MJN

THE PYRAMID OF PATIENT ADVOCACY: A PRACTICAL MODEL AMONG MUSLIM NURSES

Manfred Mortell[1*], Khatijah L. Abdullah[2], Chean Ahmad[3], Adel F. M. Al Mutair[4]

[1]*Nurse Specialist Critical Care; Ministry of the National Guard Health Affairs, King Abdulaziz Medical City, Riyadh, Saudi Arabia*
[2]*Associate Professor, Nursing Studies, University of Malaya, Kuala Lumpur, Malaysia*
[3]*Professor Postgraduate Nursing studies, MAHSA University, Kuala Lumpur, Malaysia*
[4]*Associate Research Scientist; Ministry of the National Guard Health Affairs, King Abdulaziz Medical City, Riyadh, Saudi Arabia*

**Corresponding Author's Email: mannymortell@gmail.com*

ABSTRACT

Introduction: Patient advocacy is a central concept for the profession of nursing as it assures patient rights and safety. This article presents the findings from a study which explored the perceptions of patient advocacy from Muslim ICU nurses. **Methods and participants:** Our study utilized a constructivist grounded theory approach. Thirteen registered intensive care nurses from an adult critical care setting in a tertiary academic teaching hospital in Riyadh, Saudi Arabia, participated in the study. The researcher employed semi-structured interviews that were digitally recorded and transcribed verbatim, with an additional data collection strategy of reflective journaling. A reflective journal was provided to all study participants following each interview. **Results:** The study generated codes which connected to vulnerable patients, and subsequently identified a core category of *"Caring critically"* which was exemplified by six additional inter-related advocacy categories of *"Essential caring"; "Vulnerable-acy"; "Familial-acy"; "Cultural-acy"; "Religion-acy";* and "Human-acy". These categories generated the model for patient advocacy. **Conclusion:** The pyramid of patient advocacy can be applied in clinical practice to guide Muslim nurses, in addition to being utilized in the educational setting as a standard to teach registered nurses about the role and responsibilities of a patient advocate.

Keywords: Advocacy, Intensive Care, Grounded Theory, Muslim, Saudi Arabia, Nursing

INTRODUCTION

Historically, patient advocacy is neither a new role for nurses, nor a new obligation for the nursing profession. The role of a patient advocate is an ethical ideal for professional nurses based on the notion that nurses provide continuity of care and therefore have a greater intimacy with the patient (Mathews, 2012). Three foundings, Curtin (1979), Kohnke (1980) and Gadow (1980), proposed advocacy models which supported a nurse's duty of care for patients. The major practical limitation of these advocacy models however, was that they could not be employed for patients who were unable to communicate. While these traditional models do provide an ethical framework for the nurse to comprehend the advocacy role, it is extremely difficult to employ these models as paradigms for clinical practice. Henderson (1991) also contended that the nursing literaure did not provide fitting models for nurses coveting the responsibility of advocate. This study's conceptual model for patient advocacy supports and illustrates patient advocacy from the perspective of Muslimintensive care nurses (ICN). The advocacy model*"Caring critically"(Figure1)*depicts the sixessential elements required foreffective advocacy, *"Essential caring","Vulnerable-acy", "Familial-acy", "Cultural-acy","Religion-acy"and"Human-acy"* which achieve the goal of providing safe nursing care for seriously ill patients.

METHODS AND PARTICIPANTS

Objective of the study

To explore the concept of patient advocacy among Saudi Arabian ICN in a critical care setting.

Study design

A qualitative grounded theory design was selected

for this study to explore the perceptions of patient advocacy among Muslim ICN. The essential elements included theoretical sampling, the constant comparative technique, coding and categorizing, and memo writing, all of which generated data which constructed insight into the phenomenon of patient advocacy (Charmaz, 2006).

Study sample and setting

The sample consisted of 13 registered ICN who were practicing in a critical care setting. Ten were female and three were male. The participants were recruited purposively, employing a grounded theory theoretical sampling method. Inclusion criteria was based on the following standards: a) being a Saudi Arabian registered nurse, b) being proficient in the English language, c) being an ICN working in a critical care setting, and d) being willing to participate in this study. Their ages ranged from 20 to 30 years. The participants in the study were provided with a label to ensure their anonymity and indicate their level of experience as an ICN. The *"Novice"* nurse had less than year experience, The *"Transitional"* nurse had 1 – 5 years' experience and the *"Expert"* nurse had 5 years or more experience.

