Advocacy: A Concept Analysis

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Advocacy for patients is seen as a necessary function of nursing; nonetheless, being self-advocates of nursing has not. The American Nurses Association Code of Ethics for Nurses (2001) states: “The nurse owes the same duty to self as to others…” Advocacy is recognized as essential in numerous fields and presents an intricate concept. The intent of this paper is to use the Walker and Advant (2005) method of concept analysis to clarify advocacy’s contextual meaning and to define advocacy’s attributes towards furthering the profession of nursing and to maximize the advocacy for nurse’s effort.

*Key words:* advocacy, nursing advocacy, self-advocacy, nurse profession, empowerment, autonomy, concept analysis, concept mapping, and concept formation.
Introduction

Advocacy is a vital component for nursing—a discipline motivated to obtain professional status. Advocacy for professional nursing is introduced during baccalaureate educational programs. The nursing profession has been seeking full professional status for many years (Wade 1999). An important goal for nurses is to promote self-advocacy. The concept of advocacy will be analyzed and defined to establish its importance in furthering the profession of nursing.

Purpose of Analysis

The term advocacy is prevalent in literature relating to numerous subjects. Unfortunately, this representation lacks references when tied to the field of nursing itself. The concept of advocacy in nursing has been largely associated with nurses being advocates for patients, not being advocates for self. Professional advocacy in nursing is necessary to remove barriers in practice (Partin, 2009). Advocacy exists for promotion and protection of the nursing profession (Rowles, 2009). Avant and Walker’s (2005) eight steps for concept analysis assist in exploring the concept of advocacy in nursing (Appendix A).

Uses of Concept

Merriam-Webster’s online dictionary on November 14, 2009 dates the word “advocacy” to the 15th century and defines it as “the act or process of advocating or supporting a cause or proposal.” The American Heritage College Dictionary (Houghton-Mifflin, 2002, p.20) defines advocacy as “the act of pleading or arguing in favor of something, such as a cause; active support” and its root form, advocate, is described in Latin, advocatus or advocare, as meaning “to summon for counsel” and “to call.” The Webster’s American College Dictionary (Random House, 1998, p.13) defines advocacy as “the act of pleading for, supporting, or recommending a
cause or course of action.” On November 15, 2009, a World Book Student Dictionary online search defined advocacy as “1) the act of speaking or writing in favor of something; public recommendation; support and 2) a. the profession or art of pleading a case before a court b. the pleading of a case.” Synonyms are useful in providing additional perspectives. The Synonym Finder (Rodale, 1978, p.21) cites support, encouragement, backing, sponsorship, and promotion as synonyms to advocacy. Comprehension of the advocacy concept promotes nurses to be self-advocates. This comprehension can be achieved through reviews of literature, clarifying the defining attributes, and identifying antecedents and consequences.

**Review of Literature**

**Introduction**

The topic of advocacy as it relates to nursing was investigated on September 20, 2009. Search engines included Google Scholar, GoodSearch, MSN and Yahoo, returning a large amount of information on the key word “advocacy”. Literature searches were performed using Washburn University’s Mabee Library’s online library guides. The key words advocacy and concept analysis together returned 9,374 hits on the SAGE database. The initial searches using the ProQuest, SAGE, PubMed/MEDline, Cochrane Library, and CINAHL databases included the key words advocacy, nursing advocacy, self-advocacy, nurse profession, empowerment, autonomy, concept analysis, concept mapping, and concept formation. Searches of all the databases led to the same articles. The majority of articles for this concept analysis were retrieved from the CINAHL and ProQuest databases (Appendix B). The authors studied 21 articles specific to nursing advocacy, 13 of which were selected for review.

**Discussion Articles**
A concept analysis utilizing Walker and Avant’s 2005 method was written by Hanks (2007) to evaluate existing barriers that thwart nursing advocacy for patients. It involved a literature search of articles related to patient advocacy, nursing, subservience and barriers. Of the 55 abstracts found using searches of Cumulative index of Nursing and Allies Health, MEDLINE, PschoInfo and Sociological Abstracts, 36 provided analysis that pertained to the concept. The analysis aim was to promote nursing advocacy by overcoming determined barriers. Barriers were conflict between nurse’s duty to employer versus responsibility to patient, lack of support, lack of power, and lack of education. In a related model case Hanks describes a situation where the nurse refuses to work an overtime shift by stating that she “must first assure that she remains healthy and able to provide the best care to her clients by allocating sufficient rest periods from work” (Hanks, 2007, p. 174). Though the article is limited by referencing patient advocacy, the barriers determined also exists for nursing advocacy. Hanks antecedents of barriers included fear of job loss, fatigue, frustration and burnout which demonstrate the negative consequences of the lack of professional nursing advocacy.

