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Advocacy in Nursing: A Qualitative Discourse Analysis of Fundamental Nursing Textbooks

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Advocacy in Nursing: A Qualitative Discourse Analysis of Fundamental Nursing Textbooks

Abstract
Advocacy in nursing has been provided to patients by nurses inconsistently with grave consequences for both patients and nurses. Patients have suffered debilitation or injury when nursing advocacy has not been operationalized effectively, and nurses have been ostracized, experienced job loss, and some have been prosecuted criminally for advocating for patients. The American Nurses Association (ANA) and the International Council of Nurses (ICN) have maintained that inherent to the role of nursing is advocating for patients, yet advocacy in nursing remains ill defined. The purpose of this research study was to investigate how advocacy was defined and taught in fundamental nursing textbooks, using discourse analysis. Four widely used fundamental nursing textbooks were analyzed. The analysis revealed that advocacy definitions were inconsistent, and the textbooks failed to prepare nurses for the complexities of real-world applications of advocacy. Nurses are asked to support patient autonomy and well-being, but nurses are not instructed with reasonable ways to do so in realistic, complex, modern healthcare settings. Recommendations for those who educate nursing students should consider adding additional, more realistic, advocacy resources to supplement nursing advocacy education, and textbooks should be updated to improve the discussion of nursing advocacy. Recommendations for the ANA are to consider developing a code of advocacy to protect nurses while they follow instructions to protect patients and avoid potential personal, professional, and legal ramifications.

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Advocacy in Nursing: A Qualitative Discourse Analysis of Fundamental Nursing Textbooks

By

Theresa Gleason

Submitted in partial fulfillment of the requirements for the degree Ed.D. in Executive Leadership

Supervised by

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St. John Fisher College

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Dedication

*I attribute my success to this – I never gave or took any excuse.* Florence Nightingale

This dissertation is dedicated to my family and friends for all the love and support while on my dissertation journey. I could not have completed this process without your consistent and loving encouragement. I would like to especially thank my dissertation committee, Dr. Guillermo Montes and Dr. David Bell, and my fieldwork mentor, Dr. Linda McGinley. Your expertise and knowledge have shaped me into a leader who will always be led by the literature and who will always have a question. Special thanks go to my parents, Sharon and William; my husband, Donald Black; children, Nicholas, Angela, Jesse, Mary Grace, Hailey, and Trace; and sister, Gail. I am forever grateful for the support during the many hours of study and for the direct instructions to “stop procrastinating and get to work.”

While this process was not easy, especially when having to overcome adversity, it was embraced with joy because of my dear friends and colleagues. I would like to acknowledge Mitchell Ball, Myra Henry, Torrance Jones, Thomas Cummings, Suzanne Newton, and Steven Denacker for walking with me through this dissertation journey.

When I look back at the process, I recognize that, at times, there were only one set of footprints in the sand. I am forever grateful for my Lord and Savior, Jesus Christ, for His enduring love and countless answers to prayer. Thank you.
Biographical Sketch

Theresa Gleason is the Director of Nursing at Monroe Community Hospital (MCH) in Rochester, New York. Ms. Gleason attended Alfred State College from 1990-1992 and graduated with an Associate in Applied Science in nursing. She attended Roberts Wesleyan College from 1996-1999 and 2010-2013 and graduated with a Bachelor of Science degree in Nursing and a Master of Science degree in nursing. She began her doctor studies in the Ed.D. Program in Executive Leadership. Ms. Gleason pursued her research in nursing advocacy under the direction of Dr. Guillermo Montes and Dr. David Bell and received the Ed.D. degree in 2019.
Abstract

Advocacy in nursing has been provided to patients by nurses inconsistently with grave consequences for both patients and nurses. Patients have suffered debilitation or injury when nursing advocacy has not been operationalized effectively, and nurses have been ostracized, experienced job loss, and some have been prosecuted criminally for advocating for patients. The American Nurses Association (ANA) and the International Council of Nurses (ICN) have maintained that inherent to the role of nursing is advocating for patients, yet advocacy in nursing remains ill defined. The purpose of this research study was to investigate how advocacy was defined and taught in fundamental nursing textbooks, using discourse analysis. Four widely used fundamental nursing textbooks were analyzed. The analysis revealed that advocacy definitions were inconsistent, and the textbooks failed to prepare nurses for the complexities of real-world applications of advocacy. Nurses are asked to support patient autonomy and well-being, but nurses are not instructed with reasonable ways to do so in realistic, complex, modern healthcare settings. Recommendations for those who educate nursing students should consider adding additional, more realistic, advocacy resources to supplement nursing advocacy education, and textbooks should be updated to improve the discussion of nursing advocacy. Recommendations for the ANA are to consider developing a code of advocacy to protect nurses while they follow instructions to protect patients and avoid potential personal, professional, and legal ramifications.
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Chapter 1: Introduction

In 2017, a press release by the ANA reported the arrest of a Utah emergency nurse for advocating for the rights of her patient. A police detective requested the nurse provide law enforcement with a blood sample from her unconscious patient. Because Nurse Wubbles believed she was responsible for the care of the patient, and she also recognized her expected role as the patient’s advocate, she refused to comply with the request. As a result, in a dramatic display of power, the detective forcefully took Nurse Wubbles into custody, arresting her for disobeying his request. The arrest of Nurse Wubbles was highly publicized. CNN reported that Nurse Wubbles was arrested for protecting the rights of her patient (Karimi & Moshtaghian, 2017).

The events of the story continued to unfold as the media publicized interviews with Nurse Wubbles and her attorney. In the end, Wubbles reached an agreement with the Salt Lake City Hospital and Salt Lake City government to pay Wubbles a restitution, equally, in the amount of $500,000 (Wamsley, 2017). The strong views about how advocacy by nurses like Wubbles are viewed, and the complexities of their real-world applications have their origins in nursing advocacy that stems back to the 19th century. While the Nurse Wubbles case ended with a clear moral victory, an historical view on the practice of advocacy is not so clear cut.
Background and History

The rights of patients have been recognized by the field of nursing as an important aspect of nursing since the turn of the 20th century when Florence Nightingale advocated for a better environment to improve the quality of care for patients (Mason, Leavitt, & Chaffee, 2006; Nightingale, 1911). During the Crimean War in 1854, and using the principles she had developed, Nightingale demonstrated that she could improve the health care of patients by advocating for their needs. For instance, Nightingale wrote about the essence of patient equity of care without consideration of the patient’s religion (Sanford, 2012). She proposed that nurses be skilled in the ability to professionally advocate for the needs of patients. Arguably, such patient needs are the same today as they were then. Patients continue to face poverty, lack access to health care, and they continue to fight communicable diseases from unsanitary environments such as inadequate housing (Ruel, 2014). While Nightingale (1911) did not use the word *advocacy* to describe her efforts, she instructed student nurses based on her own philosophy, which throughout the history of nursing has come to be interpreted by what we now term *patient advocacy*.

Over the past 100 years, advocacy in nursing has not been disputed as a fundamental tenet within the profession of nursing. Advocacy provided by nurses has been established as a process throughout nursing research literature since the modernization of nursing. Nursing has further explored the role of nurse advocates and borrowed the term advocacy from the legal profession as an action taken by nurses on behalf of patients (Hanks, 2013). Specifically, during the Civil Rights movement, patient advocacy gained popularity. With the power of consumerism increasing, personal autonomy and self-determination provided a focus for the rights of the patient. Patient
protection became important to nurses. Patients, together with nurses, faced ethical
decision making collaboratively, while nurses were establishing their roles as advocates
for patients (Water, Ford, Pence, & Rasmussen, 2016). George Annas, a lawyer and
professor at Boston University, was a leader in promoting the role of the nurse as an
advocate. He was vocal about his position that the nurse is best to serve as an advocate
for the patient while convalescing in the hospital (Annas & Healey, 1974).

Annas and Healey (1974) studied the role of the nurse advocate, concluding that
there is need of an advocate for a patient so that the power of decision making could
remain with the patient. They believed that the nurse was ideal in this role because of the
intimate relationship that is developed between the nurse and the patient (Annas &
Healey, 1974). In the following decades, other researchers began studying the role of the
nurse advocate. Curtin (1983), Gadow (1980), Kohnke (1980), and Benner (1994) also
researched the role of the nurse as a patient advocate. Early nursing researchers, such as
these, compared the action of advocacy with the concept of advocacy and how they were
related. By synthesizing how advocacy in action and the concept of advocacy are related,
nursing researchers developed the current understanding of the process of patient
advocacy leading to several advocacy models (Choi, 2015).

One of the first patient advocacy models was developed by Curtin (1979). Curtin
began her career by earning a diploma certificate in a hospital-based program in 1965.
She later earned a bachelor’s degree in nursing and a master’s degree in philosophy
(Hanks, 2007). The model she developed described patient advocacy as human advocacy,
and it was based on a humanistic need for a relationship between the nurse and the
patient. Her philosophy encouraged creating an environment where support was provided
to the patient. Curtin (1979) reported that nurses develop a relationship with their patient freely because of the commonality of being self-determined human beings. Early in her research, she discovered nurses assist in creating an environment where support is provided to the patient in the process of decision making, giving structure to nursing activities such as comforting patients when they are in distress (Curtin, 1979). Further, Curtin (1979) claimed that nurses advocate by assisting patients to determine and understand personal wishes while encouraging them to make demands based on their own dignity.

Later, Curtin (1983) described patient advocacy as the nurse providing care to the patient in a manner that supported the patient’s return to independence while also alleviating suffering. Curtin (1983) described this process of the nurse developing a relationship with the patient while becoming more in tune with the patient and more cognizant of the influences that may have positive or negative effects on the patient’s outcome (Hanks, 2013). When a patient is most vulnerable, Curtin (1983) emphasized the role of the nurse advocate as interceding between health care professionals and the patient (Ware, Bruckenthal, Davis, & O’Conner-Von, 2011).

While Curtin (1979) concluded that nursing advocacy is based on each individual’s human need, Gadow (1983) defined her advocacy model as existential, meaning that the patient should exercise their right of self-determination with the assistance of the nurse. For instance, a nurse may provide care to a patient in the name of the professional opinion of the nurse without the consent of the patient, such as in emergency or life and death situations. Self-determination is the patient’s right to make decisions regarding the state (and arguably, future) of their own body, even if the patient
will face a life-threatening disability (Gadow, 1983). The nurse may not agree with the patient’s choice, but as a professional nurse, he or she should recognize the inequity in the relationship with the patient and assist the patient to become more autonomous within the nurse-patient relationship as opposed to encouraging the patient to conform to others’ ideas (Gadow, 1983). Only the patient can determine what is preferred. The role of the nurse is to participate in the care of the patient by assisting that patient with self-determined choices (Gadow, 1983).

Gadow’s (1980) existential advocacy model is much like Curtin’s (1979) model, except that it encourages the nurse to analyze the values of patients to assist in helping the patients to make informed choices relating to their health care status. Gadow’s (1983) advocacy model cited a partnership that was developed between a nurse and a patient, recognizing the risk of paternalism in an attempt to enhance the patient’s autonomy. For the patient, autonomy is critical, as it is the means by which one expresses clearly one’s desires based on a current clinical condition. Gadow (1983) underscored the importance of the nurse as inhabiting an intimate position to assist the patient in discerning and clarifying the patient’s own wishes, values, and beliefs when choosing a course of action. This is especially true when considering the silent patient, or a patient who cannot communicate (Gadow, 1989). Following Curtin’s (1979) work and Gadow’s (1983) work, Kohnke’s (1982a) model is seen as being more of a functional patient advocacy.

The practical model of patient advocacy developed by Kohnke (1982b) is operationalized by the nurse assisting patients in making informed choices about their health care needs and by providing patients with information about their condition (Hanks, 2013, Kohnke, 1982 a). While providing patients with information about their
personal health condition and assisting patients in making health care choices, the nurse must also consider ethical standards (Kohnke, 1982b). In other words, nurses should be conscious of the potential for unwittingly assuming an unethical position such as paternalism. Kohnke (1982a) suggested that nurses need to remember that patients have the ability to make their own decisions, and the role of the nurse is to support those decisions without bias or influence. A nurse’s support must include care not to interject personal opinions when decisions are made by the patient (Kohnke, 1982a).

Benner (2001) also focused on ethics in nursing. However, along with ethics, Benner (2001) included nursing competence and the power held by the nurse when in the role of patient advocate (Benner, 2001). She described an example of a nurse advocating for a patient who was unable to communicate due to a complicated medical condition. In an effort to advocate for the patient, the nurse persuaded the physician to change the treatment modality by communicating on behalf of the patient. By speaking on behalf of the patient, the nurse assisted the patient in self-determination (Benner, 2002).

Researchers like those described previously have provided the field of nursing with numerous examples and advocacy models based on the frameworks of human relationships, of self-determination, of safeguarding the patient’s interest, and of empowering the patient through shared information to collaborate with the nurse in health care choices. Many current nursing researchers are following the seminal work conducted by Benner (2001, 2001, 2012), Curtin (1979), Gadow (1983), and Kohnke (1982a), and they are contributing to models of patient advocacy in nursing. For example, a model developed by Bu and Jezewski (2007) included a midrange theory about nursing advocacy. Their concept analysis encompassed patient advocacy attributes that were
identified and examined. Examples of these attributes were safeguarding the patient, protecting patient rights, and ensuring access to healthcare in multiple service areas such as in the community or with a health care provider.

Based on the nursing advocacy literature, professional organizations, such as the ANA and the ICN, have promoted nursing as an inherent role in patient advocacy (Water et al., 2016). Nurses who are aligned with the patient increase the patient’s power of self-determination. The independence of nurses who position themselves to advocate for patients by protecting the patients’ rights are also placed on equal footing within the medical community (Water et al., 2016). While professional organizations support nursing advocacy models, the notion of the nursing advocacy term remains yet ill-defined.

**Problem Statement**

Along with the lack of a shared definition of what nursing advocacy actually is, nursing professors are teaching advocacy inconsistently, and nurses are ultimately operationalizing and conceptualizing advocacy inconsistently. While debate has existed between nursing experts in determining advocacy practice guidelines (Water et al., 2016), nursing advocacy models continue to evolve. Models provide structure and a means to deliver advocacy in a systematic manner, but the specific models that have driven the action of advocacy are also conflicting (Vaartio, Leino-Kilpi, Suominen, & Puukka, 2008). In short, a number of models exist for how nursing can best apply the role of advocacy, but the profession, as a whole, has yet to agree which model might best serve as a standardized set of best practices.
Nurses have learned how to operationalize advocacy through formal education, based on research, literature, developed models, and practical experience. Yet, nurses fail to advocate even—after they confirm they understand advocacy—as central to their duties in the practice of nursing. For instance, in 2008, nurses chose not to advocate while working in a gastroenterology outpatient clinic in Nevada. The State of Nevada discovered violations of infection control practices in two Las Vegas clinics. Equipment designated for single-use only was reused by the staff. Syringes, medication vials, and bite blocks were used without standardized sterilization procedure on multiple patients (Black, 2011).

According to the Gastroenterology Society of Nurses (Black, 2011), devices that have the potential to be introduced into the blood stream are designed for single-use only. The reuse of these products caused several patients, who were receiving care at these clinics, to contract hepatitis C. The breach of infection control practices was not because of a lack of professional knowledge, but the practice of reusing equipment was because nurses feared reprisal, such as the loss of their reputation or job if the unsafe practices were reported. The investigation of the clinics found that nurses expressed fear of being mistreated, terminated from employment, or ostracized (Black, 2011).

Anecdotal and clinical evidence has shown that when nurses fail to advocate for patients, the results can be detrimental. However, when nurses provide advocacy effectively, the role can have both positive and negative effects (Hanks, 2007). These effects have been determined by nursing researchers’ semi-consistently depending on the area of focus. While advocacy benefits both the nurse and the patient, in some instances, it is not without risk. An example of this kind of risk is when a nurse was challenged in
her professional advocacy during patient care in the case of Tuma v. Board of Nursing (1979).

In the landmark court case of Jolene Tuma v. Board of Nursing (1979), a nurse was challenged in her attempt to effectively advocate for her patient. The patient requested information from the nurse about alternate treatments for cancer. Nurse Tuma felt obligated to provide the requested information as a role of advocacy and informed the patient of alternate treatments that were still in experimental stages. While the patient ultimately agreed to undergo the treatment advised by the patient’s physician, rather than Tuma’s alternatives, the nurse was charged with professional misconduct by violating Idaho’s Code Section 54-1422(a)(7) and interfering with the physician-patient relationship.

Nurse Tuma believed she was acting in the best interest of her patient; however, she was terminated from her job and her nursing license was revoked in a disciplinary action imposed by the State of Idaho for a total of 6 months. Tuma asked for a trial de novo but was denied. Because the State of Idaho’s Board of Nursing made the decision to suspend her license, based on the finding of the hearing officer without consideration of any professional medical opinion, Tuma requested an appeal to the court.

After Nurse Tuma’s appeal was granted with the district court, the court ruling was reversed because of a lack of written guidelines as to the genesis of Tuma’s conduct. During the process of the decision, the court deliberated on the possibilities that Tuma might have had a poor relationship with this specific physician or that those within the general medical community led her to suggest to the patient other treatment options for cancer treatments as requested. Given that Nurse Tuma was not warned as to how her
actions might compromise the patient-physician relationship, the district court reversed the licensing suspension. While Nurse Tuma was successful in regaining her ability to practice nursing in the State of Idaho, all the costs associated with the appeal were ordered to be paid by appellant Tuma.

Nursing researchers have continued to investigate advocacy cases where nurses fail to advocate, or where nurses are challenged by charges of inappropriate advocacy. While the nursing profession attempts to mitigate these outcomes by teaching advocacy formally, there remain barriers against nursing advocacy—even when appropriate (Barlem et al., 2015; Dadzie, Aziato, & Aikins, 2017; Hanks, 2008; Mortell, Abdullah, & Ahmad, 2017; Oliveira & Tariman, 2017; Pecanac & Schwarze, 2018). For nurses who do not appear to have barriers, and who advocate effectively, research should answer specific questions about the basis for successful advocacy. Review of the literature regarding nursing advocacy has provided many models and theoretical frameworks, yet little has been studied about how nurses are trained in advocacy through the use of textbooks (Hanks, 2008, 2010; Kalaitzidis & Jewell, 2015).

The use of textbooks has been a primary mechanism to educate nurses (Albach et al., 1991). According to a Barnes & Noble representative (personal communication, May 17, 2018), the four most commonly selling fundamental nursing textbook in the United States were written by Kozier and Erb (2016), Potter, Perry, Hall, & Stockert (hereafter called *Perry and Potter*, 2017), Pearson Education (2019), and Taylor (2019). All have been requested by nursing schools across the United States for the 2017/2018 academic school years. Textbooks that include education about nursing advocacy have provided nursing students with knowledge and expectations to acquire, and then operationalize, the
skill. While the information provided in a textbook communicates specific knowledge, it also has the potential to be used as a powerful instrument (Kleppe, Heggen, & Engebretsen, 2016); therefore, the use of textbooks has the power to impose ideas that are integral to the profession.

Healthcare professions, such as nursing, are expected to provide care using specific strategies to meet the needs of patients. Historically, textbooks have remained a consistent source by which nurses develop their professional identities and realize an understanding about the expected professional role of the nurse, which has included patient advocacy (Kleppe et al., 2016). According to Gee (2008), the discourse of textbooks has the proclivity to impact the role of the nurse with positive and negative results because of the idea communicated by the authors (Gee, 2008).

Discourse analysis (DA) is a process that has provided structure with a protocol for analysis of a specific area of text (Gee, 2011). The focus on advocacy text identifies generative power with what is being produced by the authors when examining fundamental nursing texts that may not be evident using other research methods. According to Gee (2011), the analysis of the language used in the form of text goes far beyond the meaning of words and includes the interpreted meaning behind the constructs. Fairclough (2001) suggested that textbooks are studied to expose how language is used in practice. The connection of language with generative power (Fairclough, 2013) influences nurses via the language contained in the textbooks (Fairclough, 2001; Fairclough & Wodak, 1997; Gee, 2011).

Gee (2008) also argued that textbooks are a domain where ideas should be impartial but have the potential to be political, driving the structure of curricula while
differences are observed in practice. The authors of textbooks choose how they prefer language to be interpreted via the construct of language, thus wielding power over the student to accept the authors’ perspectives according to their philosophical underpinnings. Thus, how information is communicated to students has the potential to ultimately influence how advocacy is understood and is practiced (Zimmerman, 2012). By studying the language of fundamental nursing textbooks, norms and deviations were discovered as well as what perspectives dominate in written instruction, which was compared between recent and older information, as well as information that has never been challenged or updated for accuracy (Gee, 2011; Pinto, 2007).

Nursing advocacy problems, as described by Hanks (2017), agrees that a lack of a nursing advocacy definition has been identified and warrants an evaluation of how fundamental nursing textbooks serve the nursing profession at its post-basic level; the education of nurses. Without a consensus on the definition of advocacy, debate about the nurse-advocate role and expectations have persisted between expert nurses who support advocacy practice guidelines (Hanks, 2018). Moreover, with no structural advocacy definition, specific nursing actions have not been delineated by the literature and professional organizations in order for the nurse to carry out this role, causing patient advocacy to be provided inconsistently (Water et al., 2016). When nurses are inconsistent or fail to offer advocacy, grave consequences—including ineffective care—may threaten the well-being of a patient. Yet, little study of textbooks has been conducted on current fundamental nursing textbooks that are supposed to prepare nurses to advocate (Hanks, 2010a; Kalaitzidis & Jewell, 2015).
Theoretical Rationale

The nursing profession teaches advocacy formally, and thus far, there remain barriers against nurses advocating when appropriate (Barlem et al., 2015; Dadzie et al., 2017; Hanks, 2008; Mortell et al., 2017; Oliveira & Tariman, 2017; Pecanac & Schwarze, 2018). Nurses who do not appear to have barriers and who advocate effectively have created their own professional approach for effective nursing advocacy. To arrive at conclusive evidence to support successful advocacy, for the purpose of this study the lens through which patient advocacy was analyzed was provided by the theoretical framework developed by Pecanac and Schwarze (2018).

To recognize distinctions and to organize themes and concepts, the theoretical framework developed by Pecanac and Schwarze (2018) was well suited to study fundamental nursing advocacy textual discourse. This framework is based on themes that support strong beliefs of what nurses understand are their duties when advocating for their patients. The fours themes identified and used as a lens to analyze fundamental nursing advocacy textual discourse were: (a) the responsibility to support patient autonomy regarding treatment decisions, (b) the responsibility to protect the patient from the physician, (c) the responsibility to act as an intermediary between the physician and the patient, and (d) the responsibility to support the well-being of the patient (Pecanac & Schwarze, 2018).

