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An evolutionary concept analysis of "patients' values"

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ABSTRACT

Background: Patients' values are everywhere and nowhere in nursing: frequently invoked and associated with effective nursing care but seldom explicitly defined or subject to dedicated analysis. Clarification of the concept of patients' values is pivotal because respecting and supporting patients' values are widely recognized as crucial for ethical nursing care. Despite this and the pervasive employment of the term patients' values in theories, approaches, and clinical guidelines, the concept remains ambiguous.

Purpose: We sought to understand the key elements of the concept by investigating its use in theoretical and empirical literature.

Method: This study used Rodgers' evolutionary concept analysis approach.

Findings: We found that values are core individual beliefs that function in hierarchical systems; however, in the context of disease, the priority assigned to values by the individual may change. This is important, given that values play a foundational role in health-related decisions, such as in the context of chronic diseases.

Discussion: Values are influenced by both individual intrinsic needs and the social context, but importantly, are involved in guiding decision-making. The attributes of the values may vary according to the context of the disease, the type of disease, and the decision at hand.

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Introduction

Incorporating patients' values in individualized nursing care is crucial to forming effective partnerships which promote health outcomes. In the context of chronic conditions such as heart failure, integrating patients' values in rehabilitation plans is fundamental to fostering effective and sustainable adaptation. Accordingly, the concept of "*patients' values*" is frequently used in nursing literature, theories, and models (Dickson, Deatrick, & Riegel, 2008; Hartweg, 1991). So what do the words "patient" and "values" mean, when we use them together? The term patients' values is seldom made explicit or clearly operationalized (Lee, Low, & Ng, 2013), and is frequently used interchangeably with other terms (e.g., *values, attitudes,* and *beliefs*;

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e.g., see Black & Chitty, 2014). Complicating this interchangeability is the conflation of values with other proximal concepts, for example, when values are equated with choices (Dahl, 2005). This imprecision risk reduces the quality, validity, and trustworthiness of any scholarship associated with the concept of 'patient values'. For example, when leading to research results which address preferences rather than values. Given that evidence from such research may be used to understand or improve key aspects of care (e.g., self-care) or inform value-centered care approaches, this could also compromise nursing practice (Disch, 2012; Plumb, Stewart, Dahl, & Lundgren, 2009; Vanderford, Smith, & Harris, 1992).

Therefore, clarifying the concept of patients' values is an essential step for further knowledge development. There is great diversity in the existing theoretical and colloquial definitions (Elit, Charles, & Gafni, 2010; Petrova, Dale, & Fulford, 2006). Accordingly, in this paper, we seek to explore and describe the use of the concept of patients' values in nursing and health-related literature, and to provide a conceptual definition.

Design

Concept Analysis Model

To clarify the concept of patients' values, we adopted Rodgers' evolutionary model (Rodgers, 2000) for several reasons. First, the philosophical rationale that underlies this approach, in which concept analysis is based on inductive inquiry and on conventional standards, provides a foundation for further development of a concept through additional research (Rodgers, 2000; Tofthagen & Fagerstrøm, 2010). Second, Rodgers' evolutionary model emphasizes that concepts change according to the time and the context. Rodgers distinguishes "entity views" in which a concept is described as some type of entity or thing (e.g., words), from "dispositional views" which make use of concepts, defined as habits or capacities for certain behaviors' (p. 11). As such, a concept is the "idea or characteristics" that are related to a word (p.85). In Rodgers' view, a concept is dynamic, boundless, and influenced by time and context.

Table 1 – Rodgers' Method Analysis Involves Six Activities

- Identify the concept with associated surrogate terms
- Identify and select appropriate setting and sample for data collection
- Collect the data (attributes, antecedents, references, surrogate terms, related terms, and consequences)
- Analyze the data
- Present an exemplar of the concept identified from the literature
- Identify the implications for further development of the concept (Rodgers, 2000)

Rodgers' (2000) evolutionary approach comprises six activities (Table 1). They are not necessarily conducted in a linear process but are normally undertaken simultaneously.

The literature across the disciplines of nursing, medicine, psychology, sociology, and theology employs the concept of values in ways that help to clarify it. As such, a systematic search was conducted via CINAHL, MEDLINE, PsycINFO, ATLA Religion Database, Social Sciences Citation Index, Philosophers Index with Full Text, Religion and Philosophy Collection, Books: Library Ebsco Discovery Service. The systematic search approach captures a comprehensive index of all accessible citations which is linked to the quality and validity of the final product. Searching for *values*, along with other terms such as *preferences, wishes, attitudes*, and *beliefs* in the context of patients yielded millions of citations in English language publications. The large quantity of results was due to the use of the term *values* in the context of patients for three other major purposes: (a) as a verb to mean assessing and appraising something or someone (e.g., patients value experience); (b) as a basis for measurement (e.g., fasting blood value of four or less); (c) and, most commonly as a form of *p* values (the probability of something happening by chance). In order to limit the volume of citations, and ensure accurate identification of literature using the concept of *patients' values*, we used the terms "*patient * values*" OR "*patient * preference**." A snowballing sampling technique was also undertaken by backward and forward citation tracking of reference lists from the selected literature (Garrard, 2011). This helped us to avoid overlooking relevant published and unpublished reports in the grey literature.

Inclusion criteria were (a) theoretical and empirical references containing data on patients' values (which may be understood as individual values, but in the context of disease or illness), (b) written in English, and (c) published as full articles, books, or theses. No time period restrictions were applied through to 2018. The references were excluded if: (a) they lacked data on any of the elements of the concept of patients' values, or (b) they focused mainly on values as belonging to one or more of the following: A health care professional, or a profession, or an institution (or were referred to as health professionals' values, values of the profession, or institutional values).

Data were analyzed using a thematic approach (Rodgers, 2000). References related to various disciplines were read and reread separately to identify words or sentences relevant to the attributes, antecedents, references, surrogate terms, related concepts, and consequences. These data were entered into a table, which was divided into sections for each discipline. Major themes related to the elements of the concept were identified through a repetitive iterative process of frequently organizing and reorganizing comparable patterns in the literature "until a cohesive, comprehensive, and relevant system of descriptors is generated" (Rodgers, 2000, p. 95). However, this

process of reduction was not applicable to the surrogate terms and related concepts, which were simply recorded. The purpose of the concept analysis was to identify both consensus and failure to define a concept across disciplines. We considered not only the similar points in the literature, but also the disagreement; this is further explored in the Discussion section. A practical exemplar was also identified from the literature that represented the characteristics of the concept of values.

Findings

The search yielded 4,563 citations. Snowball searching revealed an additional 88 references. While CINHAL displays the drastic increase in the use of patients' values in the literature over the last two decades, the focus in nursing remains underexamined (Figure 1). All full references were screened based on the inclusion criteria. Of these, 124 (with publication dates ranging from 1941 through 2018) books, theses, and articles that could explicate aspects of the key elements of the concept of values were identified (Figure 2).