Wade (1999) authored a concept analysis using Walker and Avant’s 1995 model to investigate professional nursing autonomy and its application to nursing education. Boughn (1995) says “professional nurse autonomy evolves from the capacity for advocacy and activism for self” (Wade, 1999, p.312). Wade’s review of literature included statistics that used the Pankratz Nursing Attitude Scale and the Nursing Activity Scale (NAS) to illustrate how a baccalaureate education may present a base for professional autonomy and advanced education; personal and work autonomy also strongly relate to professional nurse autonomy. Wade mentions the Autonomy, the Caring Perspective (ACP) tool as described by Boughn (1995) which measures autonomy-related behaviors and attitudes of nursing students and is consistent
with measurements by the NAS. As a reference to ACP, Wade states “autonomy is demonstrated through regard for self, regard for others, advocacy and activism for self, and advocacy and activism for others” (Wade, 1999, p. 314). One of the common empirical referents Wade notes is advocacy. Theory based education develops autonomy more effectively than practiced based programs. Caring needs to be a core value in the curriculum. The analysis concludes that educational curriculum must aid in the development of attitudes towards professional autonomy which is a key element of professionalism. A limitation of the study is statistical references are over 15 years old.

A concept analysis study utilizing strategies by Norris (1992), Rodger (1989), Schwartz-Barcott and Kim (1986), and Walker and Avant (1988) was conducted by Gibson (1991) to investigate empowerments characteristics within a nursing context. The World Health Organization’s definition of health promotion in the mid-1980’s is the stimulus for the empowerment concept within a nursing perspective according to Gibson (1991). Gibson classifies the nursing perspective antecedents of empowerment to be a change in the role of the nurse. This change requires the nurse to be a resource and sensitive to self-awareness and self-growth for individuals, families, and communities. These behaviors empower, leading to personal and community health. A positive consequence of empowerment from the nursing perspective is knowledge of the health care system that provides improvements in equality in power. Health promotion benefits from people empowered with self-care, self-help, and environmental improvements. Empowerment results in the client developing a positive self-concept and a feeling of hope. Providing support is a factor that leads to empowerment. Gibson concludes that the nursing profession must “be prepared to advocate, lobby and effect changes that are consistent with the notion of empowerment”. The findings of Gibson reinforce the
The dated references are a limitation, demonstrating the need for further research which the authors recognize.

McCarthy and Freeman (2008) co-authored a concept analysis measuring empowerment utilizing a multidisciplinary approach across time, disciplines, and settings. The analysis used was Walker and Avant’s 1995 method. Implications for nursing involve the nurse’s position in community advocacy, care of individuals, and empowerment within health care organizations. These classifications provide a tool to further the development of the nursing profession. A literature search of articles between the 1920s and 2007 was obtained from multiple fields including: nursing, psychology, sociology, social work, community action, disability advocacy, organizational leadership, business management, and education. McCarthy and Freeman noted that non-nursing and nursing literature pointed to community, psychological, and organizational empowerment. Advocacy is noted as one of the earliest uses of the concept of empowerment. They cite Gordon’s (2005) and Moss’s (2005) opinions that nurses themselves need empowerment to develop skills in communication, negotiation, and conflict resolution to promote effective advocacy. McCarthy and Freeman conclude that nurses must gain skills to effectively advocate for and with clients, families, communities and themselves. Empowerment is clearly a defining attribute of advocacy. A limitation of the study is that the tools mentioned for establishing validity of measuring empowerment are not correlated with statistical findings.

Baldwin (2003) authored a concept analysis on patient advocacy aimed to clarify the ill-defined concept of patient advocacy and develop a model of advocacy. The methods for analysis used in the study were based on Wilson (1971), Walker and Avant (1983) and Rodger (1989). Baldwin was also influenced by Morse’s (1995) work on concept development and qualitative thematic analysis. The results of the analysis found the three essential defining attributes for
patient advocacy are valuing, apprising and interceding. Baldwin noted that a nurse who is proactive as well as reactive is inherent in each of the defining attributes. Resulting antecedents to advocacy included a vulnerable population and a nurse willing to take on the responsibility for advocacy. Baldwin discussed positive and negative consequences for both the patient and the nurse. A positive consequence for the patient was secured autonomy and empowerment, a negative consequence was patient discomfort. For the nurse, job satisfaction was a positive consequence and risk was a negative consequence when nurses take on the role of “whistle-blower”. The author included a model case that focused on helping a patient make an autonomous decision by empowering her through patient advocacy.

Baldwin (2003) concluded that while each of the three essential defining attributes are helping strategies in nursing when used individually, only when they are all present can advocacy be realized. Before choosing situations to advocate for, nurses need to assess the situations and consider all the consequences. Baldwin points out that while instruments of evaluation are not readily available for advocacy, consequences may be a useful criteria in determining effectiveness. Baldwin’s concept analysis was from the United Kingdom (UK), a possible limitation since it was not from a US perspective; however, it confirms that advocacy is a global issue. The article was subject to a double-blind review and had 56 references which strengthen the paper. Even though Baldwin discussed patient advocacy rather than the current focus of nursing advocacy, his analysis was helpful. There are shared attributes when advocating for patients or the profession of nursing, including valuing self and interceding. Patients and nurses are vulnerable when placed in situations where conflict or critical decision making strategies are required.
Bibliometric studies measure the size and growth of literature on a topic (patient advocacy), analyze the frequency of citation of authors within a given discipline (nursing), and interpret the structure of the literature as revealed by the citation links between journals, authors, or monographs (Mallik & Rafferty, 2000, p. 400). In a two-part bibliometric analysis on patient advocacy, Mallik and Rafferty (2000) traced the spread and effects of the claim to patient advocacy as an ‘innovation’ in nursing using the theoretical framework provided by McKinlay’s (1981) seven stage model (Appendix C). McKinlay acknowledged that if an innovation proves effective it will continue to be supported by the profession and will eventually become established (Mallik & Rafferty, 2000, p. 399).

