These two core attributes are two important aspects of nurses’ patient advocacy role in two different types of clinical situation; they complement each other and do not conflict. They stress that nurses take different advocacy actions for individual patients under different circumstances. They represent the patient advocacy role at the microsocial level.

**Championing social justice in the provision of health care**

The third core attribute of advocacy is that of championing social justice in the provision of health care. The meaning of this core attribute is based on the ethics of justice (universal access to adequate nursing and health care) and reflects Fowler’s (1989) social advocacy model. It calls for nurses to actively strive for changes on behalf of individuals, communities and society as a whole, so that inequalities and inconsistencies are identified and corrected. In this meaning, nurses become social activists by being involved in issues pertaining to health, education and welfare for people in institutions, the community, or society, and address themselves to a redistribution of power and resources. This attribute represents the patient advocacy role at the macrosocial level.

This mid-range theory of patient advocacy shows that patients are the centre of the healthcare system. It highlights patients’ legal rights and best interests, and nurses’ humanity and justice in the provision of health care. In addition, it recognizes that social and clinical circumstances can influence nurses’ patient advocacy behaviours along with philosophical ideas.

**Antecedents of patient advocacy**

Antecedents are those events or incidents that have a prior occurrence (Walker & Avant 1995). Antecedents of patient advocacy, occurring at the macrosocial and microsocial levels in the healthcare system, call for nurses to advocate for patients.

**Macrosocial antecedents**

On the macrosocial level, health disparity is one of the major antecedents of patient advocacy. This disparity often exists between white and minority populations. Research has consistently shown that, on almost any measure, minorities have

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**Table 1** Numbers of citation where core attributes were discussed

<table>
<thead>
<tr>
<th>Core attributes of patient advocacy</th>
<th>Frequency*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding patients’ autonomy</td>
<td>82</td>
</tr>
<tr>
<td>Acting on behalf of patients</td>
<td>52</td>
</tr>
<tr>
<td>Championing social justice in the provision of health care</td>
<td>33</td>
</tr>
</tbody>
</table>

*Numbers of articles in the literature that explicitly or implicitly discussed the particular attribute.
poorer health than do whites, and such health disparity in the USA is increasing among, for example, the Hispanic population (Tripp-Reimer 1999). Factors contributing to this situation include poverty; access to, and use of healthcare services; individual and institutional racism; and, cultural difference between the biomedical health system and minority populations. Hospital environment is another antecedent. Use of advanced technology, healthcare costs and changing health policies mean that the hospital environment is becoming overwhelmingly complex (Donovan 1988). In such an environment, patients’ autonomy and values can easily be ignored.

**Microsocial antecedents**

On the microsocial level, some patients’ conditions are the major antecedents of patient advocacy. Patient vulnerability is the most frequently cited condition demanding nurses’ advocacy actions (e.g. Carpenter 1992, Perrin 1992, Snowball 1996, Chafey et al. 1998, Martin 1998, Redman & Fry 1998, Davis et al. 2003). Vulnerable patients or populations refer to individuals or groups who cannot fully represent and protect their own rights, needs, benefits and wishes, are unable to make appropriate decisions, or are unable to carry out their decisions. Patients who are illiterate or lack command of the English language, who are unaware of their right to refuse treatment, or are unable to comprehend instructions or directions for some reason (e.g. learning disability), are vulnerable, and usually have difficulty in giving truly informed consent. Patients from lower socio-economic groups or minority populations are vulnerable and tend to be underserved. Patients’ illness conditions such as unconsciousness, cancer, and mental illness can cause vulnerability and compromise their ability to self-determine their health care and protect their best interests. Feelings of powerlessness because of limited knowledge about health care, or experience of being neglected in the system, can increase patients’ vulnerability. In addition, the negative way that health professionals sometimes relate to patients, specifically the disregard, dehumanizing, controlling, punitive and judgemental practices of biomedicine, can lead to varying degrees of vulnerability in patients (McCurdry 1997, Mitchell & Bournes 2000).

There are also other antecedents where nurses need to advocate for patients. One is that patients are intimated under some circumstances. They may be fully autonomous under normal circumstances but become tongue-tied when their doctors come into the room, and are shy or scared to ask questions (Carpenter 1992, Mallik 1997). There also situations where patients’ rights and/or benefits are jeopardized (Segesten 1993, Chafey et al. 1998, Breeding & Turner 2002). For example, a competent patient may wish to discontinue treatment but his or her physician or family disagrees with this wish. Other microsocial antecedents are that patients are treated unethically or incompetently by some members in the healthcare team. In addition, sometimes patients verbally request nurses to act on their behalf (Segesten 1993, Mallik 1997).