Data collection

The data collection process consisted of digitally recorded single participant interview and focus group semi-structured interviews of approximately 60 minutes in duration. Interview questions were generated from grounded theory recommendations (Charmaz, 2006). Therefore, each interview commenced with the broad open-ended question about patient advocacy, i.e. *"What do you understand by the concept of patient advocacy?"* Subsequent questions were generated by the participant's individual responses, which allowed the participant to focus on what was important to them, and were not preempted or guided by the researcher (Charmaz, 2006). Following each interview the participants were provided with a reflective journal as a triangulation strategy for data collection (Bodrick, 2011).

Data analysis

All interviews were transcribed verbatim in order to identify themes in the participant's contextual experience, which led to the creation of codes and categories. The coding process was divided into two phases: the initial phase and the subsequent focused phase (Charmaz, 2006, Glaser, 1978). The initial coding phase required the analysis of the 'raw' data 'line by line' after each interview, in order to explore all the participants' beliefs, thoughts, impressions, or feelings. As recommended by the grounded theory academics, the initial codes were then grouped into categories as repetitive patterns, similarities and relationships emerged (Charmaz, 2006; Glaser & Strauss, 1967).

Rigor

The four criteria employed to ensure rigor in this qualitative grounded theory study were:1. Originality or Uniqueness, 2.Trustworthiness also referred to as Credibility, 3.Usefulness, 4. Quality, also known as Resonance(Charmaz, 2006). The study's originality was confirmed as the first of its kind within a Saudi Arabian context. This aspect of rigor is endorsed by Charmaz (2006), when she stated that original or unique research will generate credible data, have quality, and be useful to those being studied.

Ethical considerations

Ethical approval was obtained from the Ethics Committee of both MAHSA University and King Abdullah International Medical Research Centre where the study was conducted. In accordance with ethical approval requirements, each participant was asked to sign an informed consent form which specified that all names and identifiable data would be changed within the transcript to ensure confidentiality and anonymity. Participants were also informed that their involvement was voluntary and that they could withdraw from the study at any time, without any explanation.

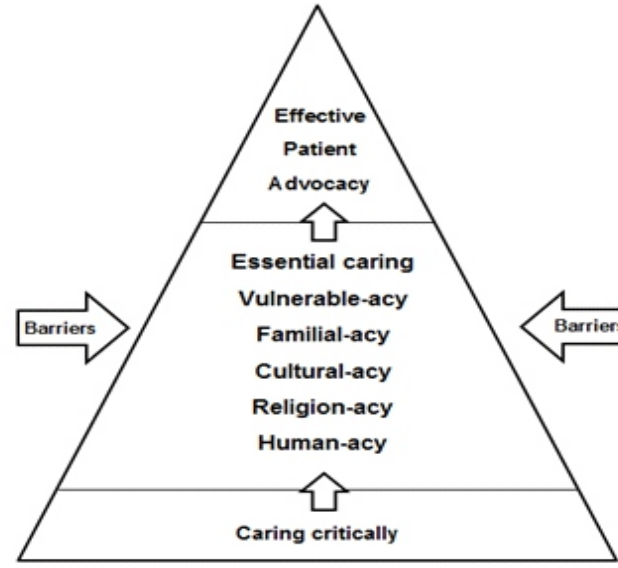

Figure 1: A conceptual model for effective patient advocacy

RESULTS

Construction of the conceptual model of patient advocacy

The model of patient advocacy was generated from the identified participant themes and subsequently created codes, which generated six categories. These included"Essential caring", "Vulnerable-acy", Familial-acy", "Cultural-acy", "Religion-acy", and "Human-acy". These six categories preceded the core category of "Caring critically", which provided the assumptions and proposals for the model. The category of "Essential caring" centered on nursing being a caring specialty in Saudi Arabia, with codes that generated the subcategories required to act for the patient's welfare and safety.