This group includes 30 empirical studies and 84 theoretical and descriptive papers. Some of the latter were identified in the process of citation tracking; they were among the most cited references. This provided a theoretical or conceptual foundation for the included studies across disciplines, such as works by Rokeach (1973) and Schwartz (2007). These 124 texts were classified by the theoretical perspective in which each paper was grounded: medicine/health sciences (48), psychology/sociology (33), nursing (30), ethics/policy (5), philosophy (5), and theology (3).

Following Rodgers (2000), we analyzed the concept of values, using empirical and conceptual literature from multiple disciplines, not only on the basis of its intrinsic attributes, but also with attention to elements of its context (antecedents, references, surrogate, related terms, and consequences; Figure 3). In addition, we defined the concept, and provided an exemplar.

Attributes

According to Rodgers (2000), *attributes* are characteristics that allow for the definition of a concept in real-world terms (p. 91). We suggest six attributes of values that are categorized into two major groups: those pertaining to *the nature of values* and those revealing *how values function*.

The Nature of Values: What Is Meant by "Values"?

The first broad category of attributes is related to the fundamental features of values, focusing on what values are at their core. Four attributes are related to the nature of values: they are a form of belief, they are abstract, they are subjective, and they are uniquely significant to individuals.

Values as a Form of Belief

Many scholarly sources provide broad or ambiguous descriptors of the concept of values, using imprecise terms such as *features, things* (Elit et al., 2010; Menzel, Dolan, Richardson, & Olsen, 2002), *views* (Petrova et al., 2006), or *ideas* (Bowen et al., 2006). The reason for this imprecision may be that some researchers regard values as immutable (Quill, 1993). In the most recognized and quoted definitions, however, values are referred to as a type of *beliefs* (Rokeach, 1973; Schwartz, 2012) which are prescriptive or proscriptive (Rokeach, 1973, p. 6-7) – that is, such beliefs determine the desirability of an action and are centrally located within one's belief system. By contrast, other types of beliefs within the system, which are more peripheral, are about facts or evaluation in terms of goodness or badness (Rokeach, 1973).

Values as Subjective

Individual values are frequently labeled as being subjective (Altamirano-Bustamante et al., 2013; Meadowcroft, 2008; Schwartz, 2012), defined as reflecting "a personal point of view" (Wingfield & Badcott, 2007, p.7). Subjectivity is referred in the literature in a variety of ways – for example, values are described as *individual, personal* (Altamirano-Bustamante et al., 2013; Plumb et al., 2009), *intrinsic* (Earley, Mentkowski, &

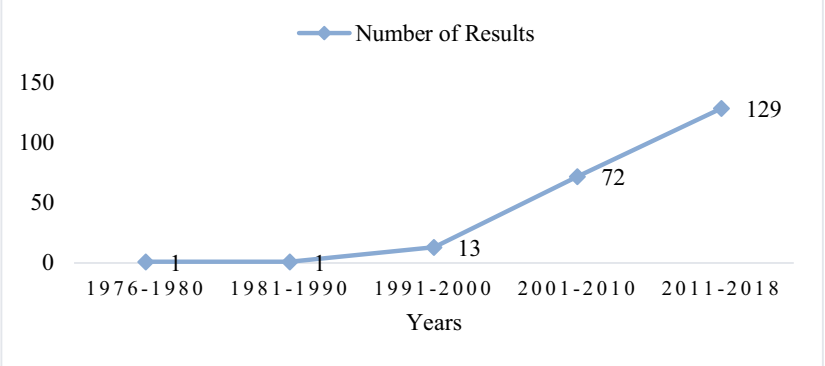

Figure 1 – Frequency of articles addressing concept of patients' values retrieved from CINHAL.

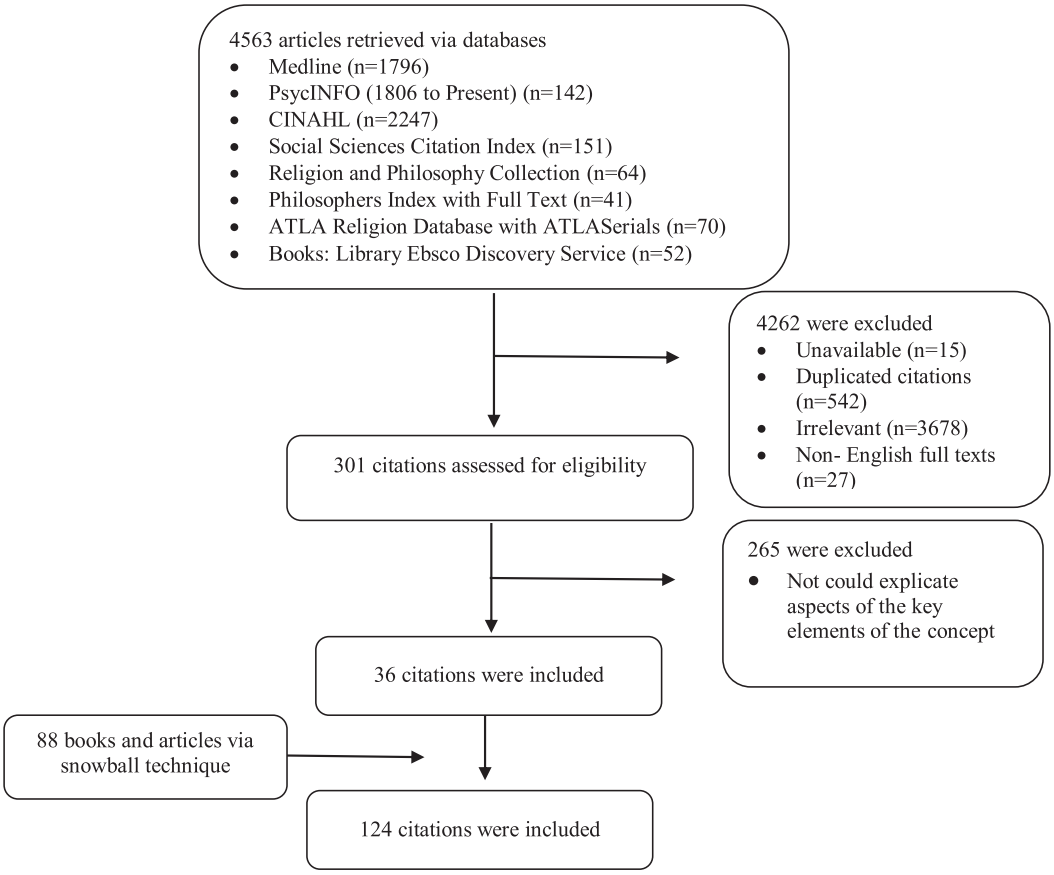

Figure 2 – Flow chart of literature selection process.