**Consequences of patient advocacy**

Consequences of patient advocacy are those events that occur as a result of nurses’ patient advocacy actions, and can be either positive or negative. Corresponding to the attributes and antecedents of patient advocacy, consequences occur at both macro- and micro-social levels.

**Positive consequences**

Nurses’ successful patient advocacy actions produce positive consequences. At the microsocial level, positive consequences mean that patients’ rights, benefits and values are preserved or protected through nurses’ particular advocacy actions. Patients are empowered and their autonomy is preserved (Bramlett et al. 1989, Clarke 1993, Lindahl & Sandman 1998). They get adequate and timely information regarding their health status and health care and so can make their own decisions (Stewart et al. 1983). Patients can get prompt and appropriate treatments such as appropriate pain management (Soderhamn & Idvall 2003). Successful patient advocacy can also improve patients’ quality of life (Gibson 1991, DiGaudio 1993) and increase their safety in the health services (Firtko & Jackson 2005). Nurses’ patient advocacy actions may encourage patients to develop positive attributes such as a positive self-concept, personal satisfaction, self-efficacy, a sense of control, and a feeling of hope (Gibson 1991, Rushton 1994, Lindahl & Sandman 1998).

Successful patient advocacy may also produce positive effects on the nursing profession and nurse advocates (O’Connor & Kelly 2005), such as enhancing their public image and improving their professional status (Bernal 1992). By successfully advocating for patients, nurses can increase their professional satisfaction, self-confidence and self-esteem, and maintain their personal integrity and moral principles.

Positive consequences at the macrosocial level means that nurses’ patient advocacy actions lead to desirable changes for the well-being of a group of patients or society in general. Participating in policy-making is viewed as a type of nurses’ patient advocacy (DiGaudio 1993). Changing inappropriate rules or policies in the healthcare system may promote social justice in the provision of health care and improve the quality of healthcare delivery, thereby enhancing patients’
well-being. For example, DiGaudio reported in her study that health policies developed by a nurse actually improved the safety of school transportation for medically frail children. Participating in policy-making can not only increase nurses' credibility but also lead to other policy-making opportunities. Increased participation in policy-making can promote nurses' control over nursing practice and enhance the respect given to nurses as professionals.

Negative consequences
In some situations, negative repercussions for individual advocates can occur. Risks are often reported and discussed when nurses advocate for patients (e.g. Robinson 1985, Gibson 1991, Perrin 1992, DiGaudio 1993, Martin 1998, Redman & Fry 1998, Svedberg et al. 2000, O’Connor & Kelly 2005). Patient advocates are sometimes accused of insubordination and suffer loss of reputation, friends, and self-esteem (Rushton 1994), or are labelled as trouble-makers or bad co-workers by nursing colleagues (Segesten 1993). Advocates may experience extreme conflicts in the form of moral distress or moral dilemma, and feel powerless to do the right thing (Redman & Fry 1998, Sundin-Huard & Fahy 1999). Some very difficult situations where nurses practise advocacy may result in loss of professional security (Becker 1986, Perrin 1992, Schroeter 2000) and lead to legal action (Tuma 1977, Schroeter 2000). In some extreme cases, whistleblowers can encounter ostracism and experience severe disruption and havoc in their personal lives (Perrin 1992, O’Connor & Kelly 2005).

Empirical referents of patient advocacy
Empirical referents are classes or categories of actual phenomena demonstrating the occurrence of the concept itself (Walker & Avant 1995). Through reviewing the 220 advocacy articles and dissertations, we identified approximately 250 empirical referents of patient advocacy (i.e. specific patient advocacy actions or actual phenomena of patient advocacy). They are classified under the three core attributes of patient advocacy described above. These empirical referents denote the concept of patient advocacy and its three attributes. Examples of identified empirical referents of patient advocacy are displayed in Table 2.

Discussion
Patient advocacy has received international recognition over the past two decades. The concept has enjoyed greater acceptance and become an integral part of nursing practice. National nursing organizations in some countries (e.g. USA, UK, Australia and Canada) have included patient advocacy in codes of professional conduct. Despite this adoption of patient advocacy internationally, people are still confused about the precise nature of the concept and what it means in practice. Early attempts to conceptualize patient advocacy in nursing focused on philosophical definition of the concept by authors such as Curtin (1979) and Gadow (1980). Recently, nurse researchers such as Mallik (1997), Chafey et al. (1998), Lindahl and Sandman (1998), Breeding and Turner (2002), Davis et al. (2003), Carver and Morrison (2005), O’Connor and Kelly (2005) and McGrath and Walker (1999) have attempted to investigate further the role of nurses as patient advocates by conducting qualitative studies concentrating on nurses’ experience and perceptions of patient advocacy. In contrast to the philosophical work on patient advocacy, these studies reveal various and dynamic expressions of the concept. Chafey et al. (1998) indicated that the nurse–patient relationship emerged as a salient feature of advocacy, and teaching, informing and supporting were frequent activities of nurses in what they described as patient advocacy. Lindahl and Sandman (1998) described the nurse’s role of patient advocacy as building a caring relationship, carrying out a commitment, empowering, making room for and interconnecting, being a risk-taker and moral agent. These empirical studies suggest that the concept of patient advocacy is complicated and that there are different interpretations about patient advocacy among nurses and nurse researchers. Inconsistency of interpreting the concept of patient advocacy could be one of the major barriers for nurses’ patient advocacy practice and the advancement of research in the advocacy area.