The design of the study evaluated and analyzed data from 1976 to 1995 in five-year segments. Between 1976 and 1980 the volume of literature increased, but only one editorial connected the term patient advocate to the role of the nurse. From 1981 to 1985 the specific role of nurses as patients’ advocate was seldom cited in the literature. From 1986 to 1990 ethical decision-making and autonomy were major themes and their connection with advocacy became clear. Finally, from 1991 to 1995 the number of citations on patient advocacy increased, reaching peak levels of ten years earlier. A comparison of review of literature shows key points between the US and UK in five-year segments (Appendix D). The limitations of a bibliometric review were the lack of contextual analysis of current health care issues (Mallik & Rafferty, 2000). One particular limitation to the study is that it was not written by a US author. However, Cronin (1984) states that Americans are ethnocentric in their citation patterns compared with authors from other countries (Mallik & Rafferty, 2000). Mallik and Rafferty suggest that patient advocacy was first proposed in American nursing literature in the 1970’s and in the British literature about ten years later. They found that patient advocacy, on the basis of a stages model
for diffusion of an innovation reached only the preliminary stages of acceptance in nursing (Mallik & Rafferty, 2000, p. 399). Subsequently, nurses continue to seek empowerment as advocates, especially in the US, by making the language of article titles more contentious and militant. Interestingly, apart from Canada, other countries do not assert the patient advocate role for nurses. There is a need for a universal definition of advocacy in health care. This will expand nursing knowledge and aid in empowering patients in their health care decisions. Nurses continue to be caught in the middle between consumers and a health care system that is reluctant to surrender control.

Mallik (1997) conducted a bibliometric analysis to analyze the concept of advocacy in nursing. In this review of literature, citing 94 sources, the author identified antecedents of patient advocacy as well as several meanings and models of advocacy. Although the focus of this article is mainly on patient advocacy, it provides meaningful insight in nurses’ participation in advocacy, areas of consensus and contention and the contribution of influential advocacy models. An analysis of the predominant themes used to justify nurses’ involvement in patient advocacy is offered followed by a discussion of risks associated with the advocacy role. Mallik concludes that patient advocacy (a relatively new role adopted by the professional nurse) is a potentially risky endeavor and ultimately remains a matter of moral choice for the individual nurse. The discussion identifying free action, effective deliberation, authenticity and moral reflection as antecedents to the concept of autonomy is helpful in clarifying the link between advocacy and personal autonomy. This assists in the identification of antecedents and defining attributes to advocacy as it pertains to advocating for the nursing profession. Mallik also recognizes the dominant influence of the American nursing profession on the role definition of British nurses. To the authors this recognition serves as a reminder of the leading role American
nurses play in global nursing. This bibliometric analysis led the authors of the present concept analysis to conclude that reasonable balance is achieved in the selection of sources from both inside and outside the United States.

Porter (1992) delivers a critical evaluation of the occupational advancement strategies used by nurses. Referencing work by Freidson (1972), he notes that professions differ from occupations through the right to control their own work. Porter argues that nursing lacks professional autonomy due to the existence of a bureaucratic hierarchy which limits individual decision making through dictation of what individual nurses do and how they do it. Proposals from nurse theorists, the ideology of professional management and the movement towards clinical professionalism are identified as three strategies used by nurses to advance their occupation along professional lines. Porter lists the failure of nursing to close the significant gap between theory and practice; between “an American academic’s prescriptions for nursing and its actual practice at ward level in Europe” (Porter, 1992, p. 723) as a barrier to occupational advancement. As positive criticism, Porter acknowledges nurses’ persistent attempts to acquire a unique knowledge base and agrees that the existence of a unique body of knowledge can indeed be seen as one of the essential traits of a true profession. The desire of the nursing occupation to enhance its professional status by means of diagnostic autonomy is also addressed. The development of the nursing process receives acknowledgement as a notable attempt towards autonomy but Porter judges that nursing is yet to achieve diagnostic and prescriptive dominance as currently seen in the medical profession. Porter challenges the aptness of professionalization as an occupational ideology for nursing and ascribes it to nurses’ awareness of the benefits associated with professional status. Porter embraces the opinion that professionalization and the roles to which nurses currently aspire cannot be achieved simultaneously. He states that nurses
should abandon the ideology of professionalization and concentrate on the more pertinent issue of maximizing the efficacy of the occupation. Porter’s assessment of the manner in which nurse managers, clinicians and theorists incorporate their professional goals into their strategies for occupational advancement should be noted. He argues that these strategies might be undermining the professional freedom of nurses as they often ignore the interests of bedside nurses. Despite the perceived controversy of Porter’s opinion, this critical analysis was of value to the authors of this concept analysis as an indication of the conflicting ideologies found among members of the nursing profession. Its failure to recommend more appropriate strategies for the advancement of nursing as a profession is seen as a limitation.