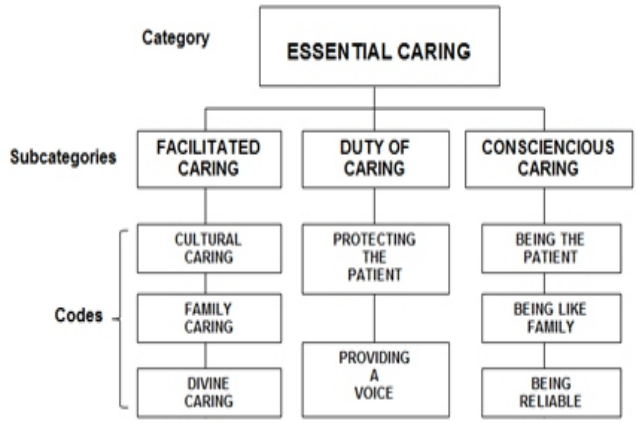

Figure 2: Codes and subcategories for the category of "Essential caring"

"Vulnerable-acy" (Figure 3) emerged from the participants' perceptions that advocacy was required for vulnerable patients who are at risk. Following are selected transcript excerpts:

"... no one wants to be a patient, because they are worried about things could go wrong or have pain... he needs someone to protect him... talk to him, explain to him, advocate for him" ("Novice female nurse C")

"So because of their condition, patient advocacy is critical in an acute care setting ... so you need to speak up for the patient, be their protector". ("Novice female nurse A")

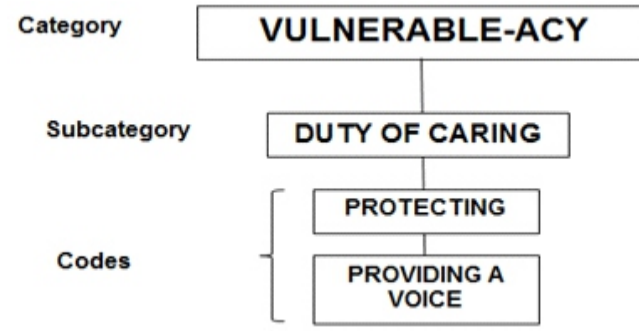

Figure 3: Codes and subcategories for the category of "Vulnerable-acy"

The concept of ***"Familial-acy"*** is revealed in the following selected participant transcripts, (Figure 4) combining features which included patient, family, awareness, and advocacy.

"I really love the patient like a brother or father and believe that they love me too... I was the nurse that took care of them... I was the nurse that they trusted...I was the nurse who made sure that they were safe while they were in the ICU" ("Expert male nurse E").

"...the patient's condition is always on my conscience... because, if you see the patient, it could be my son or daughter, or mother, or a relative... then you deal with the patient as one part of your family" ("Expert female nurse B").

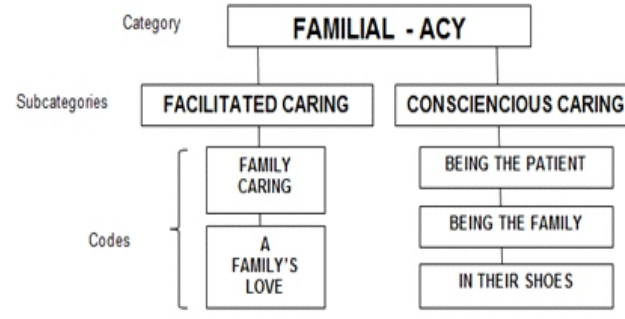

Figure 4: Codes and subcategories for the category of "Familial-acy"

"Cultural-acy" expressed the participants' concept of ethnicity awareness and competence related to the patient's culture, which is inclusive of the indigenous language, values, customs, traditions and activities of daily living (Figure 5).

"Patient advocates need to be able to communicate effectively in Arabic and be familiar with the Arabic culture, the religion, and family reasoning… otherwise you fail to comprehend the patient and will fail as a patient advocate". ("Transitional female nurse B")

"Foreign nurses are not the best for many reasons... they come from different cultures and countries with different beliefs, knowledge levels… maybe they don't know the right thing, to do for the patient". ("Expert female nurse B")

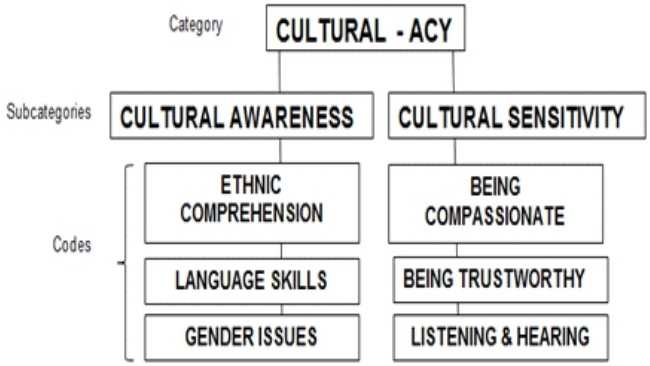

Figure 5: Codes and subcategories for the category of "Cultural-acy"