Our study adds a unique theory of patient advocacy to the nursing profession which focuses on clearly defining the concept of patient advocacy, instead of identifying factors that can explain nurses’ patient advocacy behaviours. Thus, antecedents and consequences of patient advocacy were not included in the theory. In the proposed theory, we clearly identify three core attributes or content dimensions of the patient advocacy concept that cover most patient advocacy actions occurring in the literature. Our theory recognizes that nurses’ patient advocacy behaviours are context-based. From the perspective of our proposed theory, patient advocacy includes three core attributes: safeguarding patients’ autonomy, acting on behalf of patients and championing social justice in the provision of health care. The first core attribute contains elements of Gadow’s (1980) theory of existential advocacy but is sensitive to particular clinical contexts. The second core attribute contains the heart of Curtin’s (1979) human advocacy model but extends it. The first two core attributes reflect two important aspects of nurses’ patient
advocacy role under different types of situations at the microsocial level. The third core attribute extends the patient advocacy role from the bedside care level to community and social levels. It stresses nurses’ importance in health policymaking and represents nurses’ patient advocacy role at the macrosocial level.

Limitations

Our study, a concept analysis of patient advocacy in nursing, was based on 220 articles and dissertations. It is, however, possible that some unpublished dissertations and research findings on patient advocacy in nursing might have been excluded. In addition, we only reviewed literature written in English. The mid-range theory of patient advocacy which we have developed from our concept analysis is, at present, only a proposed theory, and needs testing.

Implications for the nursing profession

The findings of our concept analysis can provide guidance to nurses, nurse educators and administrators on patient advocacy. According to our proposed theory, patient advocacy is viewed as a process or a strategy consisting of a series of specific actions for preserving, representing and/or safeguarding patients’ rights, best interests, and values in the healthcare system. We suggest that, to advocate optimally for patients, nurses need to know in which kinds of situations patients

<table>
<thead>
<tr>
<th>Attribute and empirical referent</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist patients to give voice to their values</td>
<td>Gadow (1989), Carver and Morrison (2005)</td>
</tr>
<tr>
<td>Assist patients to document their values, preferences, and life goals at every opportunity</td>
<td>Rushton (1994)</td>
</tr>
<tr>
<td>Support patient values and choices though nurse may not share their patient’s values and choices</td>
<td>Rushton (1994), Altun and Ersoy (2003)</td>
</tr>
<tr>
<td>Provide adequate and appropriate information to patients/clients so that they can make informed decisions about their health care</td>
<td>Martin (1998), Plat-Jones (1999), Borthwick and Galbally (2001), Breeding and Turner (2002), Mogg (2006)</td>
</tr>
<tr>
<td>Assure patients that they have the right and responsibility to make their own decisions</td>
<td>Kohnke (1980), Nelson (1995), Schroeter (2000), Davis et al. (2003), Mogg (2006)</td>
</tr>
<tr>
<td>Monitor the quality of health care and make sure that the patient is receiving the best possible care</td>
<td>Nelson (1988), Lindahl and Sandman (1998), Schroeter (2000)</td>
</tr>
<tr>
<td>Challenge doctors’ decisions</td>
<td>Williamson (2003)</td>
</tr>
<tr>
<td>Speak out for patients</td>
<td>O’Connor (1996)</td>
</tr>
<tr>
<td>Question orders or pursue other avenues to promote patient comfort or for the benefit of patients</td>
<td>Miller et al. (1983), Redman and Fry (1998)</td>
</tr>
<tr>
<td>Be alert and take appropriate action regarding any instances to incompetent, unethical or illegal practice</td>
<td>ANA (1985), Rushton (1994), Mallik (1997)</td>
</tr>
<tr>
<td>Represent the patient’s expressed or written wishes under circumstances (e.g. the patient cannot do so)</td>
<td>Copp (1986), Taylor (1995), Plat-Jones (1999), Breeding and Turner (2002)</td>
</tr>
<tr>
<td>Champion social justice in the provision of health care</td>
<td>Fowler (1989), Sutor (1993)</td>
</tr>
<tr>
<td>Act for patients at a policy and legislative level</td>
<td>Kosik (1972), Sutor (1993), Borthwick and Galbally (2001)</td>
</tr>
<tr>
<td>Actively strive for change on behalf of individuals, groups and society as a whole</td>
<td>Kosik (1972), Sutor (1993)</td>
</tr>
<tr>
<td>Become involved in societal issues pertaining to health, education and welfare of people and address themselves to a redistribution of power and resources</td>
<td>Nelson (1988)</td>
</tr>
<tr>
<td>Help the individual achieve well-being by mobilizing resources available in the environment</td>
<td>Rushton et al. (1996), O’Connor and Kelly (2005)</td>
</tr>
<tr>
<td>Change health policies and reform institutions</td>
<td>Borthwick and Galbally (2001)</td>
</tr>
<tr>
<td>Work and act together to influence legislators and healthcare providers</td>
<td>Ash (1984)</td>
</tr>
</tbody>
</table>
What is already known about this topic