Pecanac and Schwarze’s (2018) theoretical framework was used for the purposes of this study as a lens through which to view fundamental textbook data. The framework was used from the vantage point of the nurse as an advocate and to inform advocacy actions of nurses. While the Pecanac and Schwarze (2018) study also included an
additional theoretical framework development from the perspective of surgeons, for this current study, only the nursing theoretical framework was used to analyze the data collected in this study. The aim in using this theoretical framework was to determine if the same themes that were concluded in the Pecanac and Schwarze (2018) study were also represented in fundamental nursing advocacy instructional texts. The Pecanac and Schwarze (2018) themes are as follows:

**Theme 1: Responsibility to support the patient regarding treatment decisions.**
Nursing research literature espouses that nurses believe they have a responsibility to assist patients in understanding their options in healthcare choices, to protect patients’ rights for self-determination, and to support patients when they are making individual health care choices (Annas & Healey, 1974). According to Winslow (1990), no other health care profession is as concerned with patients’ right to personal autonomy as nursing. Nursing researchers, such as Annas and Healey (1974), Hanks (2008), and Thacker (2008) claimed that nursing position is ideal for the role of advocate because of nurses’ proximity to, and intimacy with, patients, and they are thus able to best address patient worries and questions. When a nurse recognizes the importance of patients’ independence, she is working as a patient advocate by empowering patients to ensure the treatment choices are aligned with patients’ desires (Curtin, 1983). Achieving patients’ desired outcomes through the role of nurse advocate includes both educating and supporting patients in their own decision making (Kohnke, 1982b).

**Theme 2: Responsibility to protect the patient from the physician.** Nurses communicate a need to protect patients from physicians (Pecanac & Schwarze, 2018). Yet, nurses also have relayed feelings of being powerless to advocate for patients because
physicians have the final decision-making power (Cawley & McNamara, 2011; Dadzie et al., 2017; Heelan-Fancher, 2016; Oliveira & Tariman, 2017). While nurses empower their patients to verbalize their wishes, these requests may not be in alignment with their physician’s professional opinions and judgements, putting nurses in situations where they are at risk of retribution (Barlem et al., 2015; Mortell et al., 2017; Pecanac & Schwarze, 2018). The dynamics nurses face while advocating for patients is a push-and-pull struggle between what is expected within the role of nurse advocate and what is counter to nurses’ experience in practice. For instance, according to Oliveira and Tariman (2017), administrators were more likely to comply with a physician’s request rather than a nurse’s request. Additionally, physicians are also observed by nurses as functioning in a paternalistic role, yet they are also described as making decisions based on the best interest of the patient (Pecanac & Schwarze, 2018). Nurses interpret these experiences as requiring a need for patient protection from the physician in order for patients to receive care according to the patients’ desires and values (Bu & Wu, 2008; Josse-Eklund, Wilde-Larsson, & Petzäll, & Sandin-Bojö 2014; Reed, Fitzgerald, & Bish, 2016; Thacker, 2008; Toda, Sakamoto, Tagaya, Takahashi, & Davis, 2014; Vaartio et al., 2008, 2009).

**Theme 3: Responsibility to act as an intermediary between the physician and the patient.** Protecting the patient from the physician is an act of advocacy along with ensuring that the patient and physician understand one another (Pecanac & Schwarze, 2018). In some cultures, such as within the Japanese culture, patients will refrain from communicating out of respect for authority and to maintain a harmonious environment (Toda et al., 2014). Nurses seek to recognize the wishes of the patient and will interact between the patient and the physician in a collaborative manner (Toda et al., 2014). As a
nurse advocates for a patient, the nurse takes on the role as an intermediary between the physician, the health care environment, and the patient (Bu & Wu, 2007; Dadzie et al., 2017; Pecanac & Schwarze, 2018).

**Theme 4: Responsibility to support the well-being of the patient.** Nursing research literature describes nurses feeling a responsibility to support the well-being of the patient (Bu & Wu, 2008). No other health care profession is as concerned with the patient holistically as nursing (Winslow, 1990). Where medical interventions fail to provide a return to the patient’s acceptable level of function, nurses strive to provide care to reach the patient’s optimum well-being (Hanks, 2010b; Vaartio et al., 2008). When a nurse recognizes the importance of a patient’s independence, she is working as a patient advocate (Curtin, 1983). The well-being of a patient is considered a priority and is a responsibility taken on by the nurse who believes patients should be treated beyond merely their physical or mental condition (Jansson, Nymathi, Heidemann, Duan, & Kaplan, 2015; Pecanac & Schwarze, 2018). Nurses also communicate the importance of a patient’s outcomes as a result of their service (Hanks, 2010a; Pecanac & Schwarze, 2018).

While the four components provided a theoretical framework, the role of the nurse advocating for patients remains poorly understood. Research has yet to support a consensus on the definition and guidelines for best practices when it comes to advocacy for patients.

**Statement of Purpose**

The purpose of this study was to examine fundamental nursing textbook language about patient advocacy through a discourse analysis that was guided by the theoretical
framework provided by Pecanac and Schwarze (2018). Discourse analysis assisted in the test of how well the data complied with the Pecanac and Schwarze’s (2018) frameworks, and discourse analysis assisted in investigating where any variations might occur. While nursing research about advocacy was extensive, nurses continue to advocate for patients inconsistently. The literature presented a gap in defining nursing advocacy, calling into question how authors of textbooks influence, hold position of power, and guide nurses in their actions of advocacy. The language contained in fundamental nursing textbooks also has evolved over time and had to be analyzed to ensure the alignment of current nursing advocacy expectations, standards, and evidence of effective strategies. A lack of effective nursing advocacy has been demonstrated as having risks of untoward effects on patients (Hanks, 2008).

Further investigation on the discourse of fundamental nursing textbooks is needed to identify factors contributing to inconsistent nursing advocacy. Nurses who advocate successfully demonstrate an important service during patient care, and they may provide an opportunity to learn how to achieve consistent positive patient outcomes (Hanks, 2008).

Research Questions

Professional nursing organizations designate nurses to advocate according to nursing position statements (ANA, n.d.) that determine a standard of practice for nursing advocacy (National Council of State Boards of Nursing [NCSBN], 2017). To understand the inconsistent actions of nurses who advocate for patients, the following questions guided this study:

1. Do fundamental nursing textbook authors define nursing advocacy?
2. If fundamental nursing textbook authors define nursing advocacy, are there variations among the authors regarding nursing advocacy?

3. What principles do fundamental nursing textbook authors propose to guide the action of nursing advocacy?

**Potential Significance of the Study**

The significance of this study is based on finding consistency for a shared definition of nursing advocacy and how authors of fundamental textbooks impact the work of nurses advocating for patients (Water et al., 2016). Seminal research was conducted to determine a baseline for nursing advocacy, which revealed multifaceted concepts without consensus, and to date, they have failed to effectively define nursing advocacy. Furthermore, despite the nursing profession recognizing advocacy as a role in nursing, it has been poorly understood or not formally supported by the profession (Choi, 2015). The findings of this study will offer a contribution to the literature on nursing advocacy and benefit the field, as a whole, by proposing a shared terminology and definition of a critical and foundational concept for the nursing profession.

The value of this study is to provide the nursing profession with additional information to assist in the development of a definition and explain the action of nurses advocating. Unlike other research studies, this research was conducted using a discourse analysis that focused on how textbook authors influence and have the power to shape nurses’ thinking while identifying their role as a patient advocate. The contribution of the findings of this study may change how nursing advocacy is viewed by fundamental nursing textbook authors, nursing leaders, and educators.
A review of the literature supported the centrality of advocacy in the role of the nurse. Because there is an observed gap in the research for defining nursing advocacy, failure to advocate for patients has resulted, causing grave consequences for both the patient and the nurse. A review of fundamental nursing textbooks provided an awareness of how authors are communicating the practice of nursing advocacy. The results of this study should help to clarify the definition of advocacy, inform how nursing advocacy is expressed to nurses, and how nursing advocacy could be utilized to structure a systematic approach for nurses to advocate effectively to achieve desired patient outcomes.

Figure 1.1 displays a model of advocacy. As seen in this image, the centrality of advocacy relies on a definition; however, professional organizations and empirical studies have not adopted a shared definition for advocacy. Without a shared definition, no one can say, for sure, when a nurse does or does not engage in advocacy. Nursing researchers have investigated advocacy as a concept as a means to understand advocacy-related practices within the field of nursing. Seeking change to what is loosely understood as advocacy through research projects has led to results that do not fundamentally answer the questions about what shapes advocacy in the nursing profession. Instead of beginning with a definition, advocacy has been addressed through structured approaches that are informed by research in an attempt to transform the performance of nurses.

A causal relationship between the actions of advocacy and the results of advocacy have made it impossible to establish a singular definition. As illustrated in the figure,
Figure 1.1 Advocacy Effect Model
the results of research studies have described findings in domains as diverse as communication, competence, support, education, power/empowerment, inconsistent practice, and lack of reporting, to name a few. Yet, advocacy research has been subject to many influences. As advocacy, as a concept, has developed in the field, it has been described by many terms that have changed over several decades. While the complexities of advocacy and related research have evolved, advocacy, as defined individually according to the research, has not yet been adopted.

Adopting a definition of advocacy is fundamental to achieving effective advocacy action. Nurses who are providing advocacy services in a professional setting are under pressure to constantly be effective while also providing evidence that advocacy is effective. Nurses are encouraged to invest all their efforts while being accountable to provide advocacy services. With no shared definition, when research is conducted, other scholars and professionals are not able to discern whether the research design measures are applicable and relevant. Thus, the generalizability of the research results has been uncertain.

Advocacy in nursing has been largely developed from a subjective nursing perspective where personal judgment is often used to act in any given situation. The nurse may choose to view potential options based on personal or advised experiences as a strategy, depending on the situation, but the nurse does so with risk because of the little knowledge or training about what really works. Any evidence to support claims of effective advocacy is learned through anecdotally communicated outcomes (Hanks, 2013). There have been elements of unpredictability with advocacy that have been
challenged by unavoidable issues about how advocacy is recognized, measured, implemented, and even defended (*Tuma v. Board of Nursing*, 1979).

Compared to the *concept* of advocacy, the actual skill of advocacy is not discussed in nursing research. Research studies specific to advocacy have produced perspectives that vary greatly with little capacity to discern the translatability and generalizability of the findings and results (Thacker, 2008). The basis of this model is grounded in the study described in this dissertation. Described here is a representation of how the definition of advocacy is centrally missing in many of the studies, and where defined, is specific to the particular researcher’s perspective.

**Chapter Summary**

The nursing profession has recognized, historically through research, that a part of the role of a nurse is to advocate. While professional organizations advise nurses to carry out this role, how advocacy is employed to further patient desires has not been established. Nursing research literature has demonstrated a gap in the definition of nursing advocacy and the inconsistent provision of advocacy to patients. The aim of this study was to provide clarity and to assist in the development of paradigms to contribute to the body of knowledge about nursing advocacy as an undisputed tenant of nursing.

Seminal research was conducted by Annas and Healey (1974), Benner (2001, 2001, 2012), Curtin (1979), Gadow (1983), and Kohnke (1982a), and the research resulted in models emphasizing the importance of human relationship and self-determination while empowering the patient through a shared partnership between the patient and the nurse. To further knowledge when student nurses learn about patient advocacy, textbooks are the primary source of instruction. While this is not debated,
nurses continue to advocate poorly for patients. It is evident that nursing advocacy is confusing to nurses and persists in being as area of great concern (Hanks, 2007).

A definition of nurse advocacy for patients needs to be developed while identifying the steps to operationalize the role. The directives of professional nursing organizations are that nurses have an obligation to advocate for patients (ANA, n.d.; NCSBN, 2017). While the manner in which nurses advocate has expanded over the past 40 years, a definition has not yet been formally adopted by the profession. To better understand how a lack of an advocacy definition affects the role of the nurse, Figure 1.1 illustrates how this lack of an advocacy definition affects the performance of nurses. Currently, nurses report they advocate based on what they learn in practice. Furthermore, nurses have relayed that they advocate based on their own personal experiences (Black, 2011).

Following this chapter is a foundational review of the empirical literature in relation to nursing advocacy in Chapter 2. The literature guided this study toward the existing research of advocacy, thereby exposing the gap in that literature. Chapter 3 describes the methodology for the study. The methodology for this study was an analysis of textual data using a discourse analysis. Rationale for the use of discourse analysis and the application to the field of nursing is explained. The lens identified to analyze the textual data was the theoretical framework identified by Pecanac and Schwarze (2018). The text chosen for sampling used a priori coding. The code book described followed how the data was analyzed. Chapter 4 shares the findings and the researcher’s analysis of the findings, and the chapter continues with an empirical investigation designed to answer the research questions. Chapter 5 consists of a summary of the findings and
corresponding conclusions, which is followed by recommendations for practice, policy, and future research.
Chapter 2: Review of the Literature

Introduction and Purpose

Nursing advocacy has been identified in evidence-based nursing literature as a strategy to improve health care outcomes for patients. However, the precise nature of how patient advocacy is implemented by the nurse is not fully understood (Kalaitzidis & Jewell, 2015). Yet, nurses are responsible for navigating the health care system in a manner that is acceptable to the patient and based on standards of nursing practice (Jansson et al., 2015; Kalaitzidis & Jewell, 2015). Given that patient advocacy is accepted as a tenet of nursing practice, advocacy is learned formally; however, there remain barriers at times for the practicing nurse to advocate when appropriate (Hanks, 2008). For those nurses who do not appear to have barriers, research should answer specific questions about the factors identified through research that motivate the nurse to advocate for a patient.

Patient advocacy began to emerge in the literature, specific to nursing, over the past four decades, and the literature is having an impact on the ethical treatment of patients and the work of health care professionals (Hanks, 2008, 2010a; Thacker, 2008; Vaartio et al., 2008; Walent & Kayser-Jones, 2008). While there is a vast amount of literature pertaining to nursing advocacy, because of this, it is necessary to analyze the data carefully to determine the significance of the research findings, while considering the impact of the constructs of the methods utilized. The purpose of Chapter 2 is to review recent empirical journal articles pertaining to patient advocacy, pertaining to the
role of the nurse, and to support the identified gaps in the literature requiring further study.

**Review of Nursing Advocacy Literature**

The beginning inclusion and exclusion criteria were determined to capture the most recent data. The content criteria was developed with a review of the articles based on the strength of the body of evidence and that the studies were empirical and peer reviewed. Those studies accepted were also limited to the English language. A total of 56 articles were identified and carefully analyzed while parameters were established in the strength of the information to contribute to the field of nursing based on the test of theory and the extension of the existing knowledge about advocacy. Of the 56 journal articles, 28 were omitted because of empirical strength, secondary studies, and they lacked relevance. Therefore, the 28 articles that met the requirements of the inclusion and exclusion criteria provided a framework to review the literature.

The articles selected for analysis covered a variety of clinical settings on the continents of Africa, the Americas, Europe, Asia, and Australia. Themes with emerging research problems were identified within the literature. Hence, this review was organized categorically under the themes of education in advocacy, communication, barriers of advocacy, nurse self-awareness, and advocacy empowerment. The subcategories addressed under barriers were medical dominance, organizational and administrative barriers, and advocacy repercussions.

**Important Empirical Findings**

The information gathered from the articles over the past 10-year period have largely provided data in themes and subthemes. Nursing action has been reported and
analyzed categorically with antecedents and barriers, yet advocacy action is questionable in each measure, which is due to the lack of consensus to define the term advocacy by leading experts and professional nursing organizations. While this may be an obstacle to nursing advocacy, the findings of this review of literature have been arranged according to the most often occurring themes. The literature repeatedly proposed that when the nurse advocates, the development of a relationship between the patient and the nurse begins (Hanks, 2008). The relationship is built upon a foundation of caring and empowerment for the nurse (Thacker, 2008). Once nurses develop a relationship with a patient, the nurse becomes a conduit between the patient and any health care need (Gadow, 1980). Patients may choose to rely on nurses when debilitated.

Debilitation or injury are examples of when a patient requires nursing care (Kalaitzidis & Jewell, 2015). While patients are in the hospital, they are characteristically unfamiliar with health care terms and medical procedures, and they typically find it difficult to express their desires to the health care team (Gadow, 1989). Thus, relationships with the nurses are desired by the patient. Nurses with expert knowledge about their patients are positioned well to speak on behalf of the patient through advocacy when the role is required according to the profession for the patient (Kalaitzidis & Jewell, 2015).

Emerging trends, evidence-based practice, and advances in the sciences have taken on new meaning in the 21st century. Furthermore, patients are living longer lives with death being caused from illness rather than communicable disease processes. Moreover, in the past, patients would die at home surrounded by their family members. However, today, health care professionals have been joined in the process where death
occurs in the health care setting (Gleason, 2013; Thacker, 2008). Nurses view advocacy as providing protection from potential risks of harm by tooling health care professionals with roles including listening, giving a voice to patients, and providing education about issues related to patient disease process (Vaartio et al., 2009; Walent & Kayser-Jones, 2008).

However, not all professions view nursing as an optimum vector to provide advocacy, but some accuse nurses as being self-serving (Thacker, 2008). Nurses have a fear of not being respected by coworkers, especially if communicating for a patient is perceived as causing trouble. When nurses are perceived as disrupting workflow and having negative work relationships, the likeliness of continued advocacy diminishes (Ezeonwu, 2015). Indeed, nurses who feel a moral obligation to advocate take a risk when there is a lack of support from the employer, peers, and professionals in related disciplines (Hanks, 2010a). For these reasons, considering a professionally supported nursing advocacy definition may provide clarification to nurses who are enacting the role of advocacy or for those who generally call nursing advocacy action into question.

Currently, there are many varying definitions of nursing advocacy in the literature that are broad and inconsistent. Expert nurses, including those who have conducted extensive research, have communicated these various definitions about what it means when a nurse advocates for a patient (Bu & Wu, 2008; Thacker, 2008). For instance, of the 28 studies identified to review, 11 researchers provided varying definitions of advocacy. All but two developed their own definition, and as of this writing, these definitions have not been adopted by professional nursing organizations.
The researchers in these studies either restated terms of what they believed are nursing advocacy action or have developed their own definition. Hanks (2010a) provided a definition of advocacy taken from a legal dictionary by quoting that advocacy is an “action of a person who defends, pleads, or persecutes for another” (p. 98). Likewise, Thacker (2008) and Ware et al. (2011) used terms likened to a definition developed by nursing researchers. For example, the terms provided in the research are navigator, communicator (Thacker, 2008); informer, educating patients (Hanks, 2010a; Thacker, 2008); speaking on behalf of the patient (Josse-Eklund et al., 2014); protecting patients (Toda et al., 2015; Vaartio et al., 2008), building relationships (Josse-Eklund et al., 2014; Thacker, 2008, Vaartio et al., 2008); promoting self-determination (Jugessur & Iles, 2009; Vaartio et al., 2008); and giving the patient a voice (Walent & Kaiser-Jones 2008).

Along with the wide array of terms, authors have each described their version of the definition by alluding back to interpretive statements provided by professional organizations such as Code for Ethics for Nurses with Interpretive Statements from the ANA (2015), and The ICN Code of Ethics for Nurses (Hanks, 2013). For instance, Jansson et al. (2015) developed a patient-focused nursing advocacy definition in 2011. They defined nursing advocacy as an intervention to assist patients in obtaining services, rights, and benefits that would not otherwise be attainable by them and advance their well-being. In a study conducted on the continent of Africa, Dadzie et al. (2017) defined patient advocacy as an ethical practice provided by the nurse of representing a patient and family according to their needs and wishes. The core duty of a nurse is to act to ensure that medical decision making is in line with patients’ desires (Dadzie et al., 2017; Mortell et al., 2017). Cawley and McNamara (2011) defined such practical action of patient
advocacy as a manifestation of empowerment, fundamental to nursing, and in representation of the patient. While the action of the nurse advocacy role in descriptions by nursing researchers is consistently identified and encouraged through formal nursing education, there is still a lack of a consistently supported nursing advocacy definition. It is, then, no surprise to find the most common theme in the literature relating to nursing advocacy is advocacy education.

**Advocacy as Education of the Patient and Their Families**

Education is a mechanism to provide a standard to communicate how to effectively advocate. Developing an educational advocacy standard, alone, will not ensure that nurses will provide advocacy or will provide advocacy adequately (Hanks, 2008). More work is required. The literature has supplied the nursing profession with evidence that serves as a structure to follow, procedurally, what will benefit both the patient and nurse. While there are numerous influences that may have an impact on a trustworthy educational program, such as the delivery of advocacy content to student nurses, formalization of advocacy education based on empirical findings will provide a framework and process to educate nurses (Hanks, 2008).

In a quantitative cross-sectional study conducted by Vaartio et al. (2008) with a cluster sample size of 405 patients and 118 nurses, education about the ethical duties related to advocacy was significant ($p = 0.03$). In a concurring descriptive content analysis of written narrative responses, Hanks (2010a) posed the statement: “when I am acting as an advocate for my patient, I am performing the following action” (p. 100); the frequency of nurses selecting “educating patients and families” (p. 100) was the highest of the possible choices at 32.3%. However, of the 5,000 surveys mailed to nurses, only
325 responded, representing a response rate of 6.5%. Given the low response rate, the researcher acknowledged a lack of representation of nurses in the sample (Hanks, 2010b). Results were similar in a qualitative study conducted by Mortell et al. (2017).

A constructivist qualitative study by Mortell et al. (2017) was conducted in Saudi Arabia where 13 nurses were interviewed via semi-structured interviews including a focus group discussion lasting approximately 60 minutes. A portion of the study concluded that a lack of nursing education in a formal setting and learning advocacy while in nursing practice was related to ineffective advocacy. The researchers reported that this would result in an inability for the nurse to understand the importance of implementing this role. In another pilot phenomenological study conducted by Hanks (2010b), education that was related to advocacy was described by the nurses relaying their lived experiences. One question posed was understanding how the professional role of the nurse was related to educational preparation. Similar to Mortell et al. (2017), the results were that educationally, advocacy is learned primarily on the job. Nurses, however, spoke to a lack of knowledge in both formal training and on-the-job experience (Mortell et al., 2017). In studies where both patients and nurses were included in the research process, all had communicated the importance and role of the nurse as an advocate. Keeping this in mind, it is surprising that most advocacy that was learned and reported by nurses occurs primarily at an entry level while on the job observing other nursing professionals acting as patient advocates (Hanks, 2008, 2010; Vaartio et al., 2008).