The category of ***"Religion-acy"*** (Figure 6) was generated from the participants' Islamic considerations, and the importance of understanding the patient's religious beliefs and practices in order to fulfill the role of patient advocate. The following excerpts reveal their selected views; *"It is forbidden in Islam… that we hurt someone, who didn't hurt you… as patients advocate… this makes you even more responsible for the patient and their family."* ("Transitional female nurse B")

"If I was not a good Muslim, I didn't care for the patient ... then God will teach me the meaning of being a good human being… when you will answer all his questions on judgment day… If you had the right to advocate for your patient, why didn't you." ("Expert female nurse A")

"So in the ICU… if I don't give the patient the best care that I can… one day I will see God… he will ask me why I did not follow his scriptures." ("Novice female nurse A")

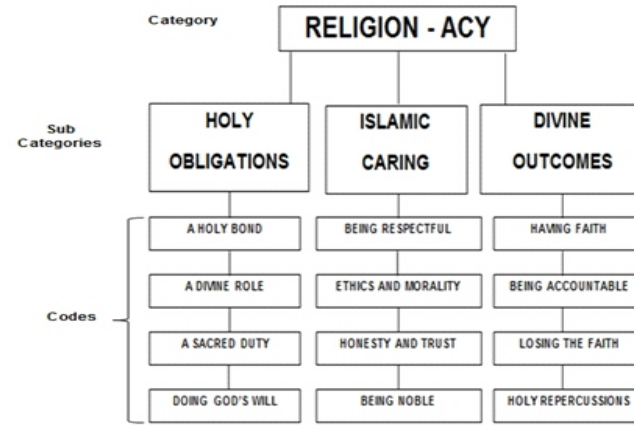

Figure 6: Codes and subcategories for the category of "Religion-acy"

The fifth category ***"Human-acy"*** emerged from the codes that communicated human qualities such as kindness, compassion, love, honesty and trust, faith, empathy, devotion, patience and tolerance, sincerity, and being selfless (Figure 7). The following selected transcripts reveal human qualities required to care:

"Nurses are people too, like the patients… I see patient advocacy, not as a nursing obligation, but, as one that belongs to humanity… we all belong to the human race" ("Expert male nurse D")

"I am an ICU nurse yes, but I am an advocate first, because it is my duty as a human, and I have to be strong, because sometimes it is hard… I must be loyal and trustworthy to my patients… because my God could be testing me…I am meant to help him as a human being... not as a nurse". ("Expert female nurse A")

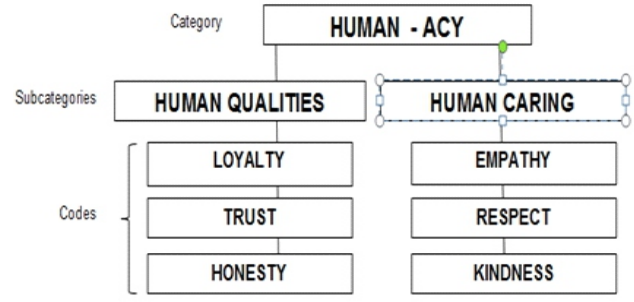

Figure 7: Codes and subcategories for the category of "Human-acy"

The inter-relatedness of these six categories generated the model for ***"Caring critically"*** and concurrently revealed potential barriers that could compromise the role of patient advocate.

DISCUSSION

Assumptions of the advocacy model

The central theme of the assumptions is *"Caring critically"* for the patient (Table 1). Patients have the need for an advocate when they are unable to advocate for themselves, and also when they are able to do so. Nurses as advocates should be culturally aware and sensitive, and not let prejudgments interfere with their advocacy role or doubt their actions when doing so. By providing advocacy which utilizes the six elements required for *"Caring critically"*, they are ensuring that they achieve the pinnacle of the model which is, ultimately, effective patient advocacy.