- The concept of patient advocacy has received international recognition.
- International Council of Nurses Code of Ethics for Nurses and American Nurses Association Code of Ethics for Nurses with Interpretive Statements require nurses to be patient advocates but do not provide definitions of patient advocacy.
- Although many definitions of patient advocacy exist in the nursing literature, there is a lack of consensus among nurses and nurse researchers about the concept.

What this paper adds

- A mid-range theory of patient advocacy that may inform future nursing practice and research is presented.
- The core attributes of patient advocacy are safeguarding patient autonomy, acting on behalf of patients and championing social justice in the provision of health care.
- Further research is needed to identify the factors that influence nurses’ patient advocacy behaviours and how to motivate nurses to take on advocacy roles.

Knowing patients’ best interests is very important for nurses when acting as patient advocates. Only when nurses know what patients’ best interests are in a particular situation will patient advocacy actions be meaningful, appropriate care provided and patients’ needs satisfied. Communicating with patients and/or their families is important in order to understand their best interests. Communication is, however, a two-way process and, where appropriate, nurses also need to provide relevant information about patients’ health situation (e.g., diagnosis, healthcare options and prognosis) and make sure that patients are fully informed so that they can make decisions consistent with their best interests.

It is critical that nurses act as patient advocates. If it is known that a patient needs an advocate and no action is taken, then the appropriate help and care will not be received.

It is important for healthcare administrators to motivate nurses to take actions to advocate for patients based on their knowledge of patient advocacy. If nurses lack knowledge and skills related to patient advocacy, education or training may be necessary. For example, nurses may need to know how to negotiate between patients, families and other healthcare providers (e.g., physicians). Good communication skills are important for nurses to achieve this. The literature shows that there are many factors impeding nurses from taking action to advocate for patients; it is important for administrators to identify such barriers and minimize or eliminate them in order to facilitate nurses’ patient advocacy roles. One of the major barriers is a lack of support from institutions, colleagues, and/or administrators (Perrin 1992, Schroeter 2000, Svedberg et al. 2000). In addition, patient advocacy actions sometimes carry negative consequences for nurse advocates which may discourage them from taking action; support from administrators could help to overcome this barrier. It is, therefore, important to provide support for nurses’ patient advocacy actions and establish a supportive environment within the institution; ideally, administrators should actively encourage nurses to advocate for patients and reward their behaviour.

Implications for nursing research

The proposed mid-range theory of patient advocacy provides a conceptual and operational definition of the concept of patient advocacy. A clear conceptual and operational definition facilitates research, especially for quantitative research. Also, based on the proposed mid-range theory of patient advocacy, the instruments related to nurses’ patient advocacy roles could be developed, which is groundwork for quantitative research. Moreover, the proposed mid-range theory of patient advocacy provides a potential direction of future study. Identifying the
factors that may influence nurses’ patient advocacy behaviours and how to motivate nurses to take on advocacy roles are important to explore in future research.

Conclusion

Developing a new theory of patient advocacy that can be operationalized is necessary for advancing nursing science and patient advocacy practice. The mid-range theory we describe in this paper provides the background and explanation of advocating necessary for nurses to carry out the role consistently and with the conviction that they have a mandate to carry out patient advocacy as part of their professional practice. Our theory needs to be further refined and tested in research and clinical nursing practice.

Author contributions

XB and MAJ were responsible for the study conception and design and XB was responsible for the drafting of the manuscript. XB and MAJ performed the data collection and XB performed the data analysis. MAJ provided administrative support. MAJ made critical revisions to the paper.

References

*The references used as literature for the empirical referents in Table 2.


*Gadow S. (1983) Basis for nursing ethics: paternalism, consumerism, or advocacy? Hospital Progress 10(11), 62–78.