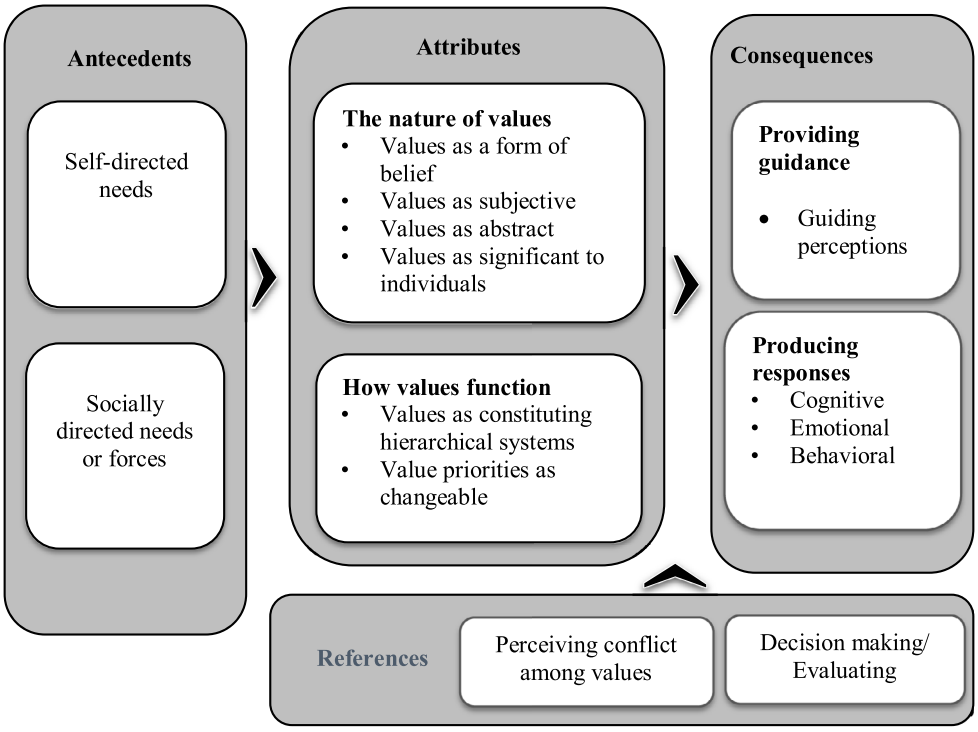

Figure 3 – Model of the concept of patients' values.

Schafer, 1980), and *self-determined* (Huxtable, 2013), and said to be *freely chosen* (Plumb et al., 2009). The compelling reasons that values are subjective are that they are closely connected to the identification of the self (Lichtenberg, 1983; Masters, 2009; Petrova et al., 2006) uniquely acquired by each individual, and that they are established very early in life (Kalish & Collier, 1981; Rokeach, 1968). Such a set of subjective values in an individual may be held consciously or unconsciously (Farrell, 1987; Lichtenberg, 1983; Plumb et al., 2009). Values are affective, given that they tend to be tied to feelings and emotions (Luce, 2005; Masters, 2009; Meissner, 1987; Segalla, 2006; Tung, Hunter, & Wei, 2008).

Values as Abstract

The idea that values are abstract is expressed in several ways. First, a number of authors characterize *values* as not being concrete and not completely explicable through rationality (Thornton, 2006; Valenti, Giacco, Katasakou, & Priebe, 2014); they are seen as elusive (Charles & Gafni, 2014; Elit et al., 2010) and arguable (Wingfield & Badcott, 2007). Furthermore, the notion that values exist outside of concrete being means they have also come to be seen as decontextualized or context-free (Rokeach, 1973; Schwartz, 2012). In other words, values such as joy, responsibility, health, justice, beauty, freedom, or obligation transcend specific situations or subjects.

Another definition of abstractness, meaning "difficult to understand" (Merriam-Webster, 2018), also influences the ways in which values are viewed. Patients' values are described as not being easily identifiable by others (Charles & Gafni, 2014; Childress, 1970; Hug, 2000), being rarely visible (Austgard, 2007) and a lack of suitable approaches to identifying them (Altamirano-Bustamante et al., 2013; Peile, 2013; Petrova et al., 2006). In addition, it has been noted that patients have difficulty expressing their values, given they may feel fear, shyness (Bosek & Savage, 2007; Curtis et al., 2001; Loughlin, 2014; Pieterse, Baas-Thijssen, Marijnen, & Stiggelbout, 2008), intimidation (Masters, 2009; Ubel & Loewenstein, 1997), or discomfort due to stigma in disclosing (e.g., values that are related to sexual orientation; Curtis et al., 2001), and this may be overwhelming to some patients, in particular in critical situations (White et al., 2012). This difficulty is related not only to difficulty in expressing them but also to patients' lack of awareness of their own values (Childress, 1970; Farrell, 1987; Lichtenberg, 1983) and to the fact that a particular value may be meant and interpreted in a variety of ways by different people (Austgard, 2007; Quill, 1993).

Values as Especially Significant to Individuals

Personal significance is another attribute used frequently to describe the concept of values (Table 2). In some definitions, particularly in practical and concise ones, significance is the key element (Fiset et al., 2000; O'Connor, Stacey, & Légaré, 2006; Vanderford et al., 1992). The concept has been simply defined as "what is most important to us" (Masters, 2009, p. 395). Significance is also indicated using such terms as *worthwhile, highest regard* (Charles, 2014; Elit et al., 2010; Fiset et al., 2000; Halpern, 1995; Masters, 2009), *core* (Masters, 2009), *most dear* (Davidson, 1992), *meaningful* (Farrell, 1987), *desirable* (Meissner, 1987), and *fundamentally valuable* (Austguard, 2007; Darling, Boyce, Cho, &

Table 2 – Values as Especially Significant to Individuals

Examples of Values as Especially Significant to Individuals	References
"The features that matter most."	Lee et al., 2013, p. 1
"...what matters most."	O'Connor et al., 2006, p. 106
"To what they care about most deeply."	McCracken & Yang, 2006, p. 138
"Important agendas in daily life."	McCormack, 2003, p. 205
"What is most important to us."	Masters, 2009, p. 395
"Core values are those values that are most important to us, the values that define who we are as human beings."	Masters, 2009, p. 172
"Ideas about what is valuable, important, or right"	Darling et al., 2015, p. 8
Life priority	Armstrong & Mullins, 2017
"Values related to one's views about what is important in life and the kind of person one has to be."	Petrova et al., 2006, p. 708
"Processes of deciding whether something is good, worthwhile and important whether something is good, worthwhile and important."	Petrova et al., 2006, p. 708
"Values as those things that are held in highest regard or most important for that individual."	Elit et al., 2010, p. 279
"More important than anything else."	Murray-García, Selby, Schmittdiel, Grumbach, & Quesenberry, 2000, p. 302
"Our judgement of what is valuable or important in life."	Wingfield & Badcott, 2007, p. 9
"What patients consider as important to decision-making."	Charles & Gafni, 2014, p. 205-6
"The term values refers broadly to those aspects of a healthy life that a person holds as most important—for instance, living an active life vs. freedom from pain and suffering."	Halpern, 1995, p. 75
"What was most important to them."	Fiset et al., 2000, p. 131

Sankar, 2015). This attribute is usually described as being linked to the patients' perceptions of their lives and their world (Fiset et al., 2000; McCormack, 2003; Segalla, 2006). For example, "what is important in life and the kind of person one has to be" (Petrova et al., 2006, p. 708).