In 2001, Borthwick and Galbally indicated that nurses were unaware of and unprepared for the rate at which health sector reform occurred. Borthwick and Galbally (2001) encourage nurse leaders to expand their role beyond that of patient advocate by laying the foundation for self-advocacy for the nursing movement. Nursing as a profession is strained due to different conceptual perceptions regarding its role, its status and its relationship to medicine resulting in a current weakness in self-concept and political status (Borthwick and Galbally, 2001). Nurses are called to end their acceptance of this weakness and adequately prepare themselves to help shape policy. Borthwick and Galbally (2001) argue that an impact on health reform, policies and institutions can only be achieved when nurses are able to effectively work in interdisciplinary teams, participate in management of services and involve communities and other key players in the planning and delivery of health care. Despite the challenges of nurses being seen as traditional and reactive instead of leaders, Borthwick and Galbally conclude that nursing, with its “long history of adaptation to an unsettled and negotiated status” (Borthwick & Galbally, 2001, p. 80), might be better fit than other more confident disciplines to make this adaptation. The
content of Borthwick and Galbally’s assessment of professional and health realignments in health sector reform was of significance to the authors of this concept analysis as it addressed the tensions within the profession and the problems associated with nursing’s alliance with medicine. Several inciting questions were raised underscoring the importance of addressing nurses’ capability and willingness to advocate on behalf of their chosen profession.

Hanks (2008) authored a qualitative study exploring two research questions using a sample of three medical-surgical nurses. The research questions were: “How do registered nurses practicing in the medical-surgical specialty area describe their experiences with nursing advocacy for their patients?” and “What reflections on educational preparation for their professional roles do registered nurses identify as related to their practices of nursing advocacy with their patients?” Hanks reviewed how nurses advocate for their patients and determined research remains active in four areas: education, influences, components, and consequences. The data was collected using the Moustaka analysis method. Rigor criteria measured for credibility, dependability, confirmability, and transferability. Two themes, “speaking out and speaking for patients” and “compelled to act on unmet needs of patients”, emerged from the research question pertaining to the nurses experiences with nursing advocacy for their patients (Hanks, 2008, p. 473). The nurses felt fulfillment that the patient is positively changed. Frustration was noted by one participant due to administrative obstacles. The research question that focused on the education level of the nurses (baccalaureate, masters and PhD) demonstrated that advocacy is learned mostly on the job after graduation from the baccalaureate level and confidence was obtained through work and practice experience. Hanks refers to Pankratz and Pankratz (1974) findings in which higher autonomy scores were obtained by nurses with higher levels of education inferring that that higher education enhances nursing advocacy. A component and
influencing factor is the vulnerable person. Hanks also voices that empowerment is essential to nursing advocacy. The article is authored from the perspective of nursing advocacy related to nurses being advocates for patients. These same attributes can be applied to nurses being self-advocates. The small sample size is a significant limitation but Hanks referenced literature does demonstrate common findings.

Maben, Latter, & Clark (2007) used an interpretive research design to conduct a longitudinal qualitative study in three well-established UK universities. Drawing on empirical data, the researchers examined the effects of professional and organizational constraints in the workplace on nursing ideals and values. The question of whether or not the current nursing mandate is sustainable was discussed. The study looked at factors that impact the ability of experienced nurses to maintain their ideals and provide high quality patient care, a topic that has received little attention globally. Data was collected between 1997 and 2000, when nursing education reforms occurred in the UK. There were three phases of the study, consisting of either self-administered questionnaires or interviews. Phase one \((n = 72)\) started the last week of the final year of nursing students courses, phase two \((n = 26)\) was 4-6 months and 11-15 months after graduation, with the final phase \((n = 26)\) three years after graduation. Participants were asked to describe activities they performed as a student and as a skilled nurse, and whether they still agreed with those ideals, and could implement them and what helped them achieve their ideals in practice (Maben et al., 2007).

Theoretical sampling (Silverman, 2000) was utilized to provide the widest array of views possible. The ideals and values of the participants were grouped into three categories: pursuit of patient-centered holistic care \((n = 26)\), pursuit of high quality care \((n = 13)\), and pursuit of theoretical knowledge and evidence-based care \((n = 12)\). Various consequences of thwarted
ideals and values included frustration, disillusionment, job-hopping, severe stress, burnout, and leaving the profession. The researchers suggest that autonomy is driven by the ideals and values taught in schools when in reality it does not happen in the practice setting. They also found that in 84% of the cases, most of the nursing was task centered, nurses were rarely involved in total care of patients, and that most of the qualified staff was given more managerial duties.