Other studies about advocacy education are said to be provided through nursing curricula, but there are questions about the efficacy of the training. Considering this gap,
Hanks (2010b) developed an instrument to measure protective nursing advocacy, termed the Protective Nursing Advocacy Scale (PNAS). The purpose of the instrument was to develop a psychometric measure of advocacy of nurses in the workplace. After the development of the instrument, a descriptive correlational design study was conducted of 419 nurses in a medical-surgical setting in the state of Texas. The study included a construct of a 43-item, 5-point Likert-scale questionnaire. Results of the study reported four components listed in subscales. Each of the subscales and the entire PNAS were all reported using Cronbach’s alpha values ranging from 0.7-0.93. These results deemed the instrument and the four components of the subscale as a valid instrument for determining nursing advocacy beliefs and actions (Hanks, 2010b).

In the fourth subscale, the instruction about nursing advocacy in nursing programs was viewed as a barrier to nurses’ confidence in practice. In additional studies, where the value of an educational program could be measured, the literature demonstrated similarities, questioning the efficacy of advocacy in curricula across the various methods chosen by the researchers to study nursing advocacy (Boersma, 2012; Hanks, 2008, 2010b; Vaartio, 2009; Ware et al., 2011). Hanks (2008), prior to the development of the PNAS, discovered in a qualitative study that confidence through practice is linked to the education leading to patient advocacy.

Jansson et al. (2015) and Ware et al. (2011) found that health care professionals with advocacy skills increase the ability of nurses to advocate and effectively care for the patient. In the study conducted by Jansson et al. (2015), the conceptual framework utilized was the theory of planned behavior to predict how health care professionals engage in advocacy with their patients. This cross-sectional design included 94 social
workers, 97 nurses, and 104 medical residents in eight Los Angeles hospitals. The research instrument, the Advocacy Engagement Scale (AES), was tested and was statistically associated with patient advocacy in a bivariate analysis. The skills identified were negotiating, bargaining, and calling unresolved problems to the attention of the physician. The higher the level of skills held by health care professionals, the more effective the patient advocacy (Jansson et al. 2015).

Where advocacy was inadequately learned, Vaartio et al. (2009) discussed an inability of the nurse to protect the patient from potential harm from the health care system. This claim is supported in a study conducted by Boersma (2012) in Ireland. In this qualitative study of self-reflective journal writing, the researcher sought to identify knowledge-based challenges faced by nurses working as advocates for dementia patients who were living in a community or in an acute-care setting. The theoretical framework utilized in the Boersma (2012) study was reflective practices to explore, analyze, and interpret nurses’ personal practices as advocates. The study’s rigor was grounded in inclusion and exclusion criteria to validate the reliability of the data collected and was provided to a peer professional for use as a critical friend for critique (Boersma, 2012).

Boersma (2012) found that nursing advocates who secure the patient’s service pathway by learning how to understand the issues a patient faces may improve access to the necessary professional services and treatments. Without advocacy, the patient may confront a potential exclusion from care of services. The researcher concluded that a nurse’s knowledge and skills can improve the competencies of that nurse, promote an elevated confidence in care provided to the client, and impact the patient positively as the nurse is able to advocate more effectively (Boersma, 2012; Vaartio et al. 2009). Effective
advocacy for the dementia patients was not only beneficial for the patient and other health care colleagues, by offering representation of both patients and relevant care providers, but also it resulted in a structure that provided staff reassurance while allowing the dementia patient to receive holistic care (Boersma, 2012).

Similar to the Boersma (2012) study, Thacker (2008) conducted a comparative, descriptive quantitative study of 317 U.S.-based nurses and found that those with training performed better than those who had no training. Once the skill of advocacy was learned, nurses who performed advocacy rated higher in providing advocacy. Interestingly, however, there was no significant difference in the mean scores, ranging from 3.46-3.78, between an expert nurse versus an experienced nurse versus a novice nurse. Thacker (2008) added to her study by reporting in an auxiliary analysis of post hoc findings. Here, she reported a significant difference ($p = 0.001$) between young nurses who were formally taught about advocacy within a 3-year period and experienced nurses. The conclusion was that experienced nurses performed better advocacy than novice nurses (Thacker, 2008).

Hanks (2008) also referred to the theme of education relating to advocacy but termed it as a phenomenon. He determined that there were additional influencing factors associated with nurses who advocate. For example, factors influencing and characterizing nursing advocacy were described by Hanks (2008) as an individual nursing concept, values, confidence to advocate, and personal beliefs by the nurse. However, Hanks (2008) did not differentiate between each individual experience of the nurses.

To summarize this section, nursing advocacy education is a process determined to be effective in providing guidance to the development of this skill. A lack of education,
whether formally or in practice, was correlated with ineffective patient advocacy. Researchers found that a deficiency in skills may also indicate a similar lack of understanding of the importance of this role (Walent & Kayser-Jones, 2008). While nurses reported recognizing there was little advocacy education, it was determined that this was a driving force for researchers to develop tools to measure the strength and value of nursing advocacy to further support the importance of education. When advocacy was not learned adequately, nurses were not able to protect patients from potential harm within the health care system. However, those who advocated effectively demonstrated an ability to maneuver within the health care system and understand the issues a patient faced in order to secure services. Securing services involves the ability to effectively communicate with a number of positions and roles within the system (Thacker, 2008).

**Advocacy Communication as a Skillset**

Communication is a skill essential for effective patient advocacy. The literature describes effective advocacy as operationalized through communication, such as active listening, as a mean for communicating with the patient, family, and multidisciplinary team (Boersma, 2012; Hanks, 2010a; Walent & Kayser-Jones, 2008). Considering the supportive data about communication as an expression of the nurse who verbalizes a moral obligation to speak on behalf of the patient, a gap was identified in the literature that indicates further study may be beneficial to learn how, first, the nurse may be motivated to recognize the importance of implementing such strategies (Hanks, 2008, 2010a; Walent & Kayser-Jones 2008).

In a mixed-design study that analyzed both qualitative and quantitative data, Walent and Kayser-Jones (2008) investigated 17 nursing home residents in two separate
facilities. The purpose of the study was to determine advocacy from the perspective of the nursing home residents. The data were collected over a 4-month period using initial interviews, resident and staff observations, and follow-up interviews. The results of the study were categorized according to three themes identified within the qualitative data: (a) residents who can voice their desires by accessing staff who can advocate, (b) implementing a formal organizational advocacy program increases residents’ desires to be heard, and (c) nurses who have ongoing interactions with residents can advocate the residents desires and needs. The quantitative data were analyzed by counting the information by hand. The significant quantitative data measured the minimum data set of activities of daily living of the residents with scores from 0-18. The total sample produced a mean of 10.5 with a standard deviation of 2.2. This represented the disabilities of the participants and their need for advocacy in personal care. The standard deviation was noted to be small and represented most accurately the population of the nursing home residents in the study (Walent & Kayser-Jones, 2008).

A second important measure was that 64% of the sample had mild to no mental impairment, while 29.4% had moderate impairment. The data made clear that residents in the nursing home where methods of advocacy were implemented, it included that communicating their needs and desires showed improved outcomes (Walent & Kayser-Jones, 2008). Residents trusted their family to speak on their behalf; however, when an employee advocated for the residents, it was effective—but only after willingness was recognized by the staff (Gleason, 2013). Advocacy was impossible with an unwilling staff, as staff failed to listen, relay information, and act on behalf of the residents.
Additionally, the effect on residents when the nursing staff did not communicate well communicated to residents an unwillingness to advocate (Walent & Kayser-Jones, 2008).

Comparing the chronic care setting to an acute-care setting, a qualitative study comparing nurses to surgeons was conducted using discourse analysis. The purpose of the study was to compare the differences in roles where conflict might have occurred between nurses and physicians when determining life-sustaining treatment in an intensive care unit (ICU) (Pecanac & Schwarze, 2018). Decision making in the ICU is often a source of conflict within a health care team. Team members can have disagreements about appropriate goals and treatment modalities to provide to the patient. In addition to conflicts between team members, patients and family members may become part of the conflict. Specifically, physicians and nurses may disagree with the treatment plan for a patient (Pecanac & Schwarze, 2018).

In nursing, a prominent role provided to the patient by the nurse is advocacy. The nurse feels a sense of responsibility to support the patient and honor the wishes of the patient while considering the best interest of the patient. As a result of the conflict in determining plans of care, patients may experience negative outcomes, while moral and practical distress is experienced by the nurse (Boersma, 2012; Pecanac & Schwarze, 2018). Both disciplines possess a strong responsibility for the patient, yet clearly, they have different roles when caring for the patient.

Nurses and physicians working collaboratively is essential for a positive outcome for patients in an ICU. The study encouraged conversation among nurses and physicians to identify the creation of a culture to find common ground in assumptions that drive behavior between both groups (Pecanac & Schwarze, 2018). By communicating in a team
meeting, members of a team should be able to discuss a proposed plan and uncover patient and family conversations individually to improve understanding about patient care decisions. The rigor of this small study was not identified except by re-reading the text to identify themes such as communication (Pecanac & Schwarze, 2018).

Communication as a novice nurse was noted in the literature, claiming that there is a lack of inclination to advocate because of poor communication skills. Young nurses in the nursing profession demonstrate little experience in knowing how and when to effectively advocate (Thacker, 2008). Thacker (2008) provided qualitative data to support that when a nurse is an expert, the ability to communicate is effective in the role of advocacy, but it is learned through a longitudinal experience that provides a positive impact on care facilitation for patients. Thacker (2008) advised additional research to further the knowledge of how nurses use communication to advocate and what prevents a nurse to speak on behalf of the patient.

In summary of this section, good communication skills have been established as essential for nurses while advocating for patients. In chronic care, three themes were identified in nursing home residents in a qualitative study (Walent & Kayser-Jones, 2008). The themes that demonstrated improved outcomes for residents in the study were for those residents who could voice their desires and were successful in having advocacy provided. Implementing an organized advocacy program increased the residents’ desires to be heard, and the nurses who had ongoing interactions with the residents effectively advocated for the residents’ desires and needs (Walent & Kayser-Jones, 2008).

In a study conducted by Pecanac and Schwarze (2018), conducted in an acute-care setting, a prominent service provided to a patient by the nurse was advocacy. In this
study, the nurse felt a sense of responsibility to support the patient by honoring his/her wishes while considering the best interest of the patient. When a nurse was a novice, however, communication was insufficient and demonstrated a lack of inclination to advocate because of poor communication skills. Moreover, poor communication was perceived by the patient as the nurses unwilling to participate in the patient’s care. Unwillingness to participate in care may have an etiology in poor communication, but it also may be related to advocacy barriers.

**Barriers in Nursing Advocacy**

Barriers in nursing advocacy are observed by nurses and interpreted as an interruption in care (Jansson, 2015). Nurses desire to honor the wishes of the patient through advocacy. Nurses who engage in advocacy are often met with several barriers (Jansson, 2015). Barriers in nursing advocacy exist on a broad spectrum within the nursing profession, and for this reason, the barriers identified in this literature review have been separated categorically to determine singular importance. The barriers that were identified as being most prominent were: knowledge about advocacy, medical dominance, organizational and administrative barriers, and advocacy repercussion.

According to Jansson et al. (2015), advocacy knowledge as a barrier is based in ethics and should be developed as a skillset. In the cross-sectional research study conducted by Jansson (2015), data were collected from 94 social workers, 97 nurses, and 104 medical residents. Barriers were identified as being a specific skillset in the inability to effectively advocate. For instance, understanding potential patient problems is essential to implement the learned skillset. Similar results were noted in the study of a program evaluation between nurse navigators and non-nurse navigators by administering a survey
to both groups. Nurse navigators reported a decrease in barriers ($n = 22, 84.6\%$) when
caring for patients who had received advocacy by the nurse (Campbell, Craig, Eggert, &
Bailey-Dorton, 2010). Additionally, statistically significant differences were also
identified between the two groups in the areas of resources, information provided in a
timely manner, being available, informing, and providing financial assistance. Nurses
who possessed knowledge about the patient’s ethical dilemmas was a factor that was
identified to predict whether a nurse would enact patient advocacy (Jansson et al., 2015).

As the relationship between the patient and the nurse is developed, ethical
dilemmas are discovered. The level of intimacy within the relationship is a strong
influence for providing advocacy. Frequent interactions between the nurse and patient
encourages the nurse to advocate for the patient as a natural progression as a patient
needs arise and are not seen as new obligations. While the opportunities to advocate are
frequent, it is undeniable that there are risks and consequences that may cause a barrier
for advocacy (Barlem et al., 2015; Boersma, 2012; Dadzie et al., 2017; Mortell et al.
2017; Oliveira & Tariman, 2009).

**Medical dominance as a barrier.** Medical doctors commonly dominate nurses in
the health care setting (Mortell et al., 2017; Dadzie et al., 2017). In a qualitative,
exploratory descriptive study by Dadzie et al. (2017), which was conducted with 15
nurses in a regional acute care setting in the country of Ghana, in-depth interviews were
conducted in English using a semi-structured interview process. The interviews were
audio recorded and transcribed for analysis. Trustworthiness was established using the
same interviewer and interview guide, and member checking was initiated after the
interviews were completed. The purpose of the study was to explore the characteristics of
how nurses were influenced in advocacy while working in a pediatric ward with male children. A requirement for the nurses was to have at least 5 years of nursing experience and to know the patients well (Dadzie et al., 2017).

Out of 15 nurses, five reported a feeling of powerlessness to influence a plan of care for the patients because of medical dominance. The organizational structure supported this culture. The results of the study were found to be similar to other studies conducted where the organizational culture was patriarchal and physicians took an autocratic role that prevailed in the decision making on behalf of the patient. The physicians were reported by nurses to balk at their authority being challenged and, depending on the culture, the doctors did not accept the perspective of the nurse (Dadzie et al., 2017; Mortell et al., 2017, Ware et al., 2011). Therefore, nurses reported that they were in a position where they did not advocate because of fear of embarrassment, humiliation, and for being at risk for termination (Dadzie et al., 2017; Mortell et al., 2017; Ware et al., 2011).

Alternatively, in a quantitative study conducted by Ware (2011) of 188 nurses, the researcher wanted to determine how advocacy was related to knowledge, practices, and education for nurses who focused their care on pain management. The results demonstrated that time was the most closely related 51.3% (n = 99) as an advocacy barrier; however, power struggles were also reported at 21.2% (n = 41) as a barrier to patient advocacy (Ware et al., 2011). The power imbalance between nurses and physicians were reported by the nurses as intimidating for the nurse, and the imbalance becomes a barrier for nurses advocating for patients. However, models where nurses and
physicians shared the decision making, nurses reported feeling empowered to advocate effectively for patients and had improved nurse job satisfaction (Dadzie et al., 2017).

**Organizational and administrative barriers.** Nurses have reported that there should be a formalized structure provided by their organizations, such as policies and procedures, to give guidance to the role of patient advocacy to be provided by nurses (Josse-Eklund et al., 2014). If the organization supports the culture of advocacy, the nurse is less likely to refuse to advocate. Nurses who do not feel supported by their organization, while understanding the safety of the patient can become compromised, are not willing to risk their careers or promotions to advocate when there are risks (Hanks, 2010a; Jansson et al., 2015; Josse-Eklund et al., 2013, 2014; Reed et al., 2016; Thacker, 2008). In a qualitative phenomenographic approach by Josse-Eklund et al. (2014), 18 interviews of nurses were conducted in Sweden. The nurses were required to have 3 years’ minimum experience and be able to communicate in Swedish.

The interviews took place on two occasions. Trustworthiness was established by member checking through interview clarification. The results of the research study identified organizational culture was related to patient advocacy. When the organizational culture was positive, nurses reported they had feelings of confidence when advocacy was required. Conversely, when the culture was negative, nurses reported feelings of lacking support, feelings of insecurity, feelings of low competency, and being at risk (Josse-Eklund et al., 2014). In a quantitative study also conducted by Josse-Eklund et al. (2013) about the factors influencing nurses’ attitudes toward patient advocacy, the working climate was also reported as significant ($n = 173$, $p < 0.005$) effect on advocacy. When the working climate was poor, the consequences for taking a risk were reported as being
humiliated, embarrassed, or being harassed by colleagues (Jansson et al., 2015; Josse-Eklund et al., 2014). The results of the Josee-Eklund et al. (2013) study demonstrated that the support of the organizational culture affected how the nurses advocated. When staff behaved more dismissive and introverted, nurses were positive toward advocacy. This may be because staff desires consistency and predictability in the workplace; however, the more humorous and playful the staff were, the more relaxed the work environment. In that environment, nurses also felt encouraged to advocate (Josse-Eklund et al., 2013, 2014).

Nurses have been observed as not advocating for the rights of patients because of the organizational culture (Black, 2011). In a quantitative study conducted by Black (2011), a questionnaire was developed and mailed to 1,725 nurses in the state of Nevada. A total of 564 (33%) nurses responded. The statements were measured using a 5-point Likert scale. While nurses reported that they understood how to report unsafe patient care situations 90% \( (N = 564) \), only 57.1% \( (N = 564) \) of the nurses reported the ability to report a concern without experiencing workplace retaliation. Additionally, a lower percentage of nurses, 56.9% \( (N = 564) \), reported feeling they could report a physician to the Nevada State Board without experiencing retribution by the organization.

Comparatively, when organizations create a climate to empower the patient to be self-determined, health care professionals engage more frequently in advocacy. Jansson et al. (2015) reported this as relating to patient advocacy under the notion of organizational receptivity \( (r = 0.57, p < 0.001) \). Because of the nurses’ perceptions that hospitals valued patient self-determination, the nurses were motivated to engage in patient advocacy. An organization that supports patients’ self-advocacy also encourages
health care professionals to advocate more because it encourages staff that may be reluctant, otherwise, to advocate (Jansson et al., 2015).

**Advocacy repercussions as a barrier.** Repercussions for nurses advocating for patients have been well documented in the literature. Nurses have been ostracized by colleagues, physicians, and at times, their employing organizations. The consequences of advocating for a patient can be severe both personally and professionally (Barlem et al., 2015; Dadzie et al., 2017; Mortell et al., 2017; Thacker, 2008). Nurses have acknowledged that when advocating, they are at risk personally and professionally for conflicts and serious ramifications. Nurses have had colleagues who have suffered serious consequences for advocating on behalf of their patients, and the nurses have stated that they are also fearful of the same reprisals (Mortell et al., 2017).

Thacker (2008) conducted a mixed comparative descriptive study to uncover the perceptions of advocacy of nurses in an end-of-life setting. The theoretical and conceptual framework was based on Benner’s (2001) seven domains of caring practice and five levels associated with skill level, then it was broken down into three categories of novice, experienced, and expert nurses as relating to patient advocacy. The premise was that the nurses advocated more over time with practice, experience, and the acquisition of skill development through levels of expertise. A survey instrument used to collect the data, the Ethics Advocacy Instrument (EAI), was used to explore and identify behaviors of nurses under the domain of advocacy. The results were coded; then a second wave of testing included a pilot study to support the reliability of the instrument, alone, with content testing for validity, clarity, and readability. The qualitative data was reviewed by experts in the field who provided feedback and advised in all phases of the
data analysis. A significant finding was demonstrated that new graduate nurses disagreed that there were negative implications for providing patient advocacy. Nurses learned how to operationalize advocacy, typically during their first few years of practice, thus having fewer hands-on experiences to create negative attitudes about advocacy. It is possible that they had not experienced the role of defending a patient, and they did not recognize the negative aspects of advocacy (Thacker, 2008).

Another barrier reported by nurses is a fear of the physician, the patient’s family as well as a fear of personal and professional harm. While novice nurses reported that barriers to advocacy were lack of time and support and lack of communication, more experienced nurses reported fear of conflict resulting in discipline and loss of job security—a high price to pay for the service of advocacy (Thacker, 2008). As a result, and as a means to avoid stress, moral suffering, and eventually burnout, nurses may choose not to advocate because of potential negative consequences. Keeping this in mind, even though advocacy has great risks, nurses have communicated through the research that they recognize their power as an attractive lure held by the nurse when advocating, and advocacy may be an external motivational construct in itself because it provides an opportunity to challenge the health care system, especially when considering ethical issues (Barlem et al., 2015).

In summary of nursing advocacy barriers that are identified within the literature, there is vast literature describing how nurses are confronted with numerous advocacy barriers. Research asserts that nurses require support in becoming effective advocates, which includes, in particular, overcoming those barriers that might limit their potential and efficacy as patient advocates (Mortell et al., 2017). Barriers in nursing advocacy
affect a myriad of disciplines that coordinate care with nursing services. Nurses see these barriers as an interruption of care. The four barriers identified in the literature are: knowledge barriers, medical dominance barrier, organizational and administrative barriers, and repercussion barriers. The first of the barriers identified is knowledge barrier. Possessing knowledge about the patient’s ethical dilemmas is identified as a predictor of the likelihood of nurses advocating for the patient. As a result of the findings, advocacy skill acquisition in nurses is recommended (Jansson et al., 2015). Knowledge about advocacy will also assist nurses in their dealings with the second barrier, medical dominance.

Nurses have reported that they fail to advocate because of fear of embarrassment, humiliation, and being at risk of termination when working with physicians. Nurses have described imbalances in power between the nurse and the physician, yet if the nurse feels supported by the physician, she also feels empowered to advocate. Where nurses do not have the leverage to develop an official process in their work environment to formalize advocacy action, the third barrier, the organization and administrative barrier, comes into play. When a formalized structure is provided by the organization, such as policies and procedures to give guidance in the role of patient advocacy, nurses advocated more frequently. Alternatively, however, when nurses do not feel supported by their organization, they are less likely to advocate. While nurses’ understanding that there are potential risks in a situation for the patient and or staff, they can remain generally unwilling to risk their career or promotion for the sake of others or for what is right.

The final barrier identified was the repercussion barrier. Nurses have described being humiliated, embarrassed, or harassed by colleagues (Jansson et al., 2015). The
results of advocating for a patient can have stiff consequences for the nurse both personally and professionally (Barlem et al., 2015; Dadzie et al., 2017; Mortell et al., 2017; Thacker, 2008). For this reason, according to the literature, nurses have become, by necessity, self-aware.