How Values Function: "How Do Values Work?"

In addition to the attributes that are related to the nature of values, two other attributes characterize the function of values. First, values constitute hierarchical systems; second, the priority of values is changeable in response to the context.

Values as Constituting Hierarchical Systems

A *system* is defined as "a whole with inter-related parts, in which the parts have a function and the system as a totality has a function" (Auger, 1967, p. 21). An individual's value system encompasses several values that are interconnected (some of these may be compatible, while some are in conflict) and positioned differently in a way that they configure a hierarchical order of values. This aspect of the concept of values has been the focus of theorists and empiricists in the disciplines of psychology, sociology, (Beckstrand, 1978; Masters, 2009; Patterson & Blocher, 1989; Valenti et al., 2014), and nursing (Flanagan & Young, 1997; Karimi & Clark, 2016).

In broader terms, the hierarchical-value notion was proposed initially in Pepper's (1941) discussion on selection and dominance of different values in different situations. This insight has continued to influence discussions of values through the decades. Twenty years after Pepper, Kluckhohn and Strodtbeck (1961) directly proposed the rank order of preference to refer to the process of prioritizing values. In 1973, Rokeach defined *hierarchies* or *priorities* as "the ordering of values according to importance, in some sense" (p. 18). The most recent and widely used definition by Schwartz also places an emphasis on values that are organized and ordered based on their importance in a system (2012). In the empirical studies reviewed here, patients' values priorities were found to be influenced and prioritized differently based on the situation (e.g., disease) and the context (e.g., family or society; Lee et al., 2013; Karimi & Clark, 2016).

Values as Changeable?

Scholars have approached the question of whether and how values change in at least four markedly different ways. Values are variously viewed as (a) changing over time (Elit et al., 2010; Kelly, 1990; Jensen & Mooney, 1990; Pollak, Childers, & Arnold, 2011); (b) being relatively fixed (Elit et al., 2010; Petrova et al., 2006) hard to change (Kalish & Collier 1981); (c) and being stable (Austgard, 2007; Nåden & Eriksson, 2004; Ridley, 1998; Rokeach, 1973). A fourth group posits basic values as being stable, but views ordered values as subject to change. The priority of values, and likewise the attributes of hierarchical systems that constitute it, both reflect how the concept of patients' values has evolved over time. Indeed, the notion of change in priority of values has emerged in the literature concurrently and in parallel with the notion of hierarchical values, as noted above. It is viewed that the ranking of values may change or may be partly stable according to factors such as the patients' situations and their health capacities (Gensler, Spurgin, & Swindal, 2004, p. 225). Change could also be due to new experiences, life circumstances, effective persuasion, societal values (Masters, 2009, p. 48), or biological processes such as normal aging (Mather & Carstensen, 2005).

Value stability, on the other hand, is a result of "experiencing satisfaction and is thus a result of the reinforcement of one's existing belief system" (Rokeach & Ball-Rokeach, 1989, p. 782). In the context of patients with particular chronic conditions, such as heart failure, diabetes, or cancer, patients may be limited in terms of their physical capability and they are also required to permanently adapt to a modified lifestyle. These demands can interfere with patients' usual values prioritization. For instance, the value of achievement might be important for an individual, but the health situation may force him/her to change the priority of their important values (Hodges, 2009; Mahoney, 2000).

Attributes in the Empirical Literature

These attributes are specifically evident within 30 empirical studies included in the larger sample (Table 3). Among other things, these studies sought to improve communication (Black, 2004), understand patients' adherence (Ahola, 2015), examine quality of care (Curtis et al., 2001), implement patient-center care, and inform care plan (Curtis et al., 2001; de Hoyos et al., 2013; Gaudiano, Nowlan, Brown, Epstein-Lubow, & Miller, 2013; White et al., 2012). Table 3, lists the characteristics of these studies and describes the attributes ascribed to patients' values, either explicitly or implicitly. As Figure 4 shows, values being significant and important to individuals was the most important and most common attribute, which appeared in 47% of research articles. The attribute of value priorities as changeable; however, was mentioned the least often at 10%.

Some of the authors of these studies tried to measure the importance and determine the hierarchical order of patients' values by using valid instruments (i.e., Portrait Values Questionnaire, Rokeach Value Survey, and Valued Living Questionnaire; Ahola, 2015; Gaudiano et al., 2013; Greszta & Sieminśka, 2011) developing their own questionnaires (Black, 2004; de Hoyos et al., 2013), or using other approaches (i.e., qualitative interviewing, value clarification methods, and patients aids (Carroll et al., 2018; Fiset et al., 2000; Feldman-Stewart et al., 2012). The nature of goals and expectations for this measurement differed significantly between authors who took the approach of

Table 3 – Overview of the Characteristics of the Empirical Studies Included in the Concept Analysis and Attributes of Patients' Values