Organizational constraints resulted in participants being further categorized into three groups: sustained idealists ($n = 4$), compromised idealists ($n = 14$) or crushed idealists ($n = 8$).

Findings of this study show that ethical responsibility, accountability, the global philosophy of providing holistic care and the coherent set of nursing ideals and values new nurses emerge from school with, combined with organizational constraints in the practice environment play a key role in determining the fate of ideals in professional practice. Nursing mandates worldwide are unrealistic and overambitious and cannot be implemented in practice without adequate levels of support, staffing and good skill mix. They need to be reformulated, along with nursing curricula. The researchers addressed several key issues including the global shortage of nurses, nurse retention, challenges for nursing ideology, and burnout, to name a few. The researchers felt that the scale of the mismatch between reality and ideals was so great that the issues discussed in their article were unlikely to be successfully addressed in education programs alone, reiterating that higher quality work environments must also be provided.

Advocacy is a key nursing role between patients and the healthcare environment and an integral attribute of nursing practice. O’Connor & Kelly (2005) co-authored an inductive qualitative study investigating general nurses’ perceptions of the role of patient advocate in Ireland and how they performed the role. Three focus group interviews ($N = 20$) were conducted using nurses from a variety of settings and skill level, including staff nurses ($n = 7$), clinical
nurse managers \((n = 7)\) and administration nurses and clinical nurse specialists \((n = 6)\). Elements of Strauss and Corbin’s (1990) approach to concept development were used for their data analysis (Appendix E). Most of the participants interviewed cited patient vulnerability as one of the main reasons for advocating. Bridging the gap between the patient and other providers were identified as the core of advocacy. Limitations of the study acknowledged by the authors’ were a small study size \((N = 20)\) in a limited timeframe. The author’s determined that replicating the study on a larger scale would be beneficial addressing the reality of nursing. One surprising aspect of advocacy that emerged in this study is the potential for conflict and confrontation with other disciplines. Conflict and confrontation may be considered a negative aspect of advocacy, however can be controlled with proper negotiation skills, a more supportive environment for nurses, and common goals of enhanced provision of care in mind. This suggestion can also be applied to nurses as advocates for the profession of nursing.

In 2004, Daiski examined the views of hospital staff nurses about their relationship with nursing colleagues and other health care professionals and their ideas of change. The purpose of this qualitative study was to enhance understanding regarding nurses’ discourse on restructuring and to identify the processes that contribute to their disempowerment. Twenty volunteer staff nurses were interviewed using broad, open-ended questions and appropriate prompts. Data analysis and coding were conducted in three layers with emphasis on the second and third layers. Nurses’ professional relationships with others, including their own colleagues (second layer) and nurses’ insights and ideas regarding their self-concept as nurses (third layer) became the focus of the study. Findings indicated a general awareness of inter-disciplinary hierarchies (mainly between nurses and physicians) as well as intra-disciplinary hierarchies and non-supportiveness within nursing itself. The phenomena of nurses looking up to other professionals, nurses eating
their young and the role of women and societal expectations were identified and analyzed. Participating nurses offered ideas on the promotion of mutually supportive relationships and steps needed to remedy negative practices (Appendix F). These are viewed as valuable recommendations on how nurses can daily advocate for themselves and the nursing profession through empowerment. This will be congruent to Daiski’s conclusion that positive change should originate from within the nursing profession through the development of effective strategies to include bedside nurses in the processes of decision-making which would affect them and their practice. Mutual respect, education to increase awareness, establishment of caring nursing communities, mentorship and non-hierarchical leadership are considered essential to the reversal and prevention of disempowering relationship patterns within the nursing profession. The findings of this descriptive and exploratory study were helpful to the authors in that it also assisted in clarification of antecedents to advocacy.

Conclusion

Thirteen articles were analyzed to provide knowledge on advocacy and its relation to nursing advocacy, self-advocacy, nursing profession, empowerment, and autonomy. The literature on advocacy has commonality to empowerment and autonomy and indicates they are not mutually exclusive. Mallik (1997) clarifies the link between advocacy and personal autonomy. Daiski (2004) provided valuable recommendations on how nurses can daily advocate for themselves and the nursing profession through empowerment. A weakness shown of the available data was that much of the advocacy literature reviewed was specific to patient advocacy but the articles could be generalized or translated to relate to nurse advocacy. Nurse leaders were encouraged to expand their role beyond that of patient advocate by laying the foundation for self-advocacy for the nursing movement. Strategies were provided for nurses to
advance their occupation along professional lines. There is a gap in nursing advocacy related to self. A universal definition of advocacy in health care needs to be established. Further studies are needed to develop the concept of advocacy for nurses.

**Defining Attributes**

Defining attributes are terms in agreement with the concept that have been determined by analyzing literature from many different sources. They aid in deciding characteristics associated with the concept. Defining attributes enable distinction from similar or related concepts. The most frequently occurring characteristics that best differentiate professional nursing advocacy from other forms of advocacy are: (i) the empowered position of professional nurses, (ii) the autonomy of professional nurses, (iii) the competency of professional nurses to effectively promote their profession (iv) professional nurses’ commitment to the nursing profession.