**Nurse Self-Awareness**

According to a research study conducted by Boersma (2012), recognizing personal emotions is an essential part of a nurse’s personal identity. While practicing nursing, emotions play an important role when one is committed to care for patients in a multitude of diverse settings. Managing emotions and being self-aware, as it relates to patients or other health care members, is essential to providing effective care. Nurses express their emotions, positive or negative, which has been shown to influence nursing practice. The outcomes of patients is, in effect, a commitment to caring, and it is seen as a motivation to advocacy (Boersma, 2012; Reed et al., 2016).

In a quantitative, correlational study conducted by Heelan-Fancher (2016), aimed at examining the interrelatedness of power when nurses were providing care to obstetrical patient, the results of a regression analysis of the nurses’ attitudes toward patient advocacy showed that the authority the nurse wielded was significantly correlated to advocacy efforts ($N = 248$, $r = .39$, $p < 0.01$). Being personally and emotionally invested, nurses described thinking about the wishes of the patient and what was most important to them as addressed by, and grounded in, the nurses’ understandings of their role in the provision of care (Reed et al., 2016; Vaartio et al., 2008). Nurses who give emotional energy are, in essence, giving of themselves beyond their expected duties in the role of nurse, and these actions represent their own value systems. Reflecting on their own
values leads nurses to manage their own reactions so they can support the desires of their patients by prioritizing their patients’ values (Reed et al., 2016).

If negative emotions are not managed, the result may be problems relating to stress, which can impact the performance of nurses at both a personal and professional level. Nurses report having difficulty in admitting that emotions are part of their professional identity; however, if they are inclined to manage them while providing care and acknowledge that they exist, they can resist negative thoughts (Boersma, 2012; Reed et al., 2016). If interprofessional collaboration is to be executed effectively, emotions must be considered.

When nurses understand their emotions and recognize their role, they also come to understand and appreciate the intricacies of patient care. In cases where the nurse experiences anger or frustration, having self-awareness of these feelings tended to motivate the nurse to gain focus to access resources for the patient, increase communication, and assist in understanding important aspects of the patient’s quality of life (Boersma 2012, Reed et al., 2016; Vaartio et al., 2008). Nurses, at times, reported making decisions while emotional, such as in cases of moral controversy because of health care practices that were deemed by the nurse to be unacceptable, such as when the needs of the patient were not met or the nurse considered the patient being underserved. This was an indirect conflict in those situations where risks were known and considered. The nurse would take a risk and felt it was worth it because of the perceived urgency viewed by the nurse for the patient (Josse-Eklund et al., 2014).

When a nurse considers herself to be aware of, and in control of, her own feelings, she reports having control over the care of the patient. The position of care she inhabits as
perceived by the nurse influences the nurse to act on behalf of the patient in accordance with the patient’s wishes (Josse-Eklund et al., 2014). For instance, in a mixed study conducted by Cawley and McNamara (2011) in West Ireland, both qualitative and quantitative research methods were utilized. In the purposive portion of the study, nine nurses participated in two focus groups with questionnaires (cross-sectional survey design) with 42 patients. The response rate was 40%. Open coding was implemented and divided into categories and then reorganized into smaller interrelated codes to identify themes. A critical friend was used to control bias. The results were that nurses had a lack of perception of their own empowerment (Cawley & McNamara, 2011). Nurses who reflected on the impact of their emotions on their work assisted in the development of mature practice and felt empowered in the delivery of care to a patient (Boersma, 2012; Josse-Eklund et al., 2014).

In summary, nurses who are self-aware recognize that their personal emotions play an essential part of their personal identity as a nurse. Self-awareness has both positive and negative impacts on how nurses provide nursing care to their patients (Boersma, 2012). The impact of self-awareness influences patient outcomes because it is related to a level of commitment to caring. Nurses see their own capacity for insight into and the management of their emotions as a reflection of their own value in providing optimum care by meeting the needs and supporting the desires of the patient (Reed et al. 2016). In instances where a nurse may experience anger or frustration, becoming self-aware allows the nurse to gain access to resources, increase communication, and assist in refocusing the priority of care (Boersma, 2012, Reed et al., 2016; Vaartio et al., 2008). The focus on position as perceived by the nurse influences the nurse to act on behalf of
the patient in accordance with the patient wishes and desires, allowing for the nurse to feel empowered to provide effective advocacy (Josse-Eklund et al., 2014).

**Advocacy Empowerment**

Nurses advocate for patients while demonstrating their own professional empowerment. A fundamental function of developing this empowerment is embracing the role of advocate (Barlem et al., 2015; Cawley & McNamara, 2011; Heelan-Fancher, 2016). Empowerment is an attribute of advocacy and, if not possessed by the nurse, the relationship the nurse desires to develop with the patient to promote a healthy lifestyle is undermined. Indeed, disempowered nurses are not able to effectively advocate for their patients. However, nurses are often situated in a position of power over a patient, who may be rendered more vulnerable than usual by medical circumstance or merely by the nature of being a patient in a hospital setting (Cawley & McNamara, 2011).

Empowerment has been linked to patient advocacy; however, nurses do not see themselves as being empowered professionally (Cawley & McNamara, 2011). In the mixed-methods study of Cawley and McNamara (2011), the researchers sought to explore nurses’ perceptions of empowerment and advocacy in the context of pediatric health screening and to determine the impact of public health nursing practice. In collecting qualitative data, Bernard’s content analysis for coding was used to control any bias, and the data were analyzed by two critical peers. Inclusion criteria for the qualitative data were nurses working with children; while saturation was reached, a sample of nine nurses was accepted for the study. From the infants in the study, 43 parents agreed to complete a survey with a return rate of 40%.
The results of the research Cawley and McNamara (2011) study support the perception of power held with the nurse. Nurses advocate for the benefit of patients to assist in their health care, protect their rights, and safeguard their rights for an increased quality of care as they serve to fill the gap between the patient and the health care system. Patients are often regarded as vulnerable while ill, and they have difficulty expressing their wishes. Yet, the health care system has failed to develop a process to provide patients with autonomy. As a result, nurses advocate to mitigate this perceived problem as a form of resolution (Barlem et al., 2015; Cawley & McNamara, 2011).

Nurses are in a unique position to advocate for patients as a means to clarify the desires of the patient for electing treatment, making related health care decisions, and coping with a lack of power (Cawley & McNamara, 2011). Nurses report that the realization of their own autonomy develops them into more effective patient advocates, and this has a lure for nurses when advocating, thus becoming an external motivational construct in itself because such autonomy provides opportunities to challenge the health care system—especially when considering ethical issues (Barlem et al., 2015; Cawley & McNamara, 2011).

In sum, empowerment is experienced by nurses when advocacy is operationalized (Barlem et al., 2015; Cawley & McNamara, 2011; Heelan-Fancher, 2016). Yet, nurses do not see themselves as being empowered, even though they are understood to hold a position of authority over vulnerable or otherwise compromised patients. Nurses are in a unique position to advocate for patients in order to promote the desired wishes of the patient for electing treatment, making related health care decisions, and coping with powerlessness (Cawley & McNamara, 2011). The empirical findings of this section have
been gleaned through analytical measures using newly developed and tested instruments developed by nurses.

**Advocacy in Nursing Research**

Numerous research designs were identified and fully analyzed, taking note of the country of origin, characteristics of the studies, and outcomes. The quality of the studies was evaluated and recorded in order to be included in this paper. The search of the data base resulted in a total of 56 journal articles, 28 of which were omitted. Of the 28 studies reviewed, 14 were quantitative studies, 11 were qualitative studies, and three were studies with mixed methodologies. Strength of the studies were established by using a rating system developed by Melnyk, Mazurek, and Fineout-Overholt (2011).

On a 1 to 7 rating scale, the Level 1-2 rating represents high level studies to include randomized control trials. Level 3 represents well-designed control trials without randomization. Level 4-5 represents case studies and qualitative studies. Level 6 represents quantitative descriptive studies, and qualitative studies, Level 7, represents evidence from the opinion of experts.

Of the 14 quantitative studies, three studies were a Level 2 rating (Bu & Wu, 2007; Gazarian, Fernberg, & Sheehan, 2014; Vaartio et al., 2008); three studies were a Level 3 (Black, 2011; Heelan & Fancher, 2016; Vaartio et al., 2009); five studies were a Level 4 (Barlem et al., 2015; Campbell et al., 2010; Hanks, 2010b; Jansson et al., 2015; Josse-Eklund et al., 2013), and three studies were a Level 5 (Hanks, 2010a; Jansson et al., 2015; Ware et al., 2011). There were no quantitative articles rated at Levels 1 or 7.

The qualitative studies comprised 11 studies in total. Of the 11 studies, two were a Level 3 rating (Boersma, 2012; Davoodeandl, Abbaszedah, &Ahmedi, 2016); six were a
Level 4 (Dadzie et al., 2017; Josse-Eklund et al., 2014; Mortell et al., 2017; Paquin., 2011; Reed et al., 2016; Sundqvist, Holmefur, Nilsson, & Anderzén-Carlsson, 2016; Toda et al., 2015); one was a Level 5 (Newman, 2010); and one study was a Level 6 (Hanks, 2008). Of the qualitative studies, no studies were rated as a Level 1, 2, or 7. Three studies represented mixed methods (Cawley & McNamara, 2011; Thacker, 2008; Walent & Kayser-Jones, 2008). These studies were determined to range between Levels 4 and 6 in the strength of the body of evidence. Finally, one study (Swanson & Koch, 2010) was excluded from the selection because of the weak quality of the study.

Comparisons were made of all the studies. Review of the statistical tests was done to ensure an understanding of the adequacy of the studies, noting control and performance of the statistical methodologies that were employed.

All the studies included patient advocacy and the role of the registered nurse. One study included registered nurses, social workers, and medical residents (Jansson et al., 2015). Of the 28 studies, 11 were conducted in international countries (Barlem et al., 2015; Boersma, 2012; Cawley & McNamara, 2011; Dadzie et al., 2017; Josse-Eklund et al., 2014, 2013; Mortell et al., 2017; Reed et al., 2016; Toda et al., 2015; Vaartio et al., 2008, 2009). The remaining 17 studies (Black, 2011; Bu & Wu, 2008; Campbell et al., 2010; Gazarian et al., 2014; Hanks, 2008, 2010; Heelan-Fancher, 2016; Jansson et al. 2015, 2015; Newman, 2010; Paquin, 2011; Sundqvist et al., 2016; Thacker, 2008; Walent, & Kayser-Jones, 2008; Ware et al., 2011) were conducted within the United States in multiple patient care settings.

**Literature Gaps and Recommendations**
Review of the literature about patient advocacy supports that nurses agree that advocacy is a role expected by patients and demanded by the profession (Hanks, 2008). However, not all nurses are advocating consistently. A gap was identified between what is ideal advocacy and the actual practice. Nurses are challenged with a myriad of barriers, bringing to light the gaps in the literature when attempting to practice patient advocacy in multiple settings. The gaps identified in this review are: lack of an advocacy definition, understanding the motivation of a nurse to advocate, recognition of paternalism with hierarchical power distribution, and nursing advocacy education.

It is understood among those in the nursing profession that advocacy is a role that is recognized and expected consistently (Kalaitzidis & Jewell, 2015). However, advocacy lacks conceptual clarity among nursing professionals and professional organizations. Confusion among nurses, themselves, is evident in the literature, and to date, there has been no development of professional guidelines within nursing to provide a structure to guide the advocacy behavior of nurses (Kalaitzidis & Jewell, 2015). The literature, from an evidenced-based perspective, is rich in anecdotes and descriptions of advocacy experiences. Nurses report that they believe they advocate, and their advocacy is valuable to the patient and family, yet researchers, such as Hanks (2008), argued that utilizing advocacy as described by the nursing profession is confusing and has not been standardized. Thus, a gap appears in the literature where patient advocacy has not been an established process with clear objectives that can be measured and evaluated (Hanks, 2008, 2010a).

Without establishing a clear cause, such as identifying a lack of a formalized system or support from upper management, the literature identified several barriers to
patient advocacy. Nurses simply being afraid to advocate has not yet been examined. While advocacy is written into nursing curricula, there remain questions about the consistency of nursing advocacy, regardless of nurses’ formal training (Hanks, 2008). To answer the questions about the behavior of nurses, studies have measured the attitude of nurses about advocacy, presumably based upon their training, but there remains a gap in understanding the advocacy action of nurses. If the definition of advocacy is not fully understood, then the reliability of the information presented in the nursing textbooks arguably should be questioned as a potential barrier.

Gadow (1989) argued that nurses who do not advocate are potentially withholding valuable information from the patient and practicing nursing in a paternalistic manner. A gap in the literature was identified regarding a lack of studies about the parental role of the nurse when serving as protector from harm for the patient. According to Josse-Eklund et al. (2013), there are several factors that influence the act of advocating: nursing competence, preferences in quality of care, quality of life, and the attitude of the nurse toward the patient. Yet, there is little research about the power imbalances between the nurse, patient, and the family. The literature discusses the hierarchical differences between the nurse and the physician and the subsequent power struggles that develop. Yet, there is a gap in the literature about those same power imbalances and levels of paternalism between the patient and the nurse.

Because nurses work closely with patients and patient advocacy is a directive of professional organizations, patient advocacy has become an important part of nursing curricula. Nursing educators report advocacy as an element of practice that is fundamental to the role of the nurse (Kalaitzidis & Jewell, 2015). However, studies about
nursing instructors in the educational setting or in the clinical setting have been found to be lacking. Little is known about the cohesiveness of advocacy curricula across the general nursing education spectrum. An analysis of nursing textbooks to examine and compare advocacy textbooks for consistency, theoretical underpinnings, and evidence-based foundations is arguably an important first step at this point. An outcome of the effort to fill this gap in the literature will support the efforts of new graduate nurses in clearly defined advocacy efforts when in nursing practice after graduation from nursing programs.

Conclusion

This chapter highlighted what is known about current nursing research surrounding patient advocacy provided by nurses and the need for the continuation of further study. The literature review included scholarly research results spanning the last 10 years relating to nurses providing advocacy for patients. Researchers have demonstrated that although nurses are expected to provide advocacy to patients, many barriers exist. Depending on the barriers described in the research, patient advocacy has the potential to increase the quality of patient care. The literature has shown that advocacy continues to be explored diversely, and while there are many variables to be considered in the literature, there remains a substantial amount of research to be completed about patient advocacy being provided by a nurse.

Effective patient advocacy involves specific attributes derived from research as determined by nursing researchers. Some of the attributes identified in the literature are: one who protects the patient’s right in self-determination, an informer of care, an empowered supporter, and a partner. In the advocate role, nurses are aligned with the
patient and thereby increase the patient’s power to be self-determined. When nurses exercise their independence to advocate, nurses are then positioned to protect the rights of patients while placing the patient on potential equal footing within the medical community.

In conclusion, advocacy is an essential skill learned by nurses in fundamental nurse training, and then it is a service provided to patients. For this reason, it is important to study nursing advocacy. While it is understood that advocacy has positive outcomes for patients, nurses, health organizations, and the medical community at large, we do not fully understand the impact advocacy instruction, as presented in fundamental nursing education textbooks, has on the preparation and action of advocating nurses.
Chapter 3: Research Design Methodology

Introduction

Hanks (2018), the preeminent leader and distinguished researcher in the field of nursing advocacy, shared during an interview that the nursing profession has failed to develop or identify a definition for nursing advocacy. While there is no consistent definition confirmed in the literature, professional organizations, such as the ANA’s *Code of Ethics for Nurses with Interpretive Statements* (2015) direct nurse leaders that nurses should be vigilant advocates for the delivery of patient care in a dignified manner.

Professional nursing organizations, such as the ANA (2018) and the NCSBN (2017) have clearly communicated that advocacy is a responsibility of the nurse. Yet, while nursing education includes advocacy as part of the nursing undergraduate training and curriculum, nurse experts report there is a lack of proficiency and knowledge about how to effectively carry out the role (Hanks, 2008). Nursing education textbooks are a mechanism to educate nurses and strongly influence student learning about advocacy. While advocacy has been operationalized across the discipline, it is done so by nurses inconsistently thus requiring further research (Hanks, 2008). The purpose of this study was to determine how authors of fundamental nursing textbooks address and define nursing advocacy and whether there are any variations among the information. Chapter 3 provides a general perspective and overview of the problem statement, research questions, research design, research context, research participants, instruments used in the data collection, and the procedures for data collection and analysis.
Problem Statement

The problem relating to nursing advocacy in nursing education has been identified, warranting an evaluation of how fundamental nursing textbooks serve the nursing profession, functionally, by a review of these texts through ontological discourse. Without a supported definition of advocacy, confusion about the nurse advocate role and its expectations persist between expert nurses who support advocacy practice guidelines (Hanks, 2018). Therefore, specific nursing actions have not been delineated by the literature in order for a nurse to carry out this role, causing patient advocacy to be delivered inconsistently (Water et al., 2016). When nurses are inconsistent or fail to provide advocacy adequately, grave consequences—including ineffective care—may threaten the well-being of a patient. Yet, little has been studied about the specific content in core nursing textbooks that prepare nurses to advocate (Hanks, 2010a; Kalaitzidis & Jewell, 2015).

Research Questions

To understand the inconsistent action of nurses who advocate for patients, the following questions guided this study:

1. Do fundamental nursing textbook authors define nursing advocacy?
2. If fundamental nursing textbook authors define nursing advocacy, are there variations among the authors regarding nursing advocacy?
3. What principles do fundamental nursing textbook authors propose to guide the action of nursing advocacy?

According to the literature, nursing advocacy has not been fully defined or developed as a concept (Barlem et al., 2015; Black, 2011; Boersma, 2012; Hanks, 2010a;
Pecanac & Schwarze, 2018). To better understand what is known about advocacy, a qualitative research method allowed for an examination of the data.

**Research Design**

A qualitative method of text analysis was used in this study. Interpretive discourse analysis led to the meaning within the text and language (Wetherell, Taylor, & Yates, 2014). According to Riffe, Lacy, and Fico (2014), a qualitative research method possesses key features and frameworks to address symbolic information that explores social meaning that can be applied to the study of nursing advocacy in nursing textbooks. Because this study was of fundamental nursing textbooks, the fit of using a qualitative approach allowed the researcher to become a key instrument when collecting data and examining the advocacy text (Creswell, 2014). Coding, classifying, and supporting themes and concepts allowed the researcher to develop conclusions about what the textbooks are communicating to nursing students. Using discourse analysis to study the text provided an approach from an interpretive discourse analysis perspective. Because the aim of this study was not concerned with issues of power, the use of a critical discourse analysis was not warranted (Schreier, 2012).

The interpretive discourse analysis approach for the purposes of this study examined the use of language and how the expressions of language are linked to knowledge, understanding, and behavior (Gee, 2014). Gee (2014) reflected in his writing that discourse analysis is beneficial if the researcher seeks to establish, by this method and design, a retrospective historical account with consideration of the social nuances within the text. Wetherell et al. (2014) proposed that language is constantly changing, and discourse analysis provided an opportunity for the researcher to discover if differences in
the language existed, or if the language remained static over time (Wetherel et al., 2014). According to Schreier (2012), the interpretation of language through discourse analysis does not characterize reality, but discourse analysis can contribute to the construction of what is true about advocacy with the support of observed nursing action.

The analysis included open coding and a priori coding (Blair, 2015) to position the study toward the theoretical framework developed by Pecanac and Schwarze (2018). The analysis employed is considered and is understood to be a fit for this paradigm as a technique to interpret the findings (Blair, 2015; Saldaña, 2016). As a result, the strength of this design serves the nursing profession in the acquisition of connections between known education and the observed performance according to literature.

**Research Context**

The wide use of nursing textbooks is reflected in the supply and demand of the accelerated growth of the registered nursing (RN) profession in the United States (Harun, Martiniano, Rodat, & Moore, 2016). In an analysis reported by Harun et al. (2016) on behalf of the National Center for Health Workforce, there is an expected growth of RNs substantially across all states. Currently, at the national level, the growth of the profession is projected to exceed the demand of nurses, overall, by the year 2030 (Harun et al., 2016). In New York State (NYS), RNs lead the way as being the largest profession within the health care industry, and in 2016, they were reportedly balanced between supply and demand (Armstrong & Moore, 2016).

While supply and demand are relatively balanced, the U.S. Bureau of Labor Statistics (2019) reports that health care services will increase because of an aging population. The need for additional RNs is expected to grow by 15% by the year 2026.
In 2017, New York State, alone, licensed 17,215 RNs (New York State Education Department [NYSED], 2018). Consequently, nursing programs across NYS are listening to this projection by continuing to offer a diverse array of nursing education programs to prepare students for a career in nursing (Nursing.org, 2018).

Nursing education programs are formal and are meant to lead to an academic degree (Hicks & Patterson, 2017). Johnson & Johnson (2018) reported that in the United States, approximately 2,043 nursing schools provide nursing training. Of those reported, 674 are at the bachelor’s level (American Association of Critical Nurses [AACN], 2018). According to NYSED (2018), there are 60 nursing schools offering a nursing program at the baccalaureate level in New York State. The education provided at the baccalaureate level in nursing incorporates professional training along with liberal arts courses (AACN, 2018). Academic degrees in nursing convey to those receiving services that there is a mastery of knowledge contained within the discipline (Hicks & Patterson, 2017). Therefore, it is important to critically evaluate the nursing curricula and consider revisions as evidence is presented when educating nurses (Benner, 2012).

The role of nursing is changing significantly and is demanding a call to transform how nurses are being educated (Valiga & Ironside, 2012). While technology is influencing how students are engaged with course material, in a study conducted by Mennenga (2016), nursing students overwhelmingly preferred the use of textbooks over digital media. Whether printed or digital, textbooks have remained, historically, the primary source for educating nursing students (Fowler, 2017). Because nursing textbooks strongly influence student learning, the rigor of the information presented about advocacy
is called into question (Mennenga, 2016). Nursing students are expected to be clinically prepared to meet the demands of a culturally diverse population to advocate for their needs, yet there remains a practice-education gap that challenges RNs who are practicing advocacy today (Benner, 2012; National League of Nurses ([NLN], 2019).

**Sample**

A purposeful sample of four fundamental nursing textbooks from the years 2012-2019 was collected in digital and hard-copy format (Creswell & Poth, 2018). The content of these textbooks was hypothesized as being similar, although there may have been subtle differences. While there were subtle differences in the textbooks about advocacy, the following three criteria were used for data collection: the textbooks were written for beginning-level (fundamental) nursing students, the textbooks were the most recent editions being used in nursing schools in the Rochester, NY region, and the sales figures indicated that these textbooks were widely used in fundamental nursing programs.