Author/Year	Discipline	Country	Methods	Data Collection	Attributes
Ahola, 2015	Social Psychology	Finland	Survey	Face-to-face interview	Especially important to individuals, constituting hierarchical system, openness to change
Beverly, Wray, LaCoe, & Gabbay, 2014	Medicine	USA	Qualitative	Focus group	Most important, constituting hierarchical system, abstract
Black, 2004	Social Work	USA	Survey	Questionnaire	Important, general (abstract)
Boutin-Lester & Gibson, 2002	Occupational Therapy	USA	Qualitative-Phenomenology	Interview	Subjective
Carroll et al., 2018	Nursing	Canada	Qualitative	Interview	Most important, most matter
Curtis et al., 2001	Medicine	USA	Qualitative	Focus group	Beliefs, constituting hierarchical system
de Hoyos et al., 2013	Medicine	Mexico	Qualitative	Interview	Normative systems, subjective, constituting hierarchical system
Denson, 2006	Health Sciences	Australia	Mixed-method	Interview, survey	Standard, predisposition, global, abstract, value priorities as changeable, constituting hierarchical system
Earley, Mentkowski, & Schafer, 1980	Religious, Biology, Nursing, Psychology, Education, Music, Language	USA	Qualitative	Interview	Normative systems, constituting hierarchical system subjective
Feldman-Stewart et al., 2012	Epidemiology, Medicine	Canada	RCT	Assessment, telephone interview	Standards, implicit, explicit, important
Fiset et al., 2000	Nursing, Medicine, Epidemiology	Canada	Before/after study	Questionnaires	Most important, subjective
Flanagan & Young, 1997	Nursing	USA	Pretest-post test design	Survey	System of values, a belief, abstract, stable, important
Gaudiano et al., 2013	Psychology	USA	Open trial	Questionnaires	System, subjective
Gloster et al., 2017	Psychology, Epidemiology	Germany	Randomized clinical trial	Assessment	Subjective, important
Greszta & Sieminśka, 2011	Management	Poland	Cross-sectional study	Questionnaire	Enduring beliefs, value priorities as changeable under particular circumstances, constituting hierarchical system
Hack et al., 2010	Nursing, Medicine	Canada, Australia	Qualitative	Interview	Permeating feature of a one's whole life
Hodges, 2009	Nursing	USA	Mixed methods	Interview and Questionnaire	Value system, associated to one's goals, expectations, standards, and concerns. Values fall within the personal development domain
Lee et al., 2013	Medicine	Malaysia	Qualitative	Interview	The features that matter most, subjective, the positive and negative features that matter most, desirability or personal importance of outcomes of options

(*continued on next page*)

Table 3 – (*Continued*)

Author/Year	Discipline	Country	Methods	Data Collection	Attributes
Lee, 2014	Medicine	Malaysia	Interpretive descriptive approach	Interview and focus group	An enduring belief that a specific mode of conduct or end-state of existence, beliefs, motivational construct, transcend specific actions and situations, constituting hierarchical system
Leichtentritt and Rettig, 2001	Social Science	Israel	Hermeneutic phenomenology	Interview	Important, constituting hierarchical system, enduring and abstract beliefs
Martin and Roberto, 2006	Nursing	USA	Mixed-methods	Face-to-face interview	Important, beliefs, stable
Mangelsdorff and Finstuen, 2003	Public Health Medicine	USA	Survey	Instruments	Separate beliefs of a specific kind concerning a desirable end-state
Morgan and Hart, 2009	Nursing, Family & Consumer Sciences	USA	Phenomenology	Focus group	Unique preferences, concerns and expectation, subjective
Murray-García et al., 2000	Policy, Medicine	USA	Cross-sectional	Questionnaire	"More important than anything else", subjective, constituting hierarchical values
Raftopoulos, 2005	Nursing	Greece	Qualitative -Grounded theory	Interview, focus group and direct observation	Relatively stable beliefs about the personal or social desirability of certain behaviours and modes of existence
Sandelowski, 1986	Nursing, Public Health	USA	Cross-case comparison study	Interview and questionnaire	Abstract goals, important, subjective
Scheunemann et al., 2015	Medicine, Nursing	USA	Prospective, cross-sectional study	Conferences, Questionnaire	Belief, important
Stawnychy et al., 2014	Nursing	USA	Brief motivational interviewing approach	Interview	Motivation
Valenti et al., 2014	Medicine, social, psychology	UK	Qualitative	Interview	Important, not completely justifiable,
Vanderford et al., 1992	Medicine, communication	USA	Narrative discourse	Interview	Basic orientation toward life, desirable

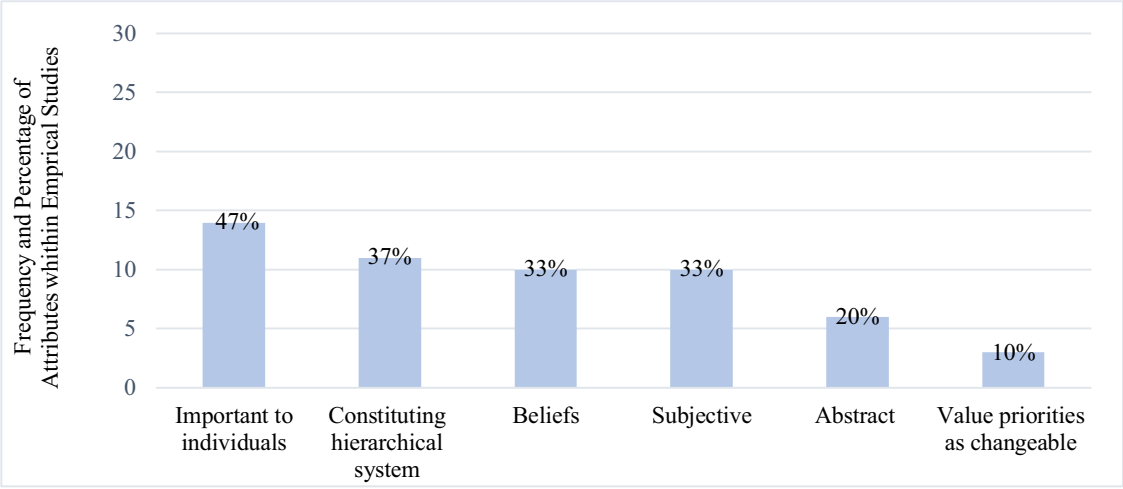

Figure 4 – Distribution of attributes within included research articles.

beginning with a range of predetermined values and sought to rank and relate them to patients' health care decisions, or simply assess a change in the hierarchy of value systems due to disease. Other authors, searched for emerging values. In contrast to the above measures, which rely on the hierarchical order of patients' values, other approaches have been adopted to identify individual's values, or to measure the relative desirability/undesirability of health care options and identify an option with the highest relative weight (Llewellyn-Thomas & Crump, 2013).

While particularly in empirical research, different instruments or approaches have been used to measure patients' values. Some of the authors of theoretical papers argue that the notion of value measurement is ideological/philosophical rather than psychological (Charles & Gafni, 2014; Childress, 1970; Ehrlich & Wiener, 1961; Kissane, Bultz, Butow, & Finlay, 2010). In the literature, there are at least three refuting views of such an argument: (a) values are measurable, (b) values are difficult to be measured, and (c) some of the values are measurable and some are difficult to be measured. We explore these differences later.

Antecedents: "What Comes Before Values?"