**Model case**

The model case described in Appendix G illustrates all of the defining attributes. Mrs. A felt empowered to effectively argue on behalf of her chosen profession. Her autonomy as a nurse was demonstrated through her presentation of a viable alternative when she advocated for the role of a professional nurse in the delivery of cost-effective health care of high standard. She demonstrated her commitment to the nursing profession by promoting and arguing in favor of a resolution where the position of nursing within the health care team would gain strength. Her competence is evident through her knowledgeable and skillful presentation of an innovative idea as well as her sense of professional responsibility to act on behalf of her profession.
Borderline Case

Clarification of the concept of advocacy for the nursing profession is hoped to be achieved by the presentation of a borderline case which contains some, but not all of the defining attributes of the concept (Appendix G).

Mrs. B displayed empowerment, autonomy and competency but lacked commitment to the nursing profession. Instead of arguing in favor of advancing the role of nurses within the health sector reform, she favored the medical profession. Subsequently her autonomy as it relates to nursing can be questioned. Her achievement of personal autonomy and competence in the business field should not be confused with her self-concept or autonomy as a nurse which is clearly lacking. It can be argued that she might experience feelings of powerlessness as a nurse which manifests in her lack of commitment to the nursing profession.

Antecedents

Following the Walker and Avant (2005) method of concept analysis, the conditions described below are those that precede the occurrence of the concept. The antecedents identified for the existence of advocacy for the nursing profession can be grouped as follows:

1. Antecedents to the empowered position of professional nurses are:
   a. The recognition of self as an equal partner in the health care team.
   b. The support of the employer and/or professional organizations.
   c. A keen understanding of the relationship between nursing, work environments, power hierarchies and moral accountability.

2. Antecedents to the autonomy of professional nurses are:
   a. The ideology of professionalization for the nursing profession.
b. The ability to continually articulate and promote the role of nursing within the health care arena.

c. The insight and experience to make astute choices and the courage to assume responsibility for the consequences.

3. Antecedents to the competency of professional nurses to effectively promote their profession are:

a. Confidence in knowledge of nursing gained through educational programs with an involved focus on current nursing issues.

b. Professional skills development to effectively communicate mutual respect and trust, both intra and interprofessionally.

c. A keen understanding of the implications of acting as a representative for the nursing profession.

4. The antecedents to professional nurses’ commitment to the nursing profession are:

a. An awareness of the vulnerability of nursing profession and the existing inequality within the health care professions.

b. An understanding of the individual and collective responsibility of nurses toward the advancement of their profession.

c. The resolve to establish and promote the significance of nursing by continuously acquainting other professions with the rights and capabilities of nurses.
Consequences

Consequences can be described as the positive and negative, actual or potential events that follow the occurrence of the concept. As a result of effective advocacy for the nursing profession, the following consequences may be expected:

1. Some of the negative consequences which may occur are:
   a. Disruption of relationships within the nursing profession and between nursing and other health care professions.
   b. Tension between nurses and health care managers.
   c. Frustration among professional nurses when the ideology of professionalization remains obstructed.

2. Some of the positive consequences which may occur are:
   a. Development of educational programs endeavoring to promote the empowerment of nurses to act on behalf of their profession.
   b. Recognition of the role of intraprofessional support systems such as nursing associations in the nurturance of professional autonomy among nurses.
   c. Further research into the interpretation of the terms “nursing advocacy” and “self-advocacy” with possible delineation of a term to describe the act of nurses advocating for the nursing profession.
   d. Increased awareness, competence and commitment to nurses’ responsibility to advocate for their profession.
   e. Change in structures which constrain nurses’ capacity to advocate for their profession.
f. Successful local, national and global lobbying supporting the rights of nurses including the right to equal recognition in the field of health care delivery.

g. Increased job satisfaction and retention of professional nurses within the nursing profession.

h. Global acceptance of nursing as a true profession.

Empirical References

Advocacy is recognized as essential in numerous fields. A measurement of advocacy would aid in the understanding of the value of professional nursing advocacy and differentiate it from other forms of advocacy. Literature indicated that the professional nurse advocate needs to display characteristics of empowerment, autonomy, competency in promoting their profession, and commitment to the nursing profession.

Conclusion

Advocacy has been shown to a vital component for supporting a cause. Professional status can only be achieved by speaking out and promoting the field of nursing. By providing a clear definition of advocacy for nursing, by defining the attributes of the concept, and by clarifying the antecedents and consequences, the nurse can be prepared to advocate for the nursing profession. A nurse that has been taught autonomy in an educational curriculum feels empowered to advocate for herself and her profession. This concept analysis demonstrated that research needs to be dedicated towards advancing the concept of self-advocacy for nurses and the profession, that involvement by the nurse is a necessary component for professional advancement, and that advocacy for the nurse is possible.
Appendix A

Walker and Advant concept analysis method (2005, p. 65)