Table 1: Assumptions made by the advocacy model

Advocacy should be provided when patients are vulnerable or naïve to potential harm
Patients require an advocate who can identify with their requirements
Advocates should be culturally aware, sensitive and competent
Patients require an advocate who is considerate to their religious requirements
An advocate provides care which is humane and compassionate
Patients require advocacy which is provided by an advocate who has a duty of care
Advocates should anticipate potential barriers which may cause harm to the patient

Proposals from the model of advocacy

The proposals for the advocacy model originated during the concurrent data collection and analysis from the participants' recommendations, which were generated from their experiences (Table 2). The proposals provide an articulated interpretation of the schematic model (Figure 1). The concept of *"Caring critically"* simply underscores caring, in that it is not what you do as a patient advocate, but that you do it in a way that you would be grateful for, if you were the patient. This notion can therefore be linked to a patient's, individuality, culture and religion and as a human being in times of wellness or in times of illness.

Table 2: Proposals from the advocacy model

Advocacy requires care provided to the patient to be altruistic
Advocacy is provided for the vulnerable patient and is open to all patients
Advocacy requires care to be provided for the patient as if the advocate was the patient
The advocate must be culturally aware, appropriate and sensitive to the patient
Advocacy ensures spiritual and religious faiths are preserved at all times
Advocacy requires care to be provided for the patient as if the advocate was the patient
The advocate must respect the patient's individuality as a human being
The barriers to advocating effectively must be considered and prevented

Nursing affiliations

The concept of patient caring, vulnerability, humanity and advocacy as requirements to protect patients from potential harm in a healthcare setting is illustrated by the model of advocacy. This concept is reflective of Florence Nightingale's theory of physical and environmental health (Selander & Crane, 2012) and the theory of caring proposed by Jean Watson, in the *"Essence of Nursing"* (Watson, 1997).

Patient vulnerability is not new to nursing, especially in the specialties of palliative care, oncology, gerontology and mental health nursing (Black, 2011; Curtis, Tzannes & Rudge 2011; Thacker, 2008; Gosselin-Acomb et al., 2007). Academics have also endorsed the importance of cultural competence for nurses (Almutairi, 2015; Rassool, 2014; Almutairi & Rodney, 2013). Spiritual and religious considerations in nursing care are also well documented in the end of life care (Touhy, Brown & Smith, 2005). However, there are no comparable findings in the literature pertaining to the critical care setting and in a Saudi Arabian context. The

concluding notion of humanitarian advocacy as a humanistic characteristic for nurses and the nursing profession is also not a unique concept as indicated in the works of Benner (2001), Watso (1997), Gadow (1980); Curtin (1979).

The majority of nurse theorists to date have focused on advocacy in nursing as a philosophy of care where the patient - and not the nurse - defines what is in their own best interests. The concept, whilst creditable and admirable, does not work effectively in a critically ill patient who is unconscious, cannot communicate and is therefore more vulnerable.

CONCLUSIONS

The nursing profession declares that patient advocacy is a fundamental principal of nursing practice (Mathews, 2012), therefore within the context of Saudi Arabia this premise is also valid. This article presents advocacy data which is known from the generic literature, but also offers contemporary findings from the study. The conceptual model for patient advocacy can therefore be applied in the clinical practice setting to visually depict the concept of advocacy for nurse clinicians. This model can also be utilized in the educational setting as a paradigm to teach student nurses, interns, residents and registered nurses about the role of a patient advocate. It provides a basis of inquiry into the nurses' responsibilities and requirements for the role. The model could also be transferable and utilized as a referencefor inquiry into the meaning of patient advocacy from the perspective of other healthcare professions.

Study limitations

Sample recruitment questionability

Grounded theory methods do not utilize representative sampling, therefore the findings are typically abstracted away from individuals, with a preference to reflect group patterns and behaviors (Charmaz, 2006). However, given the tenets of a constructivist methodology, it is important to be conscious of the sources of the data. The participants involved in the study, were all registered Saudi Arabian ICN, working in the critical care setting. However, it would be interesting to extend this research into other nursing specialties to determine whether the patient advocacy model generated in this study was applicable and therefore transferable.

Sample size issues

This sample of 13 participants could be considered small. However, in the qualitative grounded theory constructivist methodology employed, the density of the collected data achieved theoretical saturation, and therefore did not require a quantitatively large number of participants. In qualitative research, academics testify that a small sample size is of no consequence, as long as the researcher provides dense, thick descriptions of the phenomena which allow the reader to determine how their own circumstances could be fitted into the research context (Charmaz, 2006; Patton, 2002; Krefting, 1991).