Antecedents are the events and phenomena that inform and give rise to a concept (Rodgers, 2000). Scholars view the origins of values to be needs or forces (Schwartz, 2012; Singh & Rastogi, 2001; Vanderford et al., 1992), which can be classified in two major categories: self-directed needs and socially directed needs or forces. Self-directed needs are related only to oneself, such as needs for control and mastery, variety, stimulation, and joy (Schwartz, 2012). Such needs are influenced by demographic factors such as age (Kalish & Collier, 1981), status in life cycle (Hewlett, Smith, & Kirwan, 2001), personality (Rokeach, 1973), and personal experience (Hirsch & Abernethy, 2012; Segalla, 2006; Sinding, 2006). Experience, for example, was noted to be an influential factor for patients who were diagnosed with heart failure and prioritized the value of pleasure by eating out. However, experiencing worsening symptoms and hospitalizations due to nonadherence to a low-sodium diet could influence the patients' value priorities (health over pleasure) by prompting them to avoid eating high salt food at restaurants. These self-directed needs are presented in the literature in different but parallel ways: as authentic needs (Capone & Stevens, 2013), fundamental needs (Meissner, 1987), selfish needs, (Rokeach, 2000) individual needs (Rokeach, 2000), internal forces (Gaudiano et al., 2013), and biological organisms needs (Meissner, 1987; Schwartz, 2012, p. 4).

Socially directed needs are those that tend to be social in nature. They are associated with the goals that originate in families, groups, organizations, institutions, and social expectations, demands, forces, and cultures. The cultures of any of these social system levels have been identified as an important factor in influencing value development (Hanssen, 2004; Kelly, 1990; Petrova et al., 2006; Rokeach, 2000; Wingfield & Badcott, 2007). Individuals' values, for example, can be shaped by their parents' values (Kalish & Collier, 1981). Given the major influence of social context, Hanssen (2004) argues that in order to study values, cultural values or contextual values ought to be assessed (Meissner, 1987). Whether they view religion as part of a culture or distinct from culture, a large number of scholars have found religiosity to be another major factor that influences values prioritization (Kuschel & Mieth, 2001). As such, in addition to the individual's needs, one's value prioritization may also be reinforced through culture/religion in a given social system.

The contextual bases of the concept were further examined by identification of the references.

References: "In What Context Do the Values Work?"

References are the context or situations in which a concept occurs (Rodgers, 2000). In the context of health

and illness, values are manifested in two main situations: (a) patients' values become involved in all decision-making activities, (b) patients' values also become active when there is conflict among those values, either within one's own value system or between these values and the values of other parties. In the context of health and illness, this may be manifested as conflict between patients' values and health professionals' values (Nåden & Eriksson, 2004), when an ill individual has to make a decision about therapeutic recommendations. Such conflicts are evident in the literature, in particular in the context of approaches to patient centeredness in which patients have been encouraged to integrate and express their values in their own treatment decisions (Ubel & Loewenstein, 1997). The recognition of such conflicts is grounded in various approaches, such as motivational interviewing (Plumb et al., 2009) and decision aids (Ubel & Loewenstein, 1997). This requires a variety of communication strategies, such as getting closer, informed flexibility, mutuality, transparency, negotiation, and sympathetic presence. In spite of the above, there are situations in which patients with cognitive problems (e.g., dementia), depending on their level of impairments, may not be able to make decisions in a way to pursue their values.

For further clarification of the contextual bases of the concept, we also sought other ways of expressing the concept of patients' values.

Surrogate and Related Concepts: "What Are Close, Synonyms or Alternate Terms?"

Surrogate terms are alternative terms with similar meanings (Rodgers, 2000) that may be used interchangeably with the term *values*. In this analysis *preferences* and *goals* were found to be the most common surrogates which authors use interchangeably with the concept of values. References to preferences are especially common in the literature, in particular to the context of patient/person/values-centered care and shared decision-making. It is notable, that some of the surrogate terms, including preferences, goals, attitudes, beliefs, spiritual beliefs, and core beliefs, are also used by researchers as related-concepts terms. Rather than surrogate terms; *related concepts,* are terms that have some association with a concept, but have different attributes (Rodgers, 2000). For instance, preferences are sometimes defined as a person's overall most-favored option (Llewellyn-Thomas & Crump, 2013), and goals are sometimes said to be influenced by values (Jensen & Mooney, 1990). In order to categorize these terms as either surrogate terms or related concepts, we first selected the six terms that were most commonly used in the literature as surrogate terms and related concepts, and then compared their attributes with the attributes of the concept of values (Table 4). *Core beliefs* and *life goals* were found to share a similar meaning with the concept of values and were thus identified as surrogate terms. *Attitudes, beliefs, preferences*, and *spiritual beliefs* were identified as related terms. The term goals were the most difficult to categorize, so we have described it as a *potential* surrogate term.

Last components of the contextual bases were also explored by identifying consequences.

Consequences of Values: "What Happens When Values Work?"

Consequences of values are the events that follow the manifestation, either consciously or unconsciously, of particular values (Farrell, 1987; Plumb et al., 2009). This review of the literature from different disciplines suggests that the consequences of values can be viewed as (a) providing guidance, as primary effects and (b) producing responses as secondary effects.

Primary effects of values

Primary effects are the ways that values shape our perception. More specifically, values primarily provide guidance in the creation of standards to allow an individual to evaluate and judge others and oneself and also the treatment alternatives (Austgard, 2007; Halpern, 1995). Such effect is viewed as directive and organizational (Meissner, 1987). This fundamental mode of conduct has been regarded in a variety of ways in the literature, for example, as predominant reinforcers (Wilson & Dufrene, 2009), guidelines (Kalish & Collier, 1981), rules (Plumb et al., 2009), normative guidelines (Altamirano-Bustamante et al., 2013), criteria (Childress, 1970; Kalish & Collier, 1981; O'Connor et al., 2006), an approval–disapproval continuum (Kluckhohn, 1951, p. 395), directions (Wilson & Murrell, 2004), means (Beckstrand, 1978; Kinnane & Suziedelis, 1966; Kluckhohn, 1951; Patterson & Blocher, 1989; Quill, 1993), implicit or explicit standards (Jensen & Mooney, 1990; Quill, 1993; Raz, Korsgaard, Pippin, Williams, & Wallace, 2003), and value judgments (Beckstrand, 1978; Halpern, 1995; Lichtenberg, 1983; Nicoll, Reed, & Shearer, 2004). They have also been related to the concept of the superego (or individual's evaluative judgments; Lichtenberg, 1983). Secondary effects, however, has another aspect of consequences, which are multifaceted.

Secondary Effects of Values

Secondary effects are the ways values function. While guidance is a fundamental aspect of the consequence of values, producing responses are the secondary effects of values. These consequences affect cognitive, behavioral, and emotional responses.

Cognitive Impacts. Cognitive impact of values can be categorized into four functions. The first is intellectual production, which is the influence of values on creating attitudes, perspectives (political, religious), and decisions. Patients' values influence choices and preferences about choices (Armstrong & Mullins, 2017; Kinnane & Suziedelis, 1966). Decisions are made based on the extent to which a treatment is consistent with patients' values (Kissane et al., 2010; Smith et al., 2018) and whether patients' prioritized values are pursued.