1. Select a concept
2. Determine the aims or purpose of analysis
3. Identify all uses of the concept you discover
4. Determine the defining attributes
5. Identify the model case
6. Identify borderline, related contrary, invented and illegitimate cases
7. Identify antecedents and consequences
8. Define empirical referents
Table 1

Comparison of CINAHL and ProQuest Database Searches 09/20/09

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<th>Query</th>
<th>CINAHL</th>
<th>ProQuest</th>
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<td>Nursing Advocacy</td>
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<td>93</td>
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<td>Concept Analysis or Concept Mapping or Concept Formation</td>
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<td>2,041</td>
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<td>Advocacy and Nursing Advocacy and Concept Analysis or Concept Mapping or Concept Formation</td>
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<tr>
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<td>199</td>
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<tr>
<td>Self Advocacy</td>
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<td>624</td>
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<td>Empowerment</td>
<td>14,544</td>
<td>11,313</td>
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<td>Nursing Profession</td>
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<td>Autonomy</td>
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<td>Self Advocacy and Empowerment and Nursing Profession</td>
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Note. All CINAHL and ProQuest searches by the authors used English language and scholarly journals/peer reviewed as limiters for the search. All CINAHL queries were performed searching within full text of articles. All ProQuest queries were performed searching citation and document text.
Table 2

**McKinlay’s (1981) seven Stages in the Diffusion of an Innovation**

<table>
<thead>
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<th>Stage</th>
<th>Steps in the career of a medical innovation</th>
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<tr>
<td>1</td>
<td>Publication of a “promising report” in major professional journals</td>
</tr>
<tr>
<td>2</td>
<td>Professional and organizational acceptance when the innovation becomes a curriculum subject</td>
</tr>
<tr>
<td>3</td>
<td>Public and legal endorsement of the innovation</td>
</tr>
<tr>
<td>4</td>
<td>Period of entrenchment when criticism is ignored and retrospective studies provide support for the innovation</td>
</tr>
<tr>
<td>5</td>
<td>Research that reveals problems with the innovation is subjected to hostile responses</td>
</tr>
<tr>
<td>6</td>
<td>Empirical scrutiny provides inadequate evidence of worth, leading to professional denunciation</td>
</tr>
<tr>
<td>7</td>
<td>Erosion and discreditation of the innovation</td>
</tr>
</tbody>
</table>

## Appendix D

### Table 3

**Comparison of Review of Literature Key Points for US and UK in Five-Year Segments**

<table>
<thead>
<tr>
<th>Five-Year Segment</th>
<th>Key Literature Review Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US</strong></td>
<td></td>
</tr>
<tr>
<td><strong>UK</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1976-1980</strong></td>
<td>“Ethico-legal” becomes “Patient Advocacy” as subject descriptor in the INI.</td>
</tr>
<tr>
<td></td>
<td>Literature for “patient advocacy” averaged 175 per year. Consumerism; Whistle-blowing seen as “citizen advocacy.”</td>
</tr>
<tr>
<td></td>
<td>First call for nurses to be patient’s advocate appears in literature. Patients’ rights/complaints; patient as consumer. Literature output almost equal to US.</td>
</tr>
<tr>
<td></td>
<td>Total citations diminish, but proportion devoted to nurse advocacy increases. Risks of “patient advocate” highlighted; Other sources of advocacy emerge.</td>
</tr>
<tr>
<td></td>
<td>Research reports on patient advocacy. Many interpretations of advocacy; still mixed messages about acceptance as a role for nurses.</td>
</tr>
<tr>
<td></td>
<td>Key citations and critical essays appear in National League for Nursing publication.</td>
</tr>
<tr>
<td></td>
<td>Empower patients as consumers and autonomous decision-makers supported.</td>
</tr>
<tr>
<td></td>
<td>Re-focus on patient centered care.</td>
</tr>
<tr>
<td></td>
<td>Consumer models of advocacy reappear.</td>
</tr>
<tr>
<td></td>
<td>Discussions on ethical dilemmas and whistle-blowing increase.</td>
</tr>
<tr>
<td></td>
<td>Diffusion of patient advocacy as an innovation still at McKinlay’s stage one.</td>
</tr>
<tr>
<td></td>
<td>First substantial growth in literature claiming patient advocacy role is evident.</td>
</tr>
<tr>
<td></td>
<td>Citations reach 50; Nurses as patients’ advocate referenced in <em>British Journal of Nursing</em>.</td>
</tr>
<tr>
<td></td>
<td>Questioning role of patient advocate continues; Advocacy becomes part of curricula studies.</td>
</tr>
</tbody>
</table>

# Appendix E

**Table 4**

*Data Analysis Findings Based on Elements of Strauss and Corbin’s (1990) criteria for concept development.*