Fundamental nursing textbooks pedologically represent a relationship between the program curriculum and the expected knowledge that nurses should be able to demonstrate after completing a formal nursing program. According to Gazarian et al. (2016), nursing advocacy is not being taught consistently. Nurses are reportedly learning advocacy after the completion of their nursing programs and while in they are in practice (Gazarian et al., 2016). Because of the educational gaps observed, effective nursing advocacy requires more research. With the study of nursing textbooks, there are no implications or confidentiality concerns for the protection of any individuals. The study used aggregated advocacy textbook data.
The textbooks used in this study were approximately 787-1,863 pages in length. The chapters selected were those linked with patient advocacy data, and they were examined through Pecanac and Schwarze’s (2018) theoretical framework to determine if nursing advocacy was presented with: (a) responsibility to support patient autonomy regarding treatment decisions, (b) responsibility to protect the patient from the physician, (c) responsibility to act as an intermediary between the physician and the patient, and (d) responsibility to support the well-being of the patient. However, a potential problem identified with the sampling was the use of generational textbook editions. There was a possibility that the data had deteriorated over time because of the availability of specific advocacy text.

**Bracketing: The Researcher as the Instrument**

The researcher sought to determine the value of advocacy information found in four fundamental nursing textbooks, using a discourse analysis approach while applying Pecanac and Schwarze’s (2018) four themes as a lens through which to answer the research questions. The textual data was reviewed to gain an understanding about how authors have addressed advocacy, how advocacy has been defined, and if there are variations that exist between textbooks.

The primary instrument was the researcher. Because the researcher was the primary instrument, data were gathered until saturation was met (Saldaña, 2016). Employing a qualitative study involving coding as a research methodology, the researcher was cognizant of bias and the effects of the validity of the study. The development of the coding and memo writing was subjective, while interpretation was recognized as being a privilege to the researcher. Therefore, bracketing of presumptions
to set aside personal experiences was completed with great frequency to allow for an open perspective during the examination of the textual data (Creswell & Poth, 2018).

Procedures for Data Collection and Analysis

Data collection. The first step was contacting 11 nursing schools in the Rochester, NY region to identify the textbooks used in their schools for initial nurses’ training. The second step narrowed the list down further by contacting Barnes & Noble Inc. to support that the textbooks being used in the Rochester, NY area represented similar nursing programs across the nation (Barnes & Noble representative, personal communication, May 15, 2018). In 2017, four textbooks and nine editions of fundamental nursing textbooks used in the Rochester, NY area were the most purchased fundamental nursing textbooks in the United States. For this reason, the four books listed in Table 3.1 were chosen for this study.

Data analysis. To assist the researcher in managing and analyzing the data, the data was placed in a PDF searchable format, and it was also saved as an image. According to Creswell and Poth (2018), attention should be paid to the storage and security of data as this is frequently overlooked. The data are stored in two different formats that assisted in the organization of the data collected by recording codes in the margins of the PDF and then also giving the researcher the ability to view the document while in an image format. The codes generated allowed for a mechanism to document the analysis process and explain the results, such as when themes were identified, thus increasing credibility by applying multiple codes to the same section of text (Saldaña, 2016).
<table>
<thead>
<tr>
<th>Year</th>
<th>Title</th>
<th>Author/Publisher</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>North Carolina Concept-Based Learning</td>
<td>Pearson Education</td>
</tr>
<tr>
<td>2015</td>
<td>Nursing: A Concept-Based Approach to Learning</td>
<td>Pearson Education</td>
</tr>
<tr>
<td>2019</td>
<td>Nursing: A Concept-Based Approach to Learning</td>
<td>Pearson Education</td>
</tr>
<tr>
<td>2012</td>
<td>Fundamental of Nursing: Concepts, Process, and Practice</td>
<td>Kozier</td>
</tr>
<tr>
<td>2016</td>
<td>Fundaments of Nursing: Concepts, Process, and Practice</td>
<td>Kozier &amp; Erb</td>
</tr>
<tr>
<td>2009</td>
<td>Fundaments of Nursing</td>
<td>Potter &amp; Perry</td>
</tr>
<tr>
<td>2013</td>
<td>Fundaments of Nursing</td>
<td>Potter &amp; Perry</td>
</tr>
<tr>
<td>2017</td>
<td>Fundaments of Nursing</td>
<td>Potter &amp; Perry</td>
</tr>
<tr>
<td>2011</td>
<td>Fundamental of Nursing: The Art of Science of Nursing Care</td>
<td>Taylor</td>
</tr>
<tr>
<td>2015</td>
<td>Fundamental of Nursing: The Art of Science of Person-Centered Care</td>
<td>Taylor, Lillis, Lynn, LeMone, &amp; Lebon</td>
</tr>
<tr>
<td>2019</td>
<td>Fundamental of Nursing: The Art of Science of Person-Centered Care</td>
<td>Taylor, Lillis, &amp; Bartlett</td>
</tr>
</tbody>
</table>

Two forms of coding textual data from the textbooks were used to provide an evaluation with a clear, purposeful, and systematic schema. The following procedure included open and a priori coding for data analysis:

1. Examine the sample of text, pictures, figures, and tables.
2. Prepare the textual data for analysis.
4. Open code the textual data.
5. A priori code the textual data according to templated code book.
6. Collect and examine the codes to categorize and place them into concepts/themes.
7. Interpret the results.
The textual data that derived codes came out of complete paragraphs, figures, tables, and pictures. Pictures were analyzed with regard to pictorial messages about advocacy and in sections where they were located within the textbooks. Non-textual analysis was based on all pictures of people who were perceived to be engaging in advocacy between nursing students, patients, or each individually. Coding specifically was based on the perception of the researcher, which was similar to what would be perceived by the reader of a fundamental nursing textbook. Pictures including more than one representation of advocacy were counted as individual within the characterized group. Textual and pictorial information that was not analyzed in cases where there was no connection with advocacy.

Successful analysis of the data required the ability to manage a large amount of data (Creswell & Poth, 2018). To decrease the amount of data to a manageable level, data that was not relevant was eliminated from the study, while it was initially reviewed. The large data sets were placed in developed coding diagrams to provide a visual representation of similar codes, and by stringing together the coding diagrams to develop categories in broad units of information, the aggregated codes formed shared thoughts, concepts, or themes for analysis (Creswell & Poth, 2018; Gee, 2014). The analysis of the textual discourse data included the development of a code book, also known as a priori coding, to provide a means to categorize that data and ultimately identify concepts and themes. The a priori codes were based on the following thematic framework developed by Pecanac and Schwarze (2018):

- Responsibility to support patient autonomy regarding treatment decisions
- Responsibility to protect the patient from the physician
• Responsibility to act as an intermediary between the physician and the patient
• Responsibility to support the well-being of the patient

The process of data coding as an approach was a descriptive form of analysis and was optimal for use in studies where priority is given to the participant’s voice. In this case, the voice was the textbook (Saldaña, 2016). Initially, the data was read and open coded (Creswell, 2014). Phrases and text that called for bolding, underlining, or have a vocal emphasis, if read aloud, was the basis for the codes, while considering representation of the acquisition of nursing advocacy skill (Saldaña, 2016). When opening coding, it was the intent of the researcher to resist using any predetermined code book terms. Instead, the researcher allowed the meaning of the data to emerge independently. During this initial read, the researcher wrote memos noting emerging thoughts and observations (Blair, 2015).

While using a priori coding, three passes were used to analyze the data, using the codes that were preestablished. The purpose for using three passes to analyze the data was to become intimate with the data by reading it multiple times (Blair, 2015). The data was read, allowing for time to pass between reads, to limit any bias that may have developed from the previous reads. During each pass, each line was coded. As the data was being analyzed, the theoretical framework developed by Pecanac and Schwarze (2018) guided the study regarding the issues that were important to examine to answer the research questions (Creswell, 2014).

The two coding approaches were selected to provide a mechanism to find meaning. Open coding assisted in discovering meaning without any preconceptions, while the use of a priori coding drew meaning from an already established theoretical
framework. While there are not specific rules about coding, it was recognized that the researcher was positioned subjectively, influencing the process of coding. Words and phrases were singly identified by the researcher, and the context of each word required cohesive interpretation to find the true representation of the interrelated nuances of the language used by the authors (Creswell, 2014; Gee, 2014, Wetherell et al., 2001). In other words, codes coming out of the large amounts of data contained in the fundamental nursing textbooks required a focus by the researcher about how the language was being used through the identification of patterns within the text (Mertens & Wilson, 2012). The patterns identified drew upon existing the discourse about advocacy to conceptualize and provide information about how language defines and addresses advocacy, compared to related textbooks across a continuum of editions and years of publication (Wetherell et al., 2014). The organized patterns or frequency counts of the codes assisted in identifying these themes to address the research questions (Saldaña, 2016).

Throughout the study, attention to qualitative validly was of importance for the accuracy of the findings. According to Creswell (2014), validity is a strength of qualitative research, while reliability indicates a consistent approach. Steps employed in this study were the use of triangulation, self-reflection, convergence, agreement, and linguistic details (Creswell, 2014; Gee, 2011). Triangulation was demonstrated by the examination of several textbook resources to build justifiable themes (Creswell, 2014). Creswell (2014) also suggested, to dispel any bias from the researcher, self-reflection to create a genuine open narrative that would resonate with the reader.

According to Gee (2011), validity of a discourse analysis is supported by three main criterium: convergence, agreement, and linguistic details. Convergence was
demonstrated when answers to the research questions aligned with the analysis, as well as when agreement was congruent with the findings when compared to other research studies. When differing conclusions resulted, however, Gee (2011) encouraged the researcher to remain transparent by reporting fully how the language is used in relation to how the language was used and identified according to the author of the text.

**Summary of Methodology**

An interpretive discourse analysis was used to study fundamental nursing textbooks, and it was the most suitable method for the purposes of this study of nursing advocacy texts. Four textbooks were chosen to reflect a purposeful sample of the nursing textbooks most widely used in the profession. Two forms of coding were used to analyze the textbooks. The essence of this study was to determine how authors of fundamental nursing textbooks prioritize nursing advocacy text, pedagogically, to answer the three research questions.
Chapter 4: Results

Introduction

Fundamental nursing textbooks provide nursing students with information that includes professional values. Additionally, images in textbooks communicate symbolic interpretations of data, values, and information. To be sure, how a text is constructed determines how all of these elements are prioritized pedagogically. An important aspect of fundamental nursing textbooks is to teach nursing students about advocacy issues and contextualize the topic for nursing students. A qualitative discourse analysis study was conducted on how textbooks develop advocacy literacy. This analysis may benefit educators, authors, and nursing students, among others.

Research Questions

The analysis sought to answer the three research questions:

1. Do fundamental nursing textbook authors define nursing advocacy?
2. If fundamental nursing textbook authors define nursing advocacy, are there variations among the authors regarding nursing advocacy?
3. What principles do fundamental nursing textbook authors propose to guide the action of nursing advocacy?

Data Analysis and Findings

The analysis was performed by coding the textual data from fundamental nursing textbooks as depicted in Table 4.1. Gee’s (2011) discourse analysis framework was applied to specific sections of the text in all four of the textbooks. Because discourse
analysis requires relevant pieces of sampling for a detailed analysis, relevant passages of the texts were chosen from larger sections within each textbook for the data set, as described in Chapter 3. Text quotations are provided to allow for a deeper understanding and illustrate and contextualize the text.

Table 4.1

Textbooks Chapters by Chapter or Module

<table>
<thead>
<tr>
<th>Edition</th>
<th>Concept Based</th>
<th>Kozier/Erb</th>
<th>Potter/Perry</th>
<th>Taylor</th>
</tr>
</thead>
</table>
Table 4.2 and Table 4.3 demonstrate how the coding produced the themes using a multistep manual coding process. The first column lists a priori codes derived from the theoretical framework. After similar codes were organized, analytic categories were developed using verbs to denote actions. The patterns of codes were redefined for clarification through the development of assertions as understood by the researcher. The text was then organized comprehensively and revisited, again, to assist in the development of the themes to represent an analysis to fit the finding.

Research Textbooks

Four fundamental nursing textbooks were analyzed in this study; each represented a discourse about advocacy. An overview of the textbooks that were sampled is found in Table 4.1.

Textbook descriptive data. The study textbooks consisted of four fundamental nursing textbooks published from 2009-2019. A formal request was made to the St. John Fisher Library for an interlibrary loan. Textual data related to patient advocacy were identified in each textbook, and all the data were received in a PDF-searchable format. A total of 223 pages were contained in the data set. The sample of textual data in reference to patient advocacy was found in all four fundamental nursing textbooks. One out of the four textbooks addressed advocacy in one chapter entitled, “Advocacy,” while the remaining three addressed advocacy under chapters entitled, “Ethics, Values, and Advocacy” and “Community Health Nursing.” A synopsis of textbooks follows.
Table 4.2

Data Analysis Process

<table>
<thead>
<tr>
<th>Framework Supported by Textual Data by Pecanac and Schwarze (2018)</th>
<th>Themes Observed from the Data</th>
<th>A Priori Codes Based on the Pecanac and Schwarze (2018) and Additional Literature Review</th>
<th>Categories Derived from Experimental Data</th>
<th>Assertions Derived from Experimental Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Responsibility to support treatment decisions.”</td>
<td>The textbooks encourage nurses to support patient autonomy regarding treatment decisions.</td>
<td>Responsibility Assist Understand options Protect rights Self-determination Support Decision Making</td>
<td>Maintain ethical Obligation</td>
<td>The nurse has an ethical obligation to maintain advocacy.</td>
</tr>
<tr>
<td>“Responsibility to support patient well-being.”</td>
<td>Fundamental nursing textbooks indicate that nurses should support the patient’s well-being.</td>
<td>Responsibility Well-Being Recognize Patient independence Outcomes Based on Nursing Service</td>
<td>Educating Encouraging Anticipating Needs Leading to Successful Outcomes Monitoring Leading to Satisfaction Ensuring Respect Cultural Competency</td>
<td>The Nurse advocates and anticipates the needs of the patient.</td>
</tr>
<tr>
<td>“The responsibility to act as intermediary between physician and patient.”</td>
<td>The textbooks are inadequate in delivering the information needed to act as an intermediary.</td>
<td>Responsibility Communicate with Physician Speak on Behalf of the Patient Collaboration Intermediary</td>
<td>Assisting Balancing Representing Speaking Mediating Conforming to Identity Role (function vs. identity) Intervening</td>
<td>Nurses advocate by assisting within the healthcare system. The nurse must intervene on behalf of the patient.</td>
</tr>
<tr>
<td>“The responsibility to protect from the physician”</td>
<td>The textbooks instruct nurses to protect the patient.</td>
<td>Protect from Physicians Physician Final Decision Making Retribution Paternalism Patient Protection</td>
<td>Championing Social Justice Clarifying Protecting s an Action to Protect Defending</td>
<td>The role of the nurse is to support and defend the patient. The role of the nurse is to protect the patient.</td>
</tr>
</tbody>
</table>
Table 4.3

*Additional Themes from Absence of Data*

<table>
<thead>
<tr>
<th>Theme Observed from the Absence of Experimental Data</th>
<th>A Priori Codes Based on the Pecanac and Schwarze (2018) and Additional Literature Review</th>
<th>Categories Derived from Experimental Data</th>
<th>Assertions Derived from the Absence of Experimental Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy definitions in fundamental nursing textbooks are inconsistent.</td>
<td>Nursing advocacy provided to patients is not consistent because of a lack of a consistent definition.</td>
<td>Responsibility to balance potentially contradictory to advocacy objectives.</td>
<td>Responsibility to balance ethical guidelines and legal ramifications or other forms of reprisals.</td>
</tr>
<tr>
<td>Fundamental nursing textbooks do not address potential legal ramifications in their decisions about when and how they advocate for patients.</td>
<td></td>
<td>Responsibility to contextualize advocacy within a hierarchical authority framework.</td>
<td></td>
</tr>
</tbody>
</table>
**Nursing: A Concept-Based Approach.** This text, published by Pearson Education in 2019, was the third edition of this volume. The chapters in the textbook are referred to as modules instead of chapters and the textbook presents advocacy as a single subject under Module 43, situated in a section near the end of the book. Additionally, advocacy is presented in a table under cellular regulation, and it is used as a concept that is required in an example about schizophrenia. The author instructs the nurse to facilitate an environment with sufficient information so that the patient is able to make an informed choice about treatment options.

In Module 43, the author gives an outline of the content of the chapter. The outline is structured by the advocate’s role, advocacy interventions, concepts related to advocacy, and unethical or unsafe practice or unprofessional conduct. This is followed by several pages illustrating the concept of advocacy, which is described as integral to the role of the nurse and is supported by the ANA publication of *Code of Ethics for Nurses with Interpretive Statements* (2015) and *The ICN Code of Ethics for Nurses* (2012).

Module 43 provides foundational information for fundamental nursing students about advocacy. It is presented as a service that is in response to patient need, with subsequent subsections designed to assist the nursing student to contextualize advocacy as an action to deliver high-quality care with a basis in nursing ethics and moral responsibility.

Three images in this module provide a visual depiction of advocacy for the student nurse. The three images orient the student nurse toward advocacy in the clinical settings. The first image depicts providers (a physician and a nurse) assisting a Hispanic immigrant family in finding resources. The second image illustrates a story of a nurse
who coordinated a volunteer to play with a pediatric patient, while the third image demonstrated a female nurse of color assisting an elderly White patient out of bed in a clinical setting. With these images, the authors imply advanced advocacy skill for the student nurse to include a focused knowledge in a variety of settings.

*Fundamentals of Nursing: Concepts, Process, and Practice.* This text by Kozier, and Erb (2016) includes a chapter entitled, “Values, Ethics, and Advocacy” where advocacy first appears. The learning outcomes address the role of the nurse during advocacy. Following the outcomes, is the introduction, followed by topics related to essential nursing values and values clarification. The introduction of advocacy is presented throughout the chapter, interspersed with values and ethics topics. The advocacy text begins on the second-to-last page of the chapter with only five paragraphs dedicated to advocacy.

Chapter 8, entitled, “Home Care” (p. 144), describes advocacy as a concept under the “role of the nurse” and is not identified as a learning outcome for the chapter. The idea of advocacy is presented as “beginning on the first visit” (p. 146) and is linked to a broad application of care specific to the medical needs of the patient within the home. Nurses who advocate are characterized as the primary person who ensures the rights and desires of the patient are supported. Thereby skill is developed in the nurse. The nature of this skill is also related to collaborating with other care providers to improve care.

*Fundamentals of Nursing.* Chapter 1 of Potter and Perry (2017) includes advocacy as a key term and is entitled, “Nursing Today.” Nursing advocacy is next discussed under the “Scope and Standard of Practice.” It is situated as a professional responsibility and role of the nurse as a concept and key component to protecting the
patient and the patient’s health care rights. Following Chapter 1, advocacy is next addressed in Chapter 3 under “Community-Based Nursing Practice.”

In Chapter 3, the nurse, as a patient advocate, is discussed under nursing competency. The nurse as a patient advocate is characterized as being more important in community-based nursing because of the complications within the health care system in securing health care resources to overcome health challenges. The final area where advocacy is addressed is Chapter 22, entitled, “Ethics and Values.” Advocacy is presented as central to the role of the nurse, including remaining skilled about affordable care in the community to result in and ensure positive outcomes for patients.

*Fundamentals of Nursing: The Art and Science of Nursing Care.* In Taylor, Lynn, and Bartlett (2019), advocacy is found intermittently as part of nursing interventions for patients throughout Chapter 7, “Legal Dimensions of Nursing Practice”, and Chapter 17, “Implementing.” Chapter 6, however, is the first chapter where advocacy is presented under the title “Values, Ethics, and Advocacy.” Of the 10 learning objectives beginning the chapter, the authors focus on advocacy in one out of 10 objectives, with advocacy listed as a tenth objective. In this chapter, the authors suggest that the nursing student will be able to describe three typical concerns of the nurse advocate.

Advocacy in nursing practice is described at the end of this chapter. In this section, advocacy action provided by nurses for patients is by the nurses protecting and supporting patients’ rights. Subsequently, advocacy is described and discussed as representing patients and promoting self-determination. In this chapter, a great emphasis is placed on advocating for the vulnerable patient who is in need of advocacy due to being incapacitated and in a vulnerable state. Student nurses are urged to pay close
attention to the needs of the patient, including what they need from both a physical and psychological perspective.

One image within this textbook related to advocacy is located in Chapter 6, “Values, Ethics, and Advocacy,” and speaks to the view of the new nursing student, stating that advocacy is primarily provided to those in a calm and quiet environment. In this particular image, the nurse, White and middle-aged, is providing healthcare information to a female person of color. The image depicts a structured role without challenges that are freely accepted by the patient and the multidisciplinary team.