Table 4 – Analysis of Terms Used as Surrogate and Related Concepts

Term	Meaning Applied in the Literature	Analysis	Classification
Attitudes	A patient's *attitudes* focus on the desirability/undesirability of an option or outcomes (Llewellyn-Thomas & Crump, 2013)	*Attitudes* is inadequate as a surrogate term, given that it is concrete and evaluative in nature, and is associated with a specific object and situation (e.g. outcomes).	Related term
Beliefs	"Any simple proposition, conscious or unconscious, inferred from what a person says or does" (Rokeach, 1968, p.113)	*Beliefs* is inadequate as a surrogate term, as it refers to the simple convictions that a statement is true and is not abstract.	Related term
Core beliefs	Core beliefs are "fundamental to a person's world view" and function as a powerful ego-defense, which is relatively resilient to change (Charles, Gafni, Whelan, & O'Brien, 2006, p. 265); see also Sabatier, 1988 referenced in Charles et al., 2006).	*Core beliefs* have the same attributes as values and may be used as a proxy measure for values.	Surrogate term
Spiritual beliefs	*Spiritual beliefs* refer to a person's belief in a power apart from their own existence. (King et al., 1999, p. 292)	*Spiritual beliefs* are not core beliefs but are closely related to core beliefs and are connected to a specific domain of individuals' values.	Related term
Goals/life goals	*Goals*, or personal aims, are important to a person, are small in number, and are likely to be most relevant to the choices that are related to treatment options (Fowler, Levin, & Sepucha, 2011). "*Life goals* are objectives that a person strives to attain or avoid. They are hierarchically organized, accessible to conscious awareness and can be identified. Life goals may influence participation in a rehabilitation programme." (Nair, 2003, p. 200)	*Goals* is a potential surrogate term because on one hand it may be related to a specific situation or object (e.g. an option), but on other hand it may be used as an abstract idea. However, the term *life goals/ ultimate goals* may be used as a proxy for values, as life goals are both abstract and important.	Potential surrogate term (goals) Surrogate terms (life goal/ultimate goals)
Preferences	A *preference* is a person's overall most-favored option (Llewellyn-Thomas & Crump, 2013) based on patients' "perspectives, beliefs, expectations, and goals for their health and life." It is reached by "weighing the potential benefits, harms, costs, and burdens associated with different treatment" or disease management options (MacLean et al., 2012, p. e1S).	*Preferences* is inadequate as a surrogate term because the concept is related to an object and it is consequence of the process of evaluating and weighing options (e.g. treatment options) from different perspectives.	Related term

The second cognitive impact of values may be self-justification, which is engaged in order to rationalize thoughts, decisions, and actions. Such impact is also described in discussions around self-deception and ego-defensiveness (Rokeach, 1973). The third cognitive impact can be perceived as self-identification (Huxtable, 2013), in terms of who we are and what we value the most. The fourth impact, which is patient empowerment (Kvåle & Bondevik, 2008), has been examined in terms of the consequences of the patient-centered care plan, in which patients' values are explicitly integrated in the plan of nursing care.

Behavioral Impacts. Individuals' values can contribute to behavior, either positively or negatively; in other words, values may have enhancing or destructive effects (Shriver, 1980) on individual preferences, decisions, and behavior (Bowen et al., 2006; Llewellyn-Thomas & Crump, 2013; Petrova et al., 2006; Smith et al., 2018). In the caring context, patients' values have been the focus in order to understand adherent or non-adherent behavior and to take steps to support patients according to their values (Ahola, 2015; Karimi & Clark, 2016). However, the positive or harmful impact of values on behavior depends on patients' prioritized values and the impacts of these values on their subsequent behavior (Petrova et al., 2006). Nonadherent behavior, for example, arises from situations where there is conflict, clash, or inconsistency (Ahola, 2015; Valenti et al., 2014) between a patient's prioritized values and health care recommendations (Karimi & Clark, 2016). Such a

situation is described as "a complex and often situationally dependent process" (Beckstrand, 1978, p.177).

Emotional Impacts. Emotional feelings and psychological health status can result either from success or failure in pursuit of values (Plumb et al., 2009). These results may impact patients' feelings – either positively causing satisfaction, or negatively causing guilt, shame, stress, and anxiety (Luce, 2005; Meissner, 1987; Tung et al., 2008).

Definition of Values

The conceptual definition of the concept of values that is proposed in this concept analysis is based on attributes identified from literature. As such, values are defined as core beliefs, which are abstract and subjective in nature and perceived as very significant to individuals; they function within a system and a priority of values can be changed under certain circumstances.

Exemplar

A real-life example retrieved from a case study (Stawnychy, Masterson Creber, & Riegel, 2014) is presented in Table 5 to further clarify the critical attributes and consequences of the concept in practice.

Discussion

This analysis has shown that the concept of patients' values is characterized as important, subjective and abstract beliefs, which constitute hierarchical systems. The priority of values within the systems may also be changed in a particular situation. Understanding the concept of patients' values precisely is crucial because values must be integral to the work of researchers and nurses in supporting patients' health-related decisions individually.

It is also found that the concept of patients' values has expanded significantly over the last half century. This concept has been applied to elucidate a variety of behaviors in different contexts. Notably, the therapeutic relationships between patients and health care professionals, patients' roles in medical decisions, patients' autonomy, and patient-centered care. During this time, there has also been a major evolutionary shift in the concept of values, in particular, pertaining to an individual's value systems in sociology and psychology (Rokeach, 1973; Shwartz, 2007). Researchers, however, have been deliberately ignoring or simply overlooking the concept, which refers to the core and intangible elements that guide individuals in their decision-making process. The misconception in their work (e.g., using the concept interchangeably with other concepts, such as *attitudes*) is also problematic because of conceptual questions underlying the continually nebulous use of the concept of values. Thus, understanding the difference between the relevant concepts and the concept of values is crucial because they possess different attributes. Attitudes, for example, are evaluative associations and directed toward an object (people, behaviors, events, and places) and the situation in which the object is established, for example, the positive opinion of a patient with HF about eating out with friends at a restaurant on Christmas Day. Understanding patients' values may not be an easy task (Charles & Gafni, 2014; Childress, 1970; Hug, 2000; Loughlin, 2014) because values are communicated explicitly or implicitly through language (Dicken & Edwards, 2001). As such, the challenging nature of some values along with other attributes of the concept of patient's values can be considered as the foundational principle of the effective communication that