Implications

The nursing profession statesthat patient advocacy is an essential fundamental principal of nursing practice (Mathews, 2012), therefore within the context of Saudi Arabia this premise remains valid. This article presents data which reveals that the advocacy role which appearstimeworn and transparent in the generic literature, is not dissimilar to data that is recent, as from the findings in this study. The conceptual model for patient advocacy can therefore be applied in the clinical practice setting to visually depict the concept of advocacy for nurse clinicians.

ACKNOWLEDGEMENTS

To the Saudi Arabian intensive care nurses who participated in the study, revealing their inner most thoughts and concerns because of the patients they respect and care for. We thank MAHSA University, Kuala Lumpur; Malaysia and the nursing faculty for their on-going support and encouragement.

REFERENCES

Almutairi, A.F., McCarthy, A. & Gardner, G. (2015).Understanding cultural competence in a multicultural nursing workforce.Registered nurses' experiences in Saudi Arabia. *Journal of Transcultural Nursing*, 26(26), pp 6 – 23.

Almutairi, A.F. & Rodney, P. (2013). Critical cultural competence for culturally diverse workforces: Toward equitable and peaceful healthcare. *Advances in Nursing Sciences*, 36(3), pp 200 – 12

Benner, P. (2001). From Novice to Expert.Commemorative edition. Upper Saddle River, NJ: Prentice.

Black, L. (2011). Tragedy into policy: A quantitative study of nurses 'attitudes toward patient advocacy activities. *Advanced Journal of Nursing*, 111(6), pp 26-35.

Bodrick, M.M.E. (2011). The Role of the Middle Eastern Liaison Nurse in the Ambulatory Care Context of a Middle Eastern Teaching Hospital: A Practice Model. Unpublished Doctoral Thesis.

Charmaz, K. (2006). Constructing Grounded Theory: A Practical Guide, Through Qualitative Analysis. London: Sage.

Curtin, L. (1979). The nurse as advocate: a philosophical foundation for nursing. *Advanced in Nursing Science*, 1(3), pp 1-10.

Curtis, K., Tzannes, A. & Rudge, T. (2011). How to talk to doctors - a guide for effective communication. *International Nursing Review*, 58(8), pp 13-20

Gadow, S.A. (1980). Existential advocacy: a philosophical foundation in nursing, in Spicker, S.F. and Gadow, S. (eds), Nursing images of reality. New York: Springer Publishing.

Glaser, B.G. & Strauss, A.L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine.

Glaser, B.G. (1978). Theoretical sensitivity: Advances in Methodology of Grounded Theory. Mill Valley, CA, USA. Sociology Press.

Gosselin-Acomb, T., Sneider, S., Clough, R. & Veenstra, B. (2007). Nursing Advocacy in North Carolina. *Oncology Nursing Forum*, 34(5), pp 1070-74.

Henderson, V. (1991). Basic principles of nursing care. International Council of Nurses, London.

Kohnke, M.F. (1980). Advocacy: Risks and Reality. C.V. Mosby, St. Louis.

Krefting, L. (1991). Rigor in qualitative research: The assignment of trustworthiness. *The American Journal of Occupational Therapy*. 45(3), pp 214-222.

Mathews, J. (2012). Role of professional organizations in advocating for the Nursing profession. *The Online Journal of Issues in Nursing* (OJIN), 17(1), pp 123-126.

Patton, M. Q. (2002). Qualitative research and evaluation methods. 3rd Edition. Thousand Oaks, Sage Publications, CA.

Rassool, G.H. (2014). Cultural competence in nursing Muslim patients. *Nursing Times*, 111(14), pp 12-15

Selander, L.C. & Crane, P.C. (2012). The Voice of Florence Nightingale on Advocacy. *Online Journal of Issues in Nursing*, 17(1), pp 1-10.

Thacker, K. S. (2008). Nurses' advocacy behaviors in end of life nursing care. *Nursing Ethics*, 15(8), pp 174-185.

Touhy, T.A., Brown, C. & Smith, C.J. (2005). Spiritual caring: end of life in a nursing home. *Journal of Gerontology Nursing*, 31(9), pp 27-35.

Watson, M.J (1997). New Dimensions of Human Caring Theory. *Nursing Science Quarterly,* 1(8), pp 33-39.