Findings

The findings of this study were identified by six of the following themes: (a) advocacy definitions in fundamental nursing textbooks are inconsistent, (b) the textbook authors encourage nurses to support patient autonomy regarding treatment decisions, (c) fundamental nursing textbook authors indicate that nurses should support patient well-being, (d) the textbooks are inadequate in delivering the information necessary to act as an intermediary, (e) the textbooks instruct nurses to protect the patient, and (f) fundamental nursing textbooks do not address the potential legal ramifications in nurses’ decisions about when and how they advocate for patients. To further explain the themes, examples from the researcher’s own knowledge from a network of nursing professionals and the numerous codes, which were identified speak to the tremendous responsibility with which nurses are tasked when advocating for patients to illustrate how advocacy is not a simple, one-time act. In Table 4.4, the complexities of the codes are demonstrated, with descriptions of the codes and examples from the text, creating a basis for the themes that were derived.
### A Priori Code Book

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Example from Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Acting as an agent</td>
<td>One who pleads the cause of a patient’s rights</td>
</tr>
<tr>
<td>2.</td>
<td>Communicating</td>
<td>Exchanging or sharing information</td>
</tr>
<tr>
<td>3.</td>
<td>Acting as an intermediary</td>
<td>Acting on behalf of the patient</td>
</tr>
<tr>
<td>4.</td>
<td>Assuring responsibility</td>
<td>Being accountable for your patient</td>
</tr>
<tr>
<td>5.</td>
<td>Ensuring patient well-being</td>
<td>A state of being comfortable</td>
</tr>
<tr>
<td>6.</td>
<td>Defending of rights</td>
<td>Authority to defend rights</td>
</tr>
<tr>
<td>7.</td>
<td>Preserving</td>
<td>Maintain original state</td>
</tr>
<tr>
<td>8.</td>
<td>Representing</td>
<td>An intervention to help patients obtain services, rights, and benefits that would not otherwise be received</td>
</tr>
<tr>
<td>9.</td>
<td>Safeguarding</td>
<td>The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, and/or illegal practice of any person</td>
</tr>
<tr>
<td>10.</td>
<td>Speaking for the patient</td>
<td>Speaking for the patient</td>
</tr>
<tr>
<td>11.</td>
<td>Building relationships</td>
<td>Make an effort to offer attention to the patient</td>
</tr>
<tr>
<td>12.</td>
<td>Educating</td>
<td>Training of information</td>
</tr>
<tr>
<td>13.</td>
<td>Informing</td>
<td>Provide facts or information</td>
</tr>
<tr>
<td>14.</td>
<td>Caring</td>
<td>Communicating kindness and concern for others</td>
</tr>
<tr>
<td>15.</td>
<td>Protecting a voice</td>
<td>Right of the patient to have a voice and be heard</td>
</tr>
<tr>
<td>16.</td>
<td>Interceding</td>
<td>A go-between on another’s behalf</td>
</tr>
<tr>
<td>17.</td>
<td>Advising</td>
<td>To offer a suggestion</td>
</tr>
<tr>
<td>18.</td>
<td>Opposing unethical/incompetent treatment</td>
<td>Acting immorally and not having the skill to be successful</td>
</tr>
<tr>
<td>19.</td>
<td>Guiding self-determination</td>
<td>A process to control one’s own fate</td>
</tr>
<tr>
<td>20.</td>
<td>Supporting patient dignity</td>
<td>A state of being worthy of respect</td>
</tr>
<tr>
<td>21.</td>
<td>Empowering</td>
<td>Power given to someone</td>
</tr>
<tr>
<td>22.</td>
<td>Aligning representation</td>
<td>Speaking or acting between others</td>
</tr>
</tbody>
</table>
Advocacy definitions in fundamental nursing textbooks are inconsistent. The first research question of this study was how textbooks define nursing advocacy. In answering this question, four definitions emerged. Each of these definitions focused on different responsibilities nurses have: to support treatment decisions, to protect the patient from the physician, to act as an intermediary, and to support the patient’s well-being.

A summary of the advocacy definitions found in each of the textbooks is located in Table 4.5. In earlier editions of all the textbooks, two out of the four textbooks did not offer a definition for advocacy. The remaining two, and later editions, defined advocacy in the glossary sections of each textbook. In two textbooks, the definition changed between editions, while in the remaining two textbooks, the advocacy definition remained unchanged. Definitions of advocacy were unique to each textbook with the exception of those of Pearson Education (2019).

In each of the definitions, however, the authors assumed that everyone who reads these definitions understands the meaning. The definitions, at face value, contain some underlying assumptions and questions such as: How far should a nurse go in the directives given in the definition? Who is the individual? Is the definition referring to the nurse or the patient in all instances? Who should come first?
### Table 4.5

**Advocacy Definition**

<table>
<thead>
<tr>
<th>Author</th>
<th>Edition</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Education</td>
<td>Third</td>
<td>Protecting an individual by expressing and defending the individual’s cause on his or her behalf (p. G2)</td>
</tr>
<tr>
<td>Pearson Education</td>
<td>Second</td>
<td>Protecting by expressing and defending the cause of another and an advocate acts to protect the client and defend the client from harm (p. G2)</td>
</tr>
<tr>
<td>Pearson Education</td>
<td>First</td>
<td>No Definition</td>
</tr>
<tr>
<td>Kozier &amp; Erb</td>
<td>Tenth</td>
<td>Individual who pleads the cause of another or argues or pleads for a cause or proposal (p. 1429)</td>
</tr>
<tr>
<td>Kozier &amp; Erb</td>
<td>Second</td>
<td>To promote and safeguard the well-being and interests of the patient or client (p. Glossary)</td>
</tr>
<tr>
<td>Kozier &amp; Erb</td>
<td>First</td>
<td>One who expresses and defends the cause of another (p. 47)</td>
</tr>
<tr>
<td>Potter &amp; Perry</td>
<td>Ninth</td>
<td>Process whereby a nurse objectively provides patient with information they need to make decisions and supports the patients in whatever decisions they make (p. 1307)</td>
</tr>
<tr>
<td>Potter &amp; Perry</td>
<td>Eighth</td>
<td>Process whereby a nurse objectively provides patients with the information they need to make decisions and supports the patients in whatever decisions they make (p. 1296)</td>
</tr>
<tr>
<td>Potter &amp; Perry</td>
<td>Seventh</td>
<td>No Definition</td>
</tr>
<tr>
<td>Taylor</td>
<td>Ninth</td>
<td>Protection and support of another’s rights (p. 112)</td>
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<td>Taylor</td>
<td>Seventh</td>
<td>Protection and support of another’s rights (p. G1)</td>
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In Pearson (2019), the authors defined advocacy as protecting the patient by expressing and defending the patient’s cause on his or her behalf. The authors do not specify the degree to which a nurse must act in advocating for a patient. For example, is raising a question sufficient, or is the nurse obligated to physically intervene to block an interference preventing physical harm? It is not clear how far the nurse should go to protect the patient in the text.

Similarly, Pearson (2019) did not clarify whose rights are to be protected when there are conflicting interests. This is especially important in pediatric nursing where the
rights of the child patient may be in conflict with the rights of the parent. The American Medical Association (AMA, 2018) is clear that children should be vaccinated. Yet, when parents choose not to vaccinate their child for measles after a highly reported outbreak in the area where the child resides, this definition is not clear about who’s notion of protection is privileged—the parents’ or the physicians/medical system. Most agree that the patient should be protected. The question is about who gets the final say and at what level. According to Potter and Perry (2017), the nurse is to provide the patient with information to make an informed decision, then support the patient in that decision. The Pearson Education (2019) text suggests that protecting the patient is defending their cause.

While the text is clear about the need for protection, it did not include when the nurse is also in need of protection. The definition assumes that the patient is the only one who is in need of protection and that the rights of the patient are the only ones that matter. It does not address situations where the rights of the nurse may be in conflict with the rights of the patient. For example, what happens when the individual patient is a White supremacist and the nurse is a person of color? If the patient inflicts verbal or even physical abuse on the nurse, what is her obligation to the patient, and can she advocate for her own rights in that situation? According to these definitions, nursing practice indicates that the nurse has to protect her patient with the same diligence regardless of the patient’s personal or political views. Pearson Education (2019) indicates that the nurse is obligated to protect the patient’s rights as if those rights are never in conflict with the rights of others. This does not reflect the social complexities that can arise.
Kozier and Erb (2016) asked the nurse to *plead the cause* for the patient. In this definition, the authors also suggested that advocacy requires action. What is implied is that the nurse should be intervening on behalf of the patients because the patients are not able or willing to plead on their own. What the authors fail to explain in the text is how and when nurses should advocate for patients. Additionally, it is not clear how persistent the nurse must be in pleading the patient’s cause and whether there is a point at which the nurse can cease advocating. The implication is that the nurse will always know when and how persistently to advocate. The example below illustrates how advocacy is not a simple, one-time act:

Julia notified the physician on call that her patient’s condition had dramatically declined. Her patient was presenting with severe gastrointestinal symptoms that included increased rectal bleeding. Complicating the situation further, the patient held religious beliefs that limited treatment options, including accepting a blood transfusion. The nurse telephoned the physician, describing the condition of the patient. The physician became verbally curt and dismissive, communicating that no more interventions could be made based on the wishes of the patient. The physician told the nurse to continue the current physician’s order and ended the call. Later, the physician arrived at the patient’s room to evaluate the condition of the patient. Because the nurse was seeking further intervention for the patient to alleviate her suffering, she asked to speak with the physician in the hall away from the hearing of the patient. The nurse communicated to the physician that a medical resident shared with her that the patient may benefit from a balloon-assisted endoscopy to stop the bleeding. The physician told the nurse that he would speak with the resident, but also that if she would like to practice medicine, she should return to medical
school. In this example, the question for the nurse is how persistently does she intervene and how does she know intervening on behalf of the patient or pleading for a cause will escalate into a conflict? The authors of the textbooks assume that the nurse understands when, how, and to what level to intervene on behalf of the patient. It also presumes that advocacy by the nurse will be well-received by the physician or other person with whom the nurse is communicating. If the nurse was following the definition presented by Kozier and Erb (2016), the nurse was correct in arguing the cause for the patient, but the nurse was not prepared for the physician becoming dismissive and disrespectful, understanding that the power remains with the physician based on the authority conferred to him/her by the state. Nurses know their patients well, and maybe better than the physician, but they do not have the authority conferred on them at the same educational level as the physician.

Potter and Perry (2017) defined advocacy as a process whereby a nurse objectively provides a patient with information, who needs to make decisions while the nurse supports the patient in whatever decisions they make. First, the authors made an assumption that nurses have an understanding of what constitutes being objective. In the definition, the authors failed to communicate that the information that is provided to the patient should be evidence-based and that it should outline the potential risks and benefits to the patient. The authors also failed to instruct nurses to provide information on all treatment options that are available and that meet the standards of medical care. A nurse cannot provide information on only one treatment option and omit other viable and accepted options.
The obligation to provide information on all medically acceptable treatment options may conflict with a nurse’s own values and personal beliefs. This is especially the case in reproductive health. For example, patients who are facing an unplanned pregnancy must be provided with all treatment options, including continuing or terminating the pregnancy. The underlying assumption in Potter and Perry (2019) is that the nurse is in agreement with all the objective treatment options that are being offered to this patient. However, even if the nurse does not personally agree with terminating a pregnancy, it is the nurse’s obligation to provide all options so that the patient can make an informed choice.

In the second half of Potter and Perry’s (2017) definition, the nurse is asked to “support the patient in whatever decisions the patient makes.” The assumption is that the nurse should support any decision—no matter the harm or outcome for the patient or any other person who may be affected by this decision. For example, the Advisory Committee on Immunization Practices (2019) advises that parents should consider vaccinating adolescents against the human papilloma virus to protect their child against certain cancers caused by this virus. Parents may feel less inclined to vaccinate their children against this virus considering it is not mandated for registration for school. Nurses must educate parents about the risks and benefits about providing the Gardasil vaccine for the prevention of reproductive cancer. However, if the parents choose not to vaccinate their child, the nurse is asked to support the decision of the parent. Although the decision not to vaccinate may not be in the best interest of the patient, it is legal for the parent not to comply with the recommendation. Indeed, in this definition, “supporting
patients” in treatment decisions does not make clear distinctions between legal or illegal circumstances.

Potter and Perry (2017) failed to address the fact that a nurse should not participate in supporting patient choices that are not in accordance with the law or with medical regulations. For example, a 76-year-old retired farmer living in a rural area was being treated in an acute care medical facility for cellulitis of his lower legs. While the nurse was providing care, the patient admitted to taking his donkey’s veterinarian-prescribed Butazolidin to control his arthritic pain. Butazolidin is an anti-inflammatory medication used to treat pain in livestock. The patient described how he divided the tablet into doses he felt would relieve his pain. He did this because the medication prescribed by the veterinarian cost less than the medication prescribed for the patient by his own physician.

If nurses are to support patients in whatever decisions they make, the nurse would validate the patient’s decision to continue this practice. However, taking an equine anti-inflammatory medication was a violation of standard medical practice and of prescribing standards. Additionally, the nurse was alarmed by the risks posed to the patient by this practice and did not support his treatment decision. As Potter and Perry (2017) advised in the definition of advocacy, the nurse educated the patient with information about the risks associated with taking equine medication to advocate for the patient in his decision. In this example, if the patient became angry with the nurse and did not comply, then Potter and Perry’s (2017) advice failed to address the possibility that a nurse may not always be able to support patients in their decisions nor how to manage that conflict.
When defining advocacy, none of the textbooks adequately addressed the potential for conflicts between the recommended medical treatment options and patient self-determination or the individual nurse’s values. Where a treatment decision is adamantly against the philosophies and values of the nurse, the nurse may need to pursue different solutions, including involving the hospital administration for support, law enforcement, or even seeking a different job opportunity.

As an example, Nurse Tracy was working the evening shift in an acute care medical facility where she was caring for Pearl, who was dying with end-stage renal disease. Pearl had made the decision earlier in the week that she no longer wanted treatment for her renal disease, understanding that she would not survive, and she was placed in hospice care. Nurse Tracy attended to Pearl, noting that she had entered into a semi-comatose state and was moaning intermittently. The nurse reported the change in the patient’s condition to the physician, who ordered that Tracy increase the IV-administered Dilaudid (hydromorphone). However, the nurse noted that the patient’s respirations were low and that by giving an extra dose of IV Dilaudid would further decrease her respirations to a point that death would likely result more quickly. The nurse in this situation needed to make a decision about whether to comply with the physician’s order in an attempt to make the patient more comfortable—even though the prescribed level of medication would likely hasten the patient’s death.

In this example, all of the definitions of advocacy in the analyzed textbooks fail to communicate to nursing students that they have options to remove themselves from situations that violate their conscience. Nursing textbooks that are used in the foundational training of nursing practice should be clear about when nurses should refuse
to comply with a physician’s order and what are acceptable options to handle those situations. Otherwise, the nurse is at risk for accusations of, and reprimands for, insubordination.

In the ethical training related to advocacy in nursing supported by the ANA, nurses are instructed that when challenged by violating their moral convictions, nurses may object to participate in care. However, nurses are also reminded that they have an obligation to continue care and not abandon the patient until care can be continued. In the definitions, the authors of the textbooks described advocacy as promoting autonomy and protecting the patient, which is in direct conflict with a conscientious objection. The nurse risks being judged as a coward and, in some cases, depending on at what point of care the nurse objects, is judged to be morally wrong. Advocacy is deemed a positive action, except when nurses are faced with choices that challenge their conscience. While it appears plausible that advocacy may be interrupted by a nurse, it is arguable that a conscientious objection by a nurse as a vehicle may be viewed by others in the health care setting as an excuse for self-interest or discrimination against patients.

Additionally, each of the textbooks analyzed suggests that protecting, promoting the patient’s well-being and treatment choices, and supporting the patient by expressing their wishes assumes that the patient’s choices will not change. Further explanation is needed by the authors that the patient may attempt to manage their care, which includes changing their health care decisions. In essence, the nurse would have to remain with the patient at all times to be fully informed at all times. There are risks for new nursing students to follow indiscriminately the definitions established by these textbooks. For
instance, efforts to protect and speak on behalf of the patient to improve the well-being of
the patient may involve many individuals and have multiple issues.

Nurses who create an environment according to the guidance of the textbooks
should understand that patient advocacy should be flexible enough to align themselves
with potentially rapid changes patients may make in their health care decisions. While the
definitions cause nursing students to assume that there will only be positive results from
their advocacy efforts, depending on the interpretation, deviations from literal
interpretation of the definition is unavoidable.

In situations that are legally and medically appropriate, it may be clearer to nurses
what type and level of advocacy is correct. Yet, new nurses may not have the experience
to determine when not to advocate, when advocacy is appropriate, or when their
advocacy has caused a situation where unanticipated repercussions may occur. The
guidance that is provided to new nurses is described in the textbooks without further
advice to seek expert nursing mentors or supervisors. Nurse educators and authors may
believe that novice nurses may recognize problems and will be able to prioritize the
necessary steps to manage an issue, but a lack of consistent advocacy demonstrates their
limited ability to think independently with the speed and flexibility to adequately support
patient needs. The definitions do not prepare the new nurse to navigate complexities,
such as when there are conflicting situations, and especially when patients cannot speak
for themselves.

The textbook authors encouraged nurses to support patient autonomy
regarding treatment decisions. In spite of the ambiguities of the advocacy definitions
described, across the textbooks there were some common themes. The first is that the
nurse is responsible for supporting patient autonomy regarding treatment decisions. The vulnerability of patients is evident within the health care system. The textbooks analyzed in this study identified this risk for patients who required support and autonomy to make treatment decisions. For example, “The ethics of advocacy require that the nurse honor the patient’s and family's values, preferences, expressed needs, and right to self-determination. The nurse must respect the patient’s and family’s views and honor their traditions regarding healthcare decision making” (Pearson Education, 2019, p. 2717). “It is important to provide the information necessary for patients to make informed decisions in choosing and using services appropriately” (Potter & Perry, 2017, p. 37). “As an advocate, the nurse recognizes the rights of both the patient and his family” (Taylor, 2019, p.113). Kozier and Erb (2016) stated:

An advocate informs clients about their rights and provides them with the information they need to make informed decisions. An advocate supports clients in their decisions, giving them full or at least mutual responsibility in decision making when they are capable of it. (p. 109)

It is apparent from these passages that the patient must be informed of his/her rights and supported by the nurse in their autonomy for self-determination. Otherwise, the patient is at risk for being a passive recipient of health care decisions made by others. Reports of medical negligence are growing in the United States. This creates a climate where patients are more aware of their rights for, not to mention risks of, treatment. With the power of the patient as a health care consumer, the nurse must recognize the patient’s right to autonomy and the ability to make treatment decisions. The right of the patient to
participate in decision making requires that the nurse ensures that patients are well informed and have the ability to make informed choices.

An underlying assumption in the textbooks is that patient autonomy takes precedence over other factors. Drawing from the researcher’s professional network in the next example, Shannon, pregnant, reported to the labor and delivery unit in labor. The physician had determined that for the safety of the patient and her unborn child that she would need to undergo a caesarean section (c-section). Shannon stated to the nurse that she did not want a c-section, saying that she was prepared to go through whatever it took to experience a vaginal delivery. This posed a dilemma for the nurse who had to decide whether or not to support the patient’s autonomy and preference for a vaginal delivery or persuade her patient to acquiesce to the physician’s recommendation that a c-section was the better option. In a situation such as this, according to the textbook authors, a patient’s autonomy should be supported to the extent that it is legally permissible and medically appropriate.

The nurse supported the patient’s autonomy to refuse a c-section by thoroughly educating the patient about the risks and benefits of choosing this treatment option. The nurse provided the information in a way that took into account the physical, emotional, and cognitive vulnerability of a woman in labor. In this situation, the patient then agreed to the c-section. Had she not, the nurse would have supported her decision until the point when the medical risks and benefits changed, and then would have had to revisit the decision with the patient with the new status quo in mind. While supporting the autonomy of the patient appears in the text as a standard of practice, nurses should be prepared for supporting autonomous decision making that is not always a one-time act,
but rather, a process that unfolds over the course of treatment and occurs within the context of building rapport with the patient.

While the emphasis on autonomy is consistent with Western values and healthcare, Kozier and Erb (2016) cautioned nurses that this approach may not be embraced by patients from all cultures and backgrounds:

It is important, however, for the nurse to remember that client control over health decisions are a Western view.

In other societies, such decisions may normally be made by the head of the family or another member of the community. The nurse must ascertain the client’s and family’s views and honor their traditions regarding the locus of decision making. (p. 109)

In these cases, nurses should support autonomous treatment decisions while respecting the patient’s desire to include family or others in the decision-making process. While meeting the legal requirements of medical privacy, the nurse can allow the patient to determine what information should be shared with others and who is present when decisions are made. The nurse may need to hear the decision being stated by the patient to meet ethical requirements, but that does not preclude the inclusion of others, with the patient’s consent, in the discussion. In doing so, however, the nurse must be watchful for attempts to undermine patient autonomy and support the patient should a conflict arise.

In summary, in these textbooks, the authors assumed that the relationship between the patients and the nurse was one where the nurse provided the patients with information that allowed the patients to make autonomous decisions about their healthcare. As a whole, the authors of these textbooks indicated that nursing professionals should support
the patient’s autonomy, when patients are making treatment decisions, by recognizing the patient’s right to choose treatments.

**Fundamental nursing textbooks indicate that nurses should support the patient’s well-being.** In addition to providing information that supports the patient’s decision making, these textbooks also indicate that the nurse has a responsibility to support a patient’s well-being. For example, “The object of all clinical decision-making is decisions that secure the health, well-being, or good dying of the patient and that honor and respect the integrity of all participants in the decision-making process” (Taylor, 2019, p. 110); “Without clear communication, it is impossible to advocate for your patient or to give comfort and emotional support, give care effectively, make decisions with patients and families, protect patients from threats to well-being” (Potter & Perry, 2017, p. 3); “Through advocacy, nurses are champions for their clients. They empower clients and families through activities that enhance well-being, understanding, and self-care” (Kozier & Erb, 2016, p. 429); and Pearson Education (2019) posited:

> Patient advocacy can be defined as a process or strategy for acting on behalf of others (including patients, family, groups, or communities) to help them obtain services and rights that they might not otherwise receive but that they need to advance their well-being. (p. 2715)

Fostering optimum health and well-being of patients in a way that contributes to positive health outcomes is asserted in these textbooks as an important component of advocacy. Yet, what the authors failed to discuss are two important considerations. The first is the unequal power in the relationship that exists between the patient and the health care system. Although a patient may be appropriately informed about, and want to
choose, a particular treatment option, it may not be available to them. Treatments for cancer are a common example of this power dynamic. Patients may want to pursue a particular treatment that is not available to them due to: insurance coverage not being approved; the treatment being part of a clinical trial that selectively includes and excludes patients based on predetermined criteria; and few providers or facilities providing the treatment, resulting in waitlists or geographic inaccessibility of the treatment. In these cases, the nurse may support patients by advocating for access to a particular treatment. If that fails, however, the nurse must counsel the patients about their remaining options and support them in making decisions based on the available treatments.

The second consideration is that the patient is not just a body in need of repair, but a person who also has emotional, social, and, in some cases, spiritual needs that require as much attention as the physical body. Supporting the well-being of the patient requires a nurse to consider these other needs as well. Consider, for example, the case of Linda who presented at the reproductive clinic for her annual gynecological exam. During the visit, she confided with the nurse that her boyfriend had been physically abusing her and she was afraid to continue living with him. The nurse provided Linda with alternate living arrangements for her safety and the safety of her 5-year-old child. While the patient had communicated with the nurse that she was in agreement that she should seek a safer living environment, she was also displaying high anxiety and an inability to cope with her decision.