Table 5 – Exemplar

A woman with Class IV heart failure (HF), described as a noncollaborative partner, was rehospitalized because of shortness of breath and worsening symptoms. She had been hospitalized nine times in the previous year as a result of nonadherence to medication, low sodium diet, and missing follow-up appointments. During motivational interviewing, she explained that "she felt overwhelmed and fatalistic" (Stawnychy et al., 2014, p. 3), because she was pressured to follow health professionals' recommendations and was provided no alternatives (which hampered a key personal value of self-directed action). Her emotional reaction and frustration intensified due to negative treatment by nursing staff as a result of her frequent readmissions. Staff labeled her as a "frequent flyer" and said "You are back once more?" (p. 4).
In this case, the reference or situation for the occurrence of the concept of values is health-related decision-making in the context of HF. Three patient's values – self-directed action, respect, and good health– were involved. These values reflect certain attributes: they were abstract beliefs (as they existed in thought, became identifiable through the use of a suitable approach that encourages her to disclose her perceptions), they were subjective, and they were significant to her (as she made her decisions based on them). Further attributes of values, including constituting a cognitive system and changeability of the priority of values, were also exemplified. The patient came to the hospital to receive care (to pursue the value of being healthy), but she experienced a paternalistic model (which inhibited the pursuit of self-direction) and perceived that she was not respected due to her frequent rehospitalisation.
Consequently, in this situation the values of respect in addition to self-direction became more prominent cognitively, in which the value of respect was prioritized over the value of being healthy; this reflects a change in priority of values. The consequences were emotional (feeling overwhelmed) and behavioral responses (including nonadherence and missing scheduled appointment).

needs to be taken into account in efforts to promote person-centered care.

We found that the task of clarifying the concept of patients' values to be particularly challenging for three key reasons, which we explore below. These are areas for further development of the concept through further research.

The Comprehensive Influence of Chronic Disease

We argue that different disciplinary perspectives may create a challenge for the analysis of the concept of values in the context of health and illness. Sociological perspectives on values view human behavior in relation to surrounding cultural and social structures. This differs from the health-related disciplines. In these fields, patients' decisions are mainly viewed as self-directed and have personal health-status implications. Adherence/nonadherence, compliance/noncompliance, concordance, autonomy, and euthanasia in the context of chronic disease or end-stage organ failure are examples of such self-directed decisions or behavior. Some health contexts, moreover, are neither self-directed nor sociological. In the context of dementia, – a situation in which a person' cognitive condition declines– not only the reference but also the attributes of the concept of patients' values differ. The context of physical disease also influences the attributes and functions of individuals' values (Karimi & Clark, 2016). Understanding this influence will require more research focusing on patients' values– a field that researchers have emphasized and recommended for further research since the 1950s (Krasner, 1965; Meehl, 1959).

Differing Theoretical Assumptions

The findings of this evolutionary concept analysis were based on points of consensus within the literature. Nonetheless, according to Rodgers (2000) instances of disagreements must be elaborated as outliers because the study of incongruities, another aspect of concept analysis research, can also generate significant insights. One of the important disagreements in the literature is about measuring values, which in general is viewed as challenging due to the heterogeneity of existing measurements (Carroll et al., 2018).

In closely examining the refuting views, noted above, on the measurement of values, it was noticed that they are anchored in three distinct presumptions which were based upon various delineations for values and measurement. First, in approaches such as, standard gamble and time trade-off that tend to measure patients' values (Llewellyn-Thomas & Crump, 2013; Woloshin, Schwartz, Moncur, Gabriel, & Tosteson, 2001), the focus is on the relative values that individuals express for a consequence that they may face. These approaches intend to assess an individual's evaluation and preferences for, for example, treatment options that do not conform to the individual's values. Second, as in the Rokeach Value Survey (Rokeach, 1973), a widely used and valid value-measurement instrument, measurement means determining the order for values in terms of their importance. In other words, measurements in use of this approach indicates "relative ranking" of an individual's values. Third, measurement simply referred to collection or determination of patient' values. The measurement has been viewed as problematic and complex because of difficulty or unwillingness of patients to convey their values (Bosek & Savage, 2007; Charles & Gafni, 2014; Curtis et al., 2001; Entwistle & Watt. 2006; Kissane et al., 2010; Loughlin, 2014). As such, the major reason for this disagreement concerning measuring values is a conceptual inconsistency. Perhaps identifying and ranking values demand a clearer and more precise term than simply "measuring." Thus, measuring patients' values may pose a different level of challenge depending on whether the intention is the identification of patients' values, the order of patients' prioritized values, or the relative values that patients place on the treatment options.

Imprecise Use of the Concept of Values

Likewise, the incongruence in values-based approaches between the concept of patients' values as a center of their focus, and the way that the approach mirrors the process of achieving this goal (Kelly, Heath, Howick, & Greenhalgh, 2015) was another challenge in examining the concept of patient's values. This was evident in approaches, such as patient/person-centered care (Hirsch & Abernethy, 2012; McCracken & Yang, 2006; Vanderford et al., 1992), elicitation of patients' values (Pieterse et al., 2008), clarification of values (Charles & Gafni, 2014; Masters, 2009;), and motivational interviewing techniques (Plumb et al., 2009). Indeed, in some studies, these processes are grounded on patients' preferences and selections among a range of alternative therapeutic options without clarification. In general, there are three main causes for conceptual weakness of the term values as it appears in the research: (a) impreciseness, surrounding the concept; (b) interchangeable use of the concept with other terms, without distinguishing boundaries between it and associated concepts (e.g., values, attitudes, and beliefs); and (c) conflation of the concept of values (e.g., values are equated with choices). Nebulousness is evident everywhere in clarifying patients' value. Attention must focus on how this view can be amended and replaced by a proper definition in research, approaches, models, theories, practice, and policy.

Limitations

Although the applied strategy in this study served to capture potentially relevant papers in relation to patients' values, this may have resulted in missed data. This study was limited to literature in English

and mostly covered the Western understanding, which may limit cross-cultural analysis.

Conclusion

Rodgers' evolutionary approach (Rodgers, 2000) allows for a cross-disciplinary comparison that permitted us to enhance our understanding of and to clarify the concept of values. Patients' values are a paramount and fundamental concept, which is distinct from other concepts such as attitudes, preferences, choices, needs, and beliefs. Accordingly, it is essential to define the term for use in models, theories, and nursing care plans. The lack of such clarification in the literature creates a significant challenge for the reader or learner hoping to understand those approaches that are value based. The significance of such understanding is crucial, as a broad spectrum of decisions – the most important consequences of the concept of values – are made in the context of self-care (e.g., adherence, non-adherence, and participating in learning opportunity) on a daily basis, in particular by patients with chronic disease. Clarification of the concept, thus, can guide nursing practice and patient care pragmatically (Duncan, Cloutier, & Bailey, 2007). Such analysis also may provide a potential foundation for conducting research to develop more effective nursing care plans, assessments and interventions to support patients in their health-related decisions.

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.outlook.2019.03.005.

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