<table>
<thead>
<tr>
<th>Causal Conditions</th>
<th>Context</th>
<th>Intervening conditions</th>
<th>Action/Interaction Strategies</th>
<th>Consequences</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient vulnerability</td>
<td>Intervening</td>
<td>Nurse-patient relationship</td>
<td>Use of expert knowledge</td>
<td>Outcomes for patients</td>
<td>Bridging the gap</td>
</tr>
<tr>
<td>Obligation as a nurse</td>
<td>Ensuring</td>
<td>Nursing knowledge/expertise</td>
<td>Challenge to power institutions</td>
<td>Outcomes for nurses</td>
<td>Levels of advocacy</td>
</tr>
<tr>
<td>Moral</td>
<td></td>
<td>Nurses’ relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5

#### Points of recognition and change

<table>
<thead>
<tr>
<th>Dis-empowering discourse practices</th>
<th>Remedy of negative discourse/practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Going along without thinking with interdisciplinary team in decisions about patient care</td>
<td>Representing patients’ wishes assertively with the team, including doctors</td>
</tr>
<tr>
<td>Bullying practices and abuse along existing hierarchies within nursing</td>
<td>Respecting/praising each other for jobs well done, consensual decision-making</td>
</tr>
<tr>
<td>Lack of support for colleagues, aligning with outsiders against them</td>
<td>Building community of ‘sharing and caring’; assertiveness training</td>
</tr>
<tr>
<td>Competitiveness and withholding of knowledge from new-comers</td>
<td>Sharing of knowledge and mentorship programs</td>
</tr>
<tr>
<td>Believing others (e.g. more men in nursing) will empower profession</td>
<td>Exploring empowered practices, adopting those consistent with nursing values</td>
</tr>
<tr>
<td>Nursing leadership aligning with hospital administration automatically</td>
<td>Nursing leadership representing bedside nurses in fair supportive manner</td>
</tr>
<tr>
<td>Exclusion of nurses from decision-making processes on disciplinary/workplace issues</td>
<td>Nurse leaders sharing decision-making; nurses’ participation in hospital committees</td>
</tr>
<tr>
<td>Educational practices/institutions stressing conformity and obedience</td>
<td>Education about historical issues of feminism, patriarchal power relationships, non-hierarchical leadership and innovation, self-reflection</td>
</tr>
<tr>
<td>Lack of a common vision of nursing</td>
<td>Identifying and rallying around a common vision of nursing, innovative care based in nursing knowledge and values representing patients’ wishes and health goals</td>
</tr>
</tbody>
</table>

Appendix G

Figure 1

Advocacy: A concept map
Appendix H

An illustration of advocacy for the nursing profession.

A Model Case

Hamilton County Hospital (HCH) provides pediatric critical care services to a steadily growing industrial community and several surrounding areas with established primary care facilities. The demand for pediatric critical care services has increased over the last several months and local experts estimate that there will be an even greater demand for these services in the future. Local pediatricians suggested the establishment of a resident physician/pediatrician position at the hospital but since a partnership with a school of medicine to support such a position is yet to be established, management is encouraging board members to submit alternative proposals. Mrs. A, the director of nursing services is respected by her colleagues who value her input. Under her guidance several successful changes have been made in the management of nursing services resulting in higher patient satisfaction, improved quality assurance ratings and higher staff retention. She actively engages in problem solving discussions (brain storming meetings) on occasions when the HCH management team considers current issues in health sector reform. During the next board meeting, Mrs. A advocates that a local pediatric nurse practitioner, Mrs. P be considered for the position. Mrs. P has established a stable client base and is well respected in the community. In support of her proposal, Mrs. A presents the results from a controlled trial by Mitchell-DiCense et al.,(1996) which compared the delivery of neonatal intensive care by a clinical nurse specialist/neonatal practitioner (CNS/NP) team to care delivered by a pediatric resident (PR) team. This study concluded that the teams were similar with respect to all tested measures of performance and that the results were supportive of the use of CNS/NP’s as an alternative to pediatric residents in caring for critically ill newborns. Mrs. A also presents a financial analysis demonstrating the cost effectiveness of
her proposal considering the current challenges associated with health care cost. She argues that Mrs. P’s association with HCH may result in increased patient referrals as she (Mrs. P) is favored among local nurse practitioners whom often consult with her regarding patient care concerns. After deliberations the board votes in favor of Mrs. A’s proposal and offers the position of resident PNP to Mrs. P. Mrs. P accepts the position and joins the pediatric health care team at HCH.

A Borderline Case

In the same scenario as described in the Model Case, the actions of another board member need to be examined. Mrs. B has worked for Hamilton County Hospital (HCH) for almost twenty years; first as a nurse and then as the charge nurse in the surgical department. A keen interest and significant academic qualifications in health care management steered her graduate career towards business administration. She currently serves as the assistant director of business management for HCH. Following Mrs. A’s proposal advocating for the position of resident pediatric nurse practitioner at HCH, Mrs. B argued that only a physician should be considered for a residency position as this will increase the hospital’s status in the surrounding community and it will “look better” on promotional materials. Despite her extensive knowledge in the field of business management, Mrs. B neither prepared a report to support her position nor one to contest Mrs. A’s proposal. After deliberations the board votes in favor of Mrs. A’s proposal and offers the position of resident PNP to Mrs. P. Mrs. P accepts the position and joins the pediatric health care team at HCH.
References