While the textbooks direct nurses to support the well-being of the patient, they do not speak to cases where the physical well-being of the patient (e.g., seeking safe housing) is not congruent with what the patient is communicating (e.g., high anxiety and
difficulty coping with accessing safe housing). The nurse is tasked to identify a holistic understanding of the patients physical, emotional, and social needs along with an understanding of case law, if the advice the nurse offered is challenged in a court of law. This case is a common example of what occurs when women who are physically abused seek support. The highest risk to physical safety occurs after a woman leaves the abuser. Therefore, the nurse’s desire to get the patient into safe housing may need to be adjusted to support the patient in an acceptable manner to transition to physical safety. By not taking action, the nurse may be endangering the life of the patient and her child.

Nurses are in a unique position to assess and respond to patients’ emotional and social well-being. Nurses often establish long-term relationships with patients where the emotional care of the patient leads to deep knowledge of the patient’s situation and needs. However, this deeper relationship with the patient also poses risks to nurses who are vulnerable to secondary trauma and burnout when working with the most vulnerable and high-needs patients. The textbooks do not warn nurses that they should be prepared to consider their own emotional health and prepare to adopt a position of emotional neutrality, for example, so as to mitigate any effects on the nurse advocate.

The well-being of the patient may create issues with the nurse honoring the patient in decision making. Taylor (2019) suggested that good dying is synonymous with decision making and the well-being of the patient to honor and respect the patient. The term good dying assumes that the nurse is in agreement with the decision of the patient and must support the patient’s choice to respect the dignity, autonomy, and the well-being of the patient, yet this may illicit a response by the nurse to object to this decision based on her own conscience and refusal to continue to provide care to the patient. The
textbooks do not provide the nurse with an option or protocol for how to object appropriately. Instead, there is a risk of unfair burden to the nurse and other colleagues when nurses refuse to continue care or struggle internally, leading to potential long-term negative psychological effects for the nurse because of the conflict in her conscience or treatment by her colleagues.

The textbooks are inadequate in delivering information needed to act as an intermediary. The data in all four textbooks support the premise that nurses should act as an intermediary. Although not always specific about acting as an intermediary between the patient and the physician, specifically, that particular relationship was implied in all texts. Examples of advocacy interventions in which the nurse acts on behalf of patients included: “Taking action to intervene if the nurse has information that a treatment or intervention may violate the patient’s wishes, directives, or best interests, when appropriate” (Pearson Education, 2019, p. 2717); “Expressing patients’ wishes when patient cannot do so for themselves (e.g., during procedures requiring anesthesia/sedation or when patients make a conscious choice to have an advocate act on their behalf” (Pearson Education, 2019, p. 2717); “In mediating, the advocate directly intervenes on the client’s behalf, often by influencing others (Kozier & Erb, 2016, p. 109); “As an advocate, you act on behalf of your patient and secure your patient’s health care rights (Potter & Perry, 2017, p. 3); “The nurse is often involved as an intermediary between the patient and the family, especially when the patient and family have conflicting ideas about management of health care situations” (Taylor, 2019, p. 113); and, again, from Taylor (2019):
Care-based ethics would obligate Jean to serve as an effective advocate for her patient, respecting the nurse’s commitment to be faithful to the nurse-patient relationship. Jean feels from past interactions with the obstetrician that her speaking up will not influence his decision to have the patient put to sleep. She decides to speak with the obstetrician after the delivery and follow-up with whatever approach is necessary to avoid recurrence. (p. 109)

The underlying assumption that the nurse is responsible to act as an intermediary is that the nurse will do so without facing barriers in carrying out this role. The authors did not include in the text that nurses may experience conflict between the physicians, families, and the patient. This can result in the nurse being caught in the middle. Nurses who believe they have relevant information about the preferences of the patient or family may face barriers when acting on that information.

An example from this theme is John, who reported to the nurse that he no longer would like to receive physical therapy while a resident in a long-term care facility. He communicated to the nurse that the therapy was no longer helping him, and he had accepted the fact that he would never walk again. The nurse communicated this to the physician prior to a care-planning meeting to request an order to discontinue the treatment. During the care-planning meeting with the multidisciplinary team, including the physician, the patient reported to the care-planning team that his care was going great and thanked the team for his physical therapy. In this case, the nurse had to decide whether or not to share John’s earlier indication that he wished to stop physical therapy. Doing so would have potentially placed her in conflict with the physician and other members of the treatment team. It also would seemingly contradict John’s own statement
in the meeting. If the nurse followed the definitions and acted as an intermediary, the nurse would be at risk for losing credibility with the health care team by communicating inaccurate information and providing inaccurate patient information.

To be prepared for situations like this, fundamental nursing textbooks need to prepare nurses for how they may be challenged in their daily practice and communications between patients, families, physicians, and other health care providers. Specifically, nurses need to know how to maximize their interactions with clear and consistent communication, especially when speaking on behalf of the patient. Speaking for the patient requires the nurse to be empowered to do so and that the nurse’s role as advocate is respected by other professionals.

It is important that nurses be prepared to take on the role of intermediary. Otherwise, nurses may not be willing to advocate if they feel incapable of influencing decision making. This requires that nurses see themselves, and are seen by other health care providers, as active participants within the multidisciplinary team. Further, empowering nurses in their intermediary role is a shared responsibility of all members of the multidisciplinary team.

Authors of nursing textbooks promote the idea that nursing professionals assume authority by being an intermediary or speaking on behalf of the patient. In the case of an incapacitated patient, acting as an intermediary is the rule. In other cases, relationships between the patient, family, and other health care providers may make the nurse’s authority as an intermediary less authoritative. Either way, nurses’ advocacy task assumes they knows what the patient would have wanted—which is often simply not the case.
The textbooks instruct nurses to protect the patient. All four textbooks instructed nurses to protect the patient from others, and they only inferred that the physician may be the one from whom the patient needs protection. This was noted as especially true for vulnerable patients in need of protection. For example, Pearson Education (2019) stated that, “The overall goal of patient advocacy is to create an environment in which patients can exercise their right to decide, and in which those rights can be protected, regardless of the environment or setting” (p. 2716); “The overall goal of the client advocate is to protect clients’ rights. An advocate informs clients about their rights and provides them with the information they need to make informed decisions” (Kozier & Erb, 2016, p. 109); “As a patient advocate, you protect your patient’s human and legal rights and provide assistance in asserting these rights if the need arises” (Potter & Perry, 2017, p. 3); and “As bridges between vulnerable patients and the resources they need to secure health outcomes, nurses have always been strong patient advocates. Advocacy is the protection and support of another’s rights” (Taylor, 2017, p. 112).

The underlying assumption is that the nurse always knows what the patient wants, that he knows how to exercise his rights, and that the nurse’s knowledge about the patient’s preferences is always current. The admonition to protect the patient assumes that the nurse is to protect the patient at all costs, including costs to the nurse. It is important to clarify what it means to protect the patient. For every case, nurses need to understand that protection is to be congruent with the patient’s medical needs. Special care must be paid to patients who are vulnerable or have a diminished capacity for self-determination.
An example of this obligation is seen in another nurse’s experience during a follow-up evaluation in a pediatric office. Hannah was an 8-year-old child with fetal alcohol spectrum disorder who was unable to participate in diagnostic testing because of an inability to comply with directions for the procedure. Because of her inability to be compliant, the decision was made by her health care provider that she should go under general anesthesia while having a magnetic resonance imaging (MRI) scan. Several days later, after being placed on a ventilator to have the MRI, she complained of chest pain, but her complaints were ignored, and it was explained to her as just having a sore chest and throat from the endotracheal tube placement. Five days later, Hannah was diagnosed with pneumonia and placed in the hospital for intravenous antibiotic therapy.

This example demonstrates the need for the nurse to protect the patient by speaking up when the patient’s complaints are dismissed and those complaints are potential indicators of a medical problem. Protecting the patient includes listening to and taking seriously patients with compromised capacity to communicate their experiences and needs. In this example, the nurse failed to speak up and protect the vulnerable patient.

Supporting the role of the nurse as a patient advocate who protects the patient, Kozier and Erb (2016) portrayed the need for advocacy by picturing an incapacitated patient on a life-support ventilator. Student nurses are asked to protect the needs and rights of the patient, no matter the setting. The textbooks do not specify protection specific to protecting the patient from the physician, yet they suggest that the patient has human and legal rights that the nurse must protect. What the textbooks do not adequately explain is how advocating for the patient can put the nurse in conflict with others, including those who may exercise authority over the nurse. Nurses must be aware of the
risks to their own professional standing and be equipped with strategies to manage those professional risks without compromising their obligations to the patient. Additionally, there is no discussion of when those who are in authority can overrule the nurse, either because they have had conversations with the patient, or the nurse is unaware of other discussions with other clinical staff causing the patient to change his or her decision.

**Fundamental nursing textbooks do not address the potential legal ramifications in nurses’ decisions about when and how they advocate for patients.** While nurses work as advocates in the best interests of the patient, patient advocacy is not necessarily in the best interest of the nurse. In addition to professional risks, when speaking out in opposition to medical providers with higher authority than the nurse, there may be legal ramifications for the nurse. In the case of Nurse Wubble, who followed the guidance indicated in nursing textbooks, a horrifying event resulted when law enforcement used handcuffs to place her under arrest while advocating for her patient. However, none of the textbooks address these types of legal ramifications, or other professional ramifications, such as disciplinary action. The textbooks call on nurses to intervene and protect the patient by representing the patient’s best interests and supporting their wishes without discussion of the fact that this action could potentially result in reprisals.

The authors also failed to provide any guidance around the conflict between nurses intervening to protect the patient when that intervention is in direct opposition to the wishes of the patient. The textbooks do not provide nurses with guidance on how to determine when a situation warrants action, who should exercise the action, and under what leadership framework.
Summary of Results

The study of nursing textbooks began with the exploration of four fundamental textbooks and the discourses surrounding advocacy in the field of nursing. The study was divided into two phases: analysis of the definitions, and identification of the themes within the textbooks. Textual data was found in all four fundamental nursing textbooks. A discourse data analysis was performed by coding the textual data. The common theme across the textbooks was the idea of advocacy and as nurses acting or speaking on behalf of the patient. However, each of the textbooks was unique in how advocacy should be operationalized.

The Pearson Education (2019) textbook instructed nurses to provide the patient with information to encourage them with the ability to make an informed choice, including images for the student nurse to conceptualize the varieties of settings where advocacy should occur. Kozier and Erb (2016) addressed advocacy briefly at the end of a chapter about values, ethics, and advocacy, then again in a later chapter. Advocacy was characterized as a person who ensures that the rights of the patient are supported. Potter and Perry (2017) situated nursing advocacy as a professional responsibility and role that is key to protect the patient and the patient’s rights. Taylor et al. (2019) described nursing advocacy at the end of a chapter, describing advocacy as protecting and supporting a patient’s rights. The image related to advocacy depicted in the Taylor et al. textbook illustrated an uncontested role that was freely accepted by both the patient and the nurse.

Nurses are directed to work as an advocate for the best interest of the patient, yet advocacy may not be in the best interest of the nurse. Legal ramifications exist when nurses speak out in opposition to medical providers or those who are in a higher positions
compared to the nurse. Events significant to the professional welfare of the nurse can result in life- and career-altering results. Each of the textbooks analyzed did not address any type of legal or professional ramifications that nurses should consider when advocating, and those ramifications were identified as missing in the findings.

The findings in the study identified six themes, which emerged from the texts: (a) advocacy definitions in fundamental nursing textbooks are inconsistent, (b) textbook authors encourage nurses to support the patient autonomy regarding treatment decisions; (c) fundamental nursing textbooks indicate nurses should support patient well-being, (d) the textbooks are inadequate in delivering the information needed to act as an intermediary, (e) textbooks instruct nurses to protect the patient, and (f) fundamental nursing textbooks do not address the potential legal ramifications in their decisions about when and how they advocate for a patient. The themes and discourses of patient advocacy found in this study are consistent with those of Pecanac and Schwarze (2018), calling on nurses to feel a responsibility to develop relationships with their patients in a way that promotes patient autonomy, supports well-being, acts as an intermediary, and protects the patient.
Chapter 5: Discussion

Introduction

The purpose of this study was to examine fundamental nursing textbooks to determine how advocacy is defined and how authors guide fundamental nursing students in their role as advocates. The theoretical framework developed by Pecanac and Schwarz (2018) was used as a lens to view the texts using an interpretive discourse analysis of four fundamental nursing textbooks. Analyzing how the discourse surrounding patient advocacy is presented in textbooks can be used to strengthen how nurses are introduced to advocacy.

Chapter 5 is divided into a review and summary of the research study, the implications of the findings, the strengths and limitations, and the chapter ends with recommendations. The principal researcher for this study was immersed in the textual data regarding patient advocacy and was the key instrument in this study. Recognizing that qualitative research situates the researcher personally and uniquely, interpretation of the findings was according to the researcher’s position (Blair, 2015).

Review and Summary of the Research Study

The interpretive discourse analysis conducted of fundamental nursing textbooks was consistent with the findings found in the literature reviewed for Chapter 2. The evidence in the research texts reflects several obstacles to nursing advocacy. These obstacles include a lack of a consistent definition of advocacy, ineffective advocacy education, inconsistent communication skills, numerous barriers, a lack of nurse self-
awareness, and deficient advocacy empowerment (Barlem et al., 2015; Boersma, 2012; Dadzie et al., 2017; Mortell et al., 2017; Oliveira & Tariman, 2009). Additionally, the research results from the literature review uncovered that when nurses are not supported in developing effective advocacy skills, specifically, in overcoming barriers, the potential for effective advocacy is limited (Mortell et al., 2017).

To address the study research questions, the textual data collected from the fundamental nursing textbooks used to train nurses was reviewed for this study. After a discourse analysis and interpretation of the textual data from the sample of textbooks, the results of this study suggest the following themes: advocacy definitions are inconsistent; nurses should support patient autonomy regarding treatment decisions; nurses should support patient well-being; information needed to act as an intermediary is inadequate; nurses are instructed to protect the patient; and potential legal ramifications are missing of nurses’ decisions regarding when and how they advocate for patients.

**Advocacy definition.** Revisiting two of the research questions: Do fundamental nursing textbook authors define nursing advocacy? and If fundamental nursing textbook authors define nursing advocacy, are there variations among the authors regarding nursing advocacy? The present research results are similar to previous research studies: There is a lack of a consistent definition for advocacy. The definition of advocacy was not consistent in any of the textbooks examined in this study. In both the literature and the textbook data set for this study, advocacy definitions vary broadly and are inconsistent. As with the literature, textbook authors have offered their own definition, and they refer to interpretive statements provided by professional organizations as a basis
for agreement that the advocacy role belongs to nursing within the health care system (Hanks, 2013).

In the nursing research literature, nursing advocacy is defined as an intervention to improve the well-being of the patient with ethical undertones as part of a core duty of nursing. Similarly, in the study data, each of the definitions provided by the textbook authors inferred that it is the responsibility of the nurse to support treatment decisions, protect the patient from the physician, to act as an intermediary, and to support the patient’s well-being as part of being a patient advocate. While each textbook author was unique, Pearson Education (2019) included all of the elements of the other textbook advocacy definitions.

**Nursing advocacy education.** In the literature, studies suggest that ineffective patient advocacy is related to a lack of education, whether formal or informally, learned in nursing practice (Boersma, 2012; Vaartio et al., 2009). Deficiencies in advocacy skill were related to nurses’ understanding of the importance of the advocacy role, which in turn alludes to a deficiency in training during nursing school as well as in practice. Interpretation of the study data shows that the inclusion of advocacy text is considered important by authors and. combined with adequate training by the instructors implementing the textbooks, is meant to lead to proficient advocacy skills (Hicks & Patterson, 2017). Nursing textbooks strongly influence student-nurse learning. The rigor in proscription and expectations of the advocacy texts found in the study sample texts revealed an incongruency between the demands of the role and the consistency in training and education. According to the study textbooks, nurses are expected to be clinically
prepared to meet many of the advocacy demands revealed by this study. Yet, consistent with the literature review, there remain pedagogical inconsistencies.

**Effective advocacy communication skill.** The literature review suggests that effective communication skills are essential for nurses while advocating for patients. Essentially, effective communication is found to improve patient outcomes and satisfaction, thus effective nursing advocacy communication skill is evidenced by improved patient well-being (Boersma, 2012). Interpretation of the results of this study supports that fundamental nursing textbooks indicate that nurses should support patients’ well-being in a way that will contribute to positive health outcomes through communication as a component of patient advocacy. The textbook authors encouraged nurses to communicate information to the patient as a means to help them make informed choices about health care treatment options that are available to them for improved outcomes. Interpretation of the data also suggests that the nurse has adequately received communication from the patient. The nurse then, presumably, has the information to always know what the patient wants, how to exercise his rights, and that the knowledge communicated to the nurse is current and correct.

**Barriers.** While caring for patients, ethical dilemmas (at times) are discovered because of the complicated relationship developed between the patient and the nurse. A level of intimacy within the relationship may influence how advocacy is offered by the nurse (Barlem et al., 2015; Dadzie et al., 2017; Mortell et al., 2017; Thacker, 2008). The needs of patients will arise as a matter of natural progression, and the nurse will interact with patients, then work on behalf of the patients to advocate for them. During those opportunities to advocate, risks and consequences have the potential to become a barrier
for nurses to advocate. A number of the barriers that nurses have confronted are described in the literature. The four barriers identified in the literature were knowledge, medical dominance, organizational and administrative, and repercussion barriers. The results of this study indicate that nurses are responsible to act as an advocate; yet, none of the textbooks instruct nurses regarding how to navigate barriers or conflicts.

**Nurse self-awareness and empowerment.** Previous literature suggests that it is important for nurses to recognize how personal emotions have the potential to impact nursing practice. To provide advocacy care effectively, managing emotions is integral to the nurse being self-aware (Boersma, 2012; Cawley & McNamara, 2011; Josse-Eklund et al., 2014). When nurses are self-aware, they have the ability to position themselves to act on behalf of the patient in accordance with the patient’s wishes (Josse-Eklund et al., 2014). According to Josse-Eklund et al. (2014), acting on behalf of the patient allows nurses to experience the empowerment they need to effectively advocate for the patient. The literature also suggests that a fundamental function of empowerment is embracing the role of patient advocate while developing a mature practice (Barlem et al., 2015; Cawley & McNamara, 2011; Heelan-Fancher, 2016). When empowerment is experienced by nurses, then advocacy can be operationalized. Yet, the literature suggests further that while nurses are in a position of power over vulnerable patients, they do not see themselves as empowered in this regard (Cawley & McNamara, 2011).

The textual data for this research study suggests that nurses are assumed to be self-aware and empowered enough to clarify meaning. For example, nurses are expected, in every case, to clarify and understand what it means to protect the patient. Protecting a patient from a literal perspective requires the nurse to be self-aware and have the courage
to act. The study data did not address efforts on the part of nurses to be self-aware and empowered adequately enough to mitigate potential legal ramifications. Nor did the textbooks prepare nurses for potential litigation based on their advocacy actions.

**Implications of the Findings**

Fundamental nursing textbooks are used primarily to educate fundamental nursing students (Albach et al., 1991). Textbooks are a consistent source of information for nurses to learn the expectations of practice in their professional role, including how to advocate for patients. Four fundamental nursing textbooks were sampled for this research study, and they provided text-rich information about nursing advocacy. The following are the categories to address the implications of the findings:

- There is no operationalized definition of “advocacy” within the profession.
- Advocacy education impacts practice.
- Effective communication correlates with patient well-being.
- Barriers prevent the nurse serving as an effective intermediary.
- Nurse self-awareness and empowerment influences the ability of nurses to protect themselves and patients.

**No operationalized definition of advocacy.** Nursing research experts have communicated that while extensive research has been conducted on advocacy, many differing definitions continue to exist. Advocacy is a complex concept, and without a definition for advocacy, inconsistencies in understanding and operationalizing skills will remain. This dissertation opened with a vignette about a nurse who advocated for a patient while working in an emergency room. As a result of her advocacy, Wubbles was arrested and taken out of the facility in handcuffs for not complying with the request from
law enforcement, having chosen to act on behalf of her unconscious patient. While this example ended positively with Wubbles being vindicated in her action to advocate for her patient, this vignette does not correspond to the complexities of advocacy. The implications continue to remain that no matter the number of studies conducted with results about how nurses understand and implement advocacy, without a clear and consistent definition that is specific to advocacy, as depicted in Figure 1.1 of this study, grave risks will remain for nurses and patients. The results of this study imply that should a definition for advocacy be agreed upon within the profession of nursing, the advocacy effect model would likely change to reflect the need for a structure, such as the Code of Advocacy model depicted in Figure 5.5.

**Advocacy education impacts practice.** Advocacy educational information does not adequately address the findings of this study. As a result of this study, 23 advocacy-operationalized verbs were identified in the experimental text. The textbook authors did not provide an educational framework to satisfy the advocacy skill required to meet advocacy action words. Numerous influences that have an impact on the trustworthiness of the educational material have not been addressed, as evidenced by nurses reporting that they learned nursing advocacy while in practice instead of during formal training (Mortell et al., 2017). Because nurses are not learning advocacy in a formal setting, researchers are reporting that nurses then have an inability to understand the importance of engaging in the role of advocate. In response to this dilemma, researchers have identified the need to develop instruments to measure advocacy to determine the effectiveness of operationalized advocacy action in the workplace.
Figure 5.1. Advocacy Effect Model Revised.
Effective communication correlates with patient well-being. Communication is described in the literature as having a direct implication on the well-being and the autonomy of the patient through advocacy (Boersma, 2012; Hanks, 2010a; Walent & Kayser-Jones, 2008). Nurses have verbalized that they have a moral obligation to speak on behalf of the patient, yet nurses have demonstrated fear when implementing communication to speak on behalf of patients (Hanks, 2008, 2010b; Walent & Kayser-Jones 2008). The textbook authors did not provide strategies for effective communication specific to advocacy to improve the well-being or autonomy of the patient. Novice nurses, in particular, were noted in the literature as lacking the inclination to advocate due to poor communication skills (Thacker, 2008). The combination of these findings provides support that there is a disconnect between advocacy communication skills and the ability for nurses to support patients’ well-being and autonomy. The implication of this is that advocacy communication skills may impact the rights of the patient to informed choices. However, concretely interpreted, nurses may also assume that supporting the well-being and autonomy of patients under all circumstances will take precedence over any other factors.

Barriers prevent nurses from serving as an effective intermediary. Barriers pose multiple challenges when advocating for patients, including the ability for the nurse to serving as an intermediary when faced with a medical dominance barrier. The implications of this finding are that while a barrier exists against acting as an intermediary for the patient, the authors of fundamental nursing textbooks did not prepare the nurse for conflicts that might occur. According to the literature, medical doctors will often dominate nurses in the health care setting (Dadzie et al., 2017; Mortell et al., 2017).
The fundamental textbook authors seem to assume that when nurses are acting as an intermediary, they will always be in a position of power.

**Nurse self-awareness and empowerment influences the ability of nurses to protect themselves and their patients.** A correlation between nurse self-awareness, empowerment, and the ability for nurses to protect themselves and their patients is another implication when advocating for patients. The literature describes nurses becoming emotionally invested in the care of a patient, thinking about what is most important for the patient as opposed to themselves. Indeed, nurses often provide care beyond their expected duties (Reed et al., 2016; Vaartio et al., 2008). While nurses provide care to advocate beyond what is expected, health care systems continue to fail to collaboratively develop systems to provide patients’ autonomy and self-determination (Barlem et al., 2015; Cawley & McNamara, 2011). The textbook authors did not include self-awareness in the fundamental nursing textbooks. Therefore, it is plausible that nurses who do not seek self-awareness may not do so because of a lack of knowledge that impacts their ability to protect themselves and their patients. Nurses who are self-aware and empowered are able to act on behalf of the patient effectively with minimized risk to themselves—especially when they are supported by the medical doctor (Jansson et al., 2015; Josse-Eklund et al., 2014). Alternatively, while nurses are disempowered, they are not able to effectively advocate Cawley & McNamara, 2011). The authors of the fundamental nursing textbooks instructed nurses to protect the patient from others, but they did this with the assumption that nurses must protect the patient at all costs and that nurses have the most updated information about the wishes of their patients.
Strengths and Limitations

A strength of this study is that the four sampled textbooks that were analyzed represented the most commonly used textbooks chosen in introductory nursing courses in the geographic area where this author works. Therefore, the analysis of the textbooks was a representation of the local undergraduate nursing education. The analysis is also widely applicable to undergraduate nursing programs in the nation. Despite the strengths of using common fundamental nursing textbooks, it is important to keep in mind the study’s limitations when applying the findings.

One limitation that proved to be challenging was that the sample size of only four fundamental nursing textbooks was small. Because of the large volume of textual data contained in each textbook relating to advocacy, time would not allow for a broader analysis of additional fundamental nursing textbooks. A more in-depth study may have uncovered potential historical changes in nursing advocacy. However, the history of nursing advocacy, while salient, was beyond the scope of this study. In addition, an opportunity for further study might include a number of individual nursing advocacy books that might have been discovered during the course of the research in order to provide more textual data.

The individual advocacy books discovered that were dedicated to nursing advocacy only appeared to be for use by nursing students who were seeking advanced nursing education beyond the fundamental years. While including this textual data may have changed the findings of this study, the use of a small qualitative sample size has often proved reliable. Further study should include a more comprehensive research study with more diverse textual data to aid in the understanding about nursing advocacy in the
profession, as a whole, and how textbook authors influence the practice of nurse advocacy.

**Recommendations**

The themes identified in this study came from the textual data of four fundamental nursing textbooks. Based on the textual data regarding nursing advocacy, a number of recommendations are proposed. The recommendations are offered in the following four domains: nursing advocacy education, nursing practice, organization and policy, and nursing research.

**Nursing advocacy education.** The findings of this study suggest that how advocacy is taught to nurses should be further developed. The textbook authors encouraged nurses to support patient autonomy regarding treatment decisions, indicating that nurses should support the patient’s well-being, and the textbooks instructed nurses to protect the patient. Further, in a study about dementia patients, Boersma (2012) concluded that a nurse requires knowledge and skills to advocate effectively or the patient will be excluded from care services.

This study supports the connection between patients experiencing of lack of care and patient advocacy. Nurses require specialized education to provide advocacy care. Studies by Hanks (2018) indicate that systematic education about advocacy influences patient outcomes, leading to increased confidence by nurses to advocate. According to Hanks (2008), developing an educational advocacy standard, alone, will not ensure that nurses will advocate adequately. Fundamental nursing textbooks should include specific competencies that promote building confidence for nurses by using case studies to improve learning regarding how to advocate for patients more effectively.
A concern identified in the analysis was that advocacy may have repercussions. A more in-depth description is required by textbook authors to teach student nurses how to advocate within organizational rules and expectations for effective advocacy. Otherwise, the consequences for advocating poorly, while well-intended, may have devastating effects on patients. According to the literature, advocacy for a patient requires a focused set of skills that includes the ability to solve a problem, communicate, and collaborate while having an influence on others. Developing these skills requires more than simply reading about advocacy. The education course should include a course description from research-based textbooks where advocacy issues are framed and the barriers that need to be overcome by nurses who deliver advocacy services are described. In addition to the course descriptions, textbook authors should emphasize the acquisition of advocacy skills, such as communication and cultural competency, as tools for implementing strategic education to nurses.

Fundamental nursing textbook authors should also address the fact that nurses are challenged today, more than ever, to navigate a complex work environment. Skills are necessary to understand financial implications, regulatory requirements, quality improvement, and patient safety. Challenges such as these will test nurse decision-making skills when they advocate for their patients. While advocacy can create opportunities for optimum care of patients, it can also put nurses at risk for repercussions. Knowledge and skills are required to prevent putting the onus on the individual nurse to understand the consequences associated with how to maneuver the advocacy system.

Of specific importance is educating nurses about the potential legal ramifications surrounding advocacy according to the laws in the state where they practice. Textbook
authors should include text about the legal ramifications and potential accusations that could lead to charges against nurses. Education about the laws surrounding the actions of nurses and advocacy should occur during this fundamental nursing training. Including case studies and examples of nurses who have been criminally charged while advocating is important. Additionally, textbook authors should instruct nurses to educate their patients and their patients’ families about the laws associated with nursing advocacy and what they could expect from nurses.

Past accusations in the form of case studies should be considered as part of the text in fundamental nursing textbooks. Case studies can be a powerful tool, placing the student in a simulated situation to engage in practice. Nursing advocacy history has multiple powerful cases that are interesting and that will allow for rich learning and discussion. An ideal source of these case studies, however, should be using data that was produced by nurses, from a system developed by nurses, as a resource for nurses to reach out when challenged by advocacy dilemmas.

**Nursing advocacy practice.** Advocacy knowledge garnered by expert nurses is developed as a competency over time. While the textbook authors did not provide adequate information for young nurses to support patient autonomy regarding treatment decisions, support the patient’s well-being, to act as an intermediary, and to protect the patient, according to Hanks (2013), expert nurses have this skill. Expert nurses should be utilized to mentor student nurses during their clinical rotations and to make recommendations about their experiences to textbook authors to improve the development of a fundamental advocacy skillset. Additionally, while using fundamental nursing textbooks, nurse educators can assist in this process by empowering student
nurses to become more independent in their ability to advocate by debriefing with them after a clinical rotation and by examining clinical experiences with expert nurses. Nursing educators who empower their student nurses to develop advocacy skills will support early learning of advocacy by supporting a change to the current conditions where nurses learn advocacy skills in practice, on the job, rather than in a classroom setting, which is arguably ideal.

**Organization and policy.** Nursing advocacy is not merely about developing individual knowledge and skills. There are also organizational and policy changes that can impact the quality of advocacy that nurses provide to their patients. One legislative recommendation would be to lobby Congress to include protection for nurses who advocate for their patients. The Department of Justice and the Health and Human Services Department have fought in federal court, arguing for the protection of vulnerable individuals. Nurses hold a critical role in protecting the rights of those same people, yet there are few protections for nurses. If the ANA were to lobby to propose or make changes in laws by developing legislative proposals with the interest of protecting nurses who advocate, this would demand changes in fundamental nursing textbooks to articulate the need for nurse protection.

Another recommendation is working with the ANA to develop a legal defense department as part of the ANA structure, which would include expert nurses who could mitigate nursing concerns and only refer cases to legal representation when a situation has risen to that level. A majority of the requests for information could be resolved with an intervening expert without the need for legal counsel. The primary goal of the service would be to provide a low-cost legal advice service and a resource for nurses to obtain
legal advice. The advice would be to support nurses when they are faced with advocacy dilemmas, communicating to nurses that they have professional support behind them. This information then could be formatted into an educational text that could be incorporated into future textbooks.

When challenging situations occur between nurses and patients, the literature describes nurses feeling alone and powerless. An example of this is nurses reporting when physicians have become abusive, demeaning, or violent in their behavior. While textbook authors teach nurses to act as an intermediary between the patient and others, including physicians, physicians have been known to throw objects while verbalizing insulting and disrespectful comments toward nurses. The literature supports nurses experiencing a power differential with physicians while either desiring to advocate or while advocating for patients (Dadzie et al., 2017).

Another recommendation is to develop joint policies and positions between the ANA and the AMA so there is a shared understanding of roles and common practices to address professional bullying when it occurs. The partnering between nursing and medicine could be included in the text of fundamental nursing textbooks.

The hope for higher-level changes in advocacy structures would be that nurses’ voices will be heard to also make changes at the organizational level. There is no requirement, universally, to include and attend a shared governance where nurses are able to share their experiences without retribution or sit at the same table as leadership to make decisions relating to patient advocacy. Nurses who are included in advocacy decisions will be more effective and knowledgeable about advocacy to promote the well-being of the patient and the nursing profession. The voice of the nurse working at the
bedside, advocating for the patient, should be clear through the text of fundamental nursing textbooks by participating through shared ideas about advocacy.

A final policy recommendation would be a nursing Code of Advocacy (Appendix). The proposed code would serve as a guide of principles for professional nurses to follow to assist in the conduct of advocacy. The Code of Advocacy document would outline the advocacy practice of the nurse, and how nursing professionals are supposed to approach advocacy issues based on professional standards that are supported by nursing research and held by the nursing profession. While the proposed code is a first attempt at providing a professional standard of advocacy, it ultimately does not matter exactly what code is adopted by any given organization, but that organizations adopt some form of a policy code. The proposed Code of Advocacy is an example of what one might use as a basis for further development.

Nursing research. The lack of a consistent advocacy definition is an important finding, especially with the increasing complexities in the current health care system and the issues for patients who require knowing when advocacy practice should be implemented by the nurse in practice. Without a consistent definition, nurses who wish to advocate based on an adopted and conceptualized expected work performance will continue to advocate inconsistently and on a more personalized and case-by-case manner than by means of an advocacy protocol that is standardized by the profession. In order for nurses to practice advocacy effectively, further research is required to better understand how nurses, themselves, understand and practice advocacy.

Specifically, further research is warranted in three areas. First, an additional theme that emerged from the data is that fundamental nursing textbooks are inadequate in
delivering the information needed to act as an intermediary between the physician and others. Textbook authors in this study communicated that nursing students and professional nurses were obligated to intervene on behalf of the patient, yet they did not address whether the nurse was putting the safety of the patient above their own. Furthermore, the authors did not discuss what is possibly at stake for the nurse regarding power relations and consequences when nurses advocate for patients in opposition to those in a higher position, or how policies could be implemented for the practical protection of nurses who are at risk when organizations are unwilling to protect them.

Textbook authors in this study, for example, addressed the need for nurses to advocate for children, who are a naturally vulnerable population. To better understand how nurses can navigate those conflicts, research to help understand the power dynamics surrounding nursing advocacy is needed. The research questions might seek to understand how nurses feel, what they would do to intervene if it happened to a coworker with whom they were close, and with whom would they talk if it were happening in their presence.

Second, as healthcare needs increase, such as with a pediatric obese population or those who are exposed to violence, nursing requires a collaborative, multidisciplinary approach. Understanding the protection of vulnerable populations, it is important to recognize three levels of accountability. First, the nurse is responsible for protecting the safety of a child (or other vulnerable patient) to promote their well-being. Second, the nurse is responsible to the institution for whom she works. Third, the organization is responsible for the actions of the nurse. The textual data to date has not adequately explored how these responsibilities should be managed when they are in conflict with one another. To better understand conflicts and the accountability of nurses, a cross-sectional
design of nurses in an acute-care setting could be conducted. The method would include using a MISSCARE survey, which is an instrument to gather information regarding missed nursing care or any aspect of required patient care that is omitted or delayed.

Across these research areas, there are several methodological and analytical considerations to note. A qualitative study of nurses while in practice is recommended using the lens of self-determination theory (Deci & Ryan, 1996). Self-determination theory emphasizes human motivation according to the environment with an underlying tenet of the psychological well-being of the individual, such as a nurse, relating to three basic needs: autonomy, competence, and relatedness. Further research in understanding the motivation of nurses and the recognition of paternalism is recommended.

Textbook authors in this study communicated that nursing students and professional nurses are obligated to intervene, not addressing whether the nurses are putting the safety of the patient above their own. The research in this study would identify new nurses who were asked to be cognizant of advocacy action as it can influence the well-being of the patient directly. The results of this study would change how textbook authors communicate to fundamental nursing students regarding how to support the well-being of the patient.

A Delphi method could be used to study the definition of nursing advocacy. The framework of the study would involve multiple rounds of questionnaires sent anonymously to a panel of nursing advocacy experts to arrive at a definition of nursing advocacy. A Delphi study conducted from a structured group of nursing experts would more accurately identify the definition of advocacy as a method and converge toward the most accurate definition. The literature thus far has not focused on the true meaning of
advocacy, rather it has studied the characteristics of advocacy. The textbook authors provided multiple definitions with no shared basis from which the definition was derived. A single definition would operationalize and provide a framework to assist textbook authors regarding how they position the concept of nursing advocacy.

**Conclusion**

Chapter 5 discussed the examination of fundamental nursing textbooks to identify a nursing advocacy definition and determine how fundamental textbook authors guided nursing students to become prepared to advocate for patients. The textual data analyzed for this study produced rich textual data to answer the research questions. The theoretical framework provided by Pecanac and Schwarze (2018) was used as a lens through which to view the text that is provided to nursing students by fundamental textbook authors. The themes derived from the text supported previous research while uncovering additional findings.

A review and summary of the research study was provided. The research questions sought to discover a single definition of advocacy and what principles textbook authors proposed to guide the advocacy actions of nurses. Six themes were identified after collecting textual data from four fundamental nursing textbooks that are used to prepare newly trained nurses to advocate for patients. A qualitative discourse analysis was used as an approach, providing the researcher with a medium to identify themes out of the experimental textual data. The themes that emerged from the data provided evidence that a definition for advocacy has not been singly developed or embraced by the textbook authors. Additionally, advocacy guidance presented by the textbook authors was inadequate.
Implications of the six main findings of the research study were:

First, there is no single definition for nursing advocacy that was apparent within any of the textbooks studied. A lack of a consistent nursing advocacy definition contributed to how the fundamental textbook authors communicated advocacy knowledge and the skill sets required to be effective.

Second, the fundamental textbook authors instructed nurses how to support the well-being and autonomy of the patient, protect the patient, and act as an intermediary. However, the textbook authors failed to provide adequate guidance to ensure that the knowledge and skills that were to be developed by nurses would be sufficient to be effective.

Third, the fundamental nursing textbook authors did not address potential legal ramifications in their decisions about when and how nurses should advocate for patients. The textbook authors influence the actions of advocacy, yet they do not provide the education for nurses to develop skills to protect themselves from potential negative consequences as a result of well-intended advocacy.

Strengths and limitations were discussed to keep in mind when applying the findings. The strengths were that a discourse analysis was a best fit for this study, and the most commonly used textbooks for the geographic area were used for this study. While a strength of the study was the four most commonly used textbooks, a limitation was that the sample size was small. Including advocacy text that is used in advanced nursing education would strengthen future nursing advocacy research.

The information gathered from this study has informed the literature about advocacy practiced by nurses who are assisted by through the lens of the theoretical
framework. The six themes that were derived from the text collectively have described the essence of the advocacy concept. However, further research and education is needed.

In addition to further research, extended education is required. Nurses require in-depth education about advocacy. Education must address the challenges that nurses face to be equipped to navigate the work environment. Specifically, nurses should be educated regarding potential legal ramifications that could lead to charges that threaten their careers and livelihood. The nursing practice also has the opportunity to develop a system to assist nurses with advocacy while organizations and United States legislation can impact the quality of the advocacy provided by nurses to their patients. The desire is to see changes in the advocacy structures that will provide nurses with the ability to change the function of advocacy for the betterment of the patient and nursing profession.
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Appendix
Draft – Nursing Code of Advocacy

The proposed Code of Advocacy developed for the nursing profession is to improve the well-being of the patient. Historically, literature surrounding advocacy within the field of nursing has focused on the nurse meeting the need of the patient through consideration of the patient’s well-being, autonomy, the promotion of self-determination, and protection. The Code of Advocacy is designed to provide a guideline based on professional standards to guide nurses in their commission when faced with the need to advocate. The structure does not address all situations regarding how nurses should respond in all situations, but it is to provide specific guidelines according to the context where there may be a possibility of conflict among the Code and nursing standards.

Nursing advocacy is a decision-making process. Nurses may be challenged with instances where simple advocacy responses are not available to resolve a complex advocacy issue. Nurses should take into consideration the standards provided by the Code that may be relevant to the situation where implementation of judgment is needed. Nursing actions and choices should be consistent with how the Code is interpreted.

Augmented to the Code are many other resources that should also be considered when applying nursing advocacy. Nurses should consider research, regulations, rules, organizational policies, among others, as a secondary source for decision making. It is important that nurses be cognizant of the impact advocacy has on the decision making of patients compared to their own personal beliefs. It is the responsibility of the nurse to be aware of potential conflicts that may occur between personal values and professional expectations.

Instances may occur where nurses are challenged with advocacy obligations that conflict with their own beliefs. When conflicts arise, nurses must make every effort to responsibly resolve the conflict according to the standards described within the Code. When conflict resolution is not possible, the nurse should make every effort to seek professional advisement according to organizational policy before continuing to advocate. The Code of Advocacy is not a guarantee of positive advocacy service. Furthermore, the Code of Advocacy may not resolve advocacy conflicts. Rather, the Code of Advocacy is structured based on professional nursing standards to allow for a measurement of value and protection for both the patient and the nurse.

Advocacy Standards and Commissions:
Nurse advocates must follow professional standards and not compromise these standards to satisfy the wishes of the patient, their own wishes, or the desires of the professional organization that employs the nurse. While nurses are individually responsible for
advocacy conduct, the following advocacy standards and commissions have been developed based on nursing literature that has been set forth by research to which all nurses should aspire:

1. **Advocacy Standard: Ethical Obligation**  
   **Advocacy Commission:** The nurse has an ethical obligation to maintain advocacy. The primary goal of the nurse, when providing advocacy, is to assist patients in reaching their desired outcomes. Nurses draw on their expertise and training to assist patients in self-determining. When conflicts occur while advocating for a patient, the nurse should use professional discretion when decision making. Nurses should communicate with the patient when conflicts arise and take reasonable action to resolve the issue. Resolution of the issue may include, in some cases, protecting the patient’s interests or considering termination of the relationship between the patient and the nurse. When there is a need to terminate the relationship between the nurse and the patient, the nurse should notify the patient as soon as possible and make a reasonable effort to ensure that the needed services for the patient will continue. The nurse should avoid abandoning the patient in need of service. Nurses should not take advantage of their relationship with the patient to promote their personal, religious, political, or business/organizational interests.

2. **Advocacy Standards:** Compensating for disempowerment, supporting, prioritizing  
   **Advocacy Commission:** The nurse must compensate for how patients are disempowered by prioritizing and supporting the patient to reach responsible self-determination. Nurses recognize the importance in partnering with the patient to assist them in their medical choices.

3. **Advocacy Standards:** Educating, encouraging, anticipating needs  
   **Advocacy Commission:** Nurse advocates anticipate the needs of the patient. Nurses should educate patients only within their area of knowledge and competence based on the most current information available to the profession of nursing. Nurses should not educate or encourage patients when there is risk of harm to the patient or the nurse. Nurses should set clear and appropriate boundaries that are sensitive to the needs of both the patient and the nurse.

4. **Advocacy Standards:** Ensuring respect, cultural competency  
   **Advocacy Commission:** The nurse must represent and be aware of cultural competency by understanding culture and how it effects human behavior while recognizing the benefits that exists in every culture. Nurses are provided with a knowledge base in their training that allows for understanding that there are differences among people depending on their cultural group. Nurses should continue to seek and understand differences in social diversity to include how to be alerted to potential conflicts that may interfere with professional practice.

5. **Advocacy Standard:** Assisting  
   **Advocacy Commission:** Nurses advocate by assisting patients within the healthcare system. In circumstances where patients have a limited ability to understand healthcare concerns, the nurse provides understandable information to inform the patient with an
opportunity for the patient to ask questions whenever possible. Nurses should only provide assistance based on their level of competency and within the boundaries of their education, training, and professional license. When standards do not exist specific to the need of the patient, the nurse should exercise careful judgment to ensure that their work will not cause harm to the patient or cause risk of repercussions to the nurse.

6. **Advocacy Standards**: Balancing, representing, speaking, mediating, intervening

   **Advocacy Commission**: The nurse must intervene and mediate on behalf of the patient. Nurses should provide intervention and mediating only when such techniques and approaches have been provided to them through education, training, and when those applications have been observed by nursing professionals who are competent in those interventions.

7. **Advocacy Standards**: Championing social justice, clarifying

   **Advocacy Commission**: The role of the nurse is to support and defend the patient in a manner that is trustworthy. Nurses are continually aware of professional standards of practice, and they seek to promote practices that are aligned with learned professional expectations. Nurses should be aware of any conflict of interest when advocating for the patient. Where possible, nurses should set clear, culturally sensitive boundaries to not exploit the patient or the nurse.

8. **Advocacy Standards**: Protecting as an action to protect, defending

   **Advocacy Commission**: The role of the nurse is to protect the patient. Especially when the patient lacks capacity, the nurse should protect the interest of the patient by providing information according to the patients’ level of understanding. In situations where possible, the nurse should seek a third party who may provide information consistent with the patient’s wishes.

9. **Advocacy Standard**: Interdisciplinary collaboration

   **Advocacy Commission**: Nurses should partner in advocating for the patient with the understanding that decisions affect the well-being of the patient while drawing from multiple perspectives that will benefit the patient. Where disagreements emerge, nurses should attempt to resolve these issues. If issues are unable to be resolved, the nurse should pursue advisement that will be consistent with the wishes of the patient. Nurses should not take advantage of disagreements among other healthcare professionals to gain power and to potentially advance an individual’s interests.