POLITICAL ADVOCACY IN NURSING:
PERSPECTIVES FROM THE FIELD

by
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ABSTRACT

Nursing has a historical foundation based on advocacy to promote health equity and social justice for both individuals and society at large (Boutain, 2005a, 2005b, 2008). However, research has revealed a disturbing trend: the majority of individual nurses in the United States have abandoned advocacy focused on public policy and society's well-being (macro-level advocacy) (Ballou, 2000), in order to focus their efforts exclusively on advocacy for individual patients (micro-level advocacy) (Ballou, 2000).

While professional nursing organizations do participate in political advocacy, less than 1% of all nurses are members and/or active participants in these organizations (Alotaibi, 2007; DeLeskey, 2003; Hedin, 1986; Primomo, 2007; Rapp & Collins, 1999). Further, only a small percentage of nurses are actively employed as nurse/political advocates (Ballou, 2000; Falk-Rafael, 2005). Do contemporary nurses still have a mandated responsibility (Ballou, 2000; Falk-Rafael, 2005) to both societal and individual well-being? If so, how do nurses gain understanding of the concept and practice of advocacy aimed at public policy development (i.e., political advocacy)?

Through dialogue with practicing nurses and recorded narrative using open-ended, in-depth, structured interviews, this study explored the perspectives of nurse advocates on issues of advocacy skills, concepts, and practices as mandated by the American Nurses Association (ANA) and the National League of Nurses (NLN). Examining the perspectives of nurses currently engaged in political advocacy endeavors will provide greater understanding of this type
of advocacy and provide valuable insights into what pedagogical interventions, skills, and professional practices are necessary to encourage political advocacy.
DEDICATION

This dissertation is dedicated to my family. To my ancestors on whose shoulders I stand. To my parents, Thomas and Carolyn Tallent, for always believing in me. To my aunt and uncle, Judie and Junior, for your endless support. To my husband, Russell, for doing a great job “holding down the fort.” To my children, Alexander, Audrey, Ashley, and Jocelyn, you are everything to me. Thank you for your love, patience, and encouragement. Your zest for life and learning continues to inspire me. And last, but not least, to my son, Jordan (who will never be able to read this), but nevertheless, it must be said: You alone inspired me to be a nurse and your will to live, motivated me to fight for your “best care” and become the advocate I am today. I hope you have always known how much you are loved. You are not, and never have been “damaged goods.” You are, and always will be, perfect to me.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>AACN</td>
<td>American Association of Colleges of Nursing</td>
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<td>AACN</td>
<td>American Association of Critical-Care Nurses</td>
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<td>AAN</td>
<td>American Academy of Nursing</td>
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<td>ACA</td>
<td>Affordable Care Act</td>
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<td>ADN</td>
<td>Associate Degree in Nursing</td>
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<td>ANA</td>
<td>American Nurses Association</td>
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<tr>
<td>APRN</td>
<td>Advanced Practice Registered Nurse</td>
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<tr>
<td>ATP</td>
<td>Attitudes’ Towards Poverty Short Form (Yun &amp; Weaver, 2010)</td>
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<td>BSN</td>
<td>Bachelor of Science in Nursing</td>
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<td>CD ROMS</td>
<td>Compact disc, read-only-memory device</td>
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<tr>
<td>CNA</td>
<td>Certified Nursing Assistant</td>
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<tr>
<td>CNS</td>
<td>Certified Nurse Specialist</td>
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<td>DNP</td>
<td>Doctor of Nursing Practice</td>
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<tr>
<td>EdD</td>
<td>Doctorate of Education</td>
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<tr>
<td>FACHE</td>
<td>Fellow of the American College of Healthcare Executives</td>
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<td>ICN</td>
<td>International Council of Nursing</td>
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<tr>
<td>IEP</td>
<td>Individual Education Plan</td>
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<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
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<tr>
<td>LPN/LVN</td>
<td>Licensed Practical/Licensed Vocational Nurse</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MSN</td>
<td>Master of Science in Nursing</td>
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<tr>
<td>NCLEX-RN</td>
<td>National Licensure Examination for Registered Nurses</td>
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<td>NCSBN</td>
<td>National Council of State Boards of Nursing</td>
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<td>NEA-BC</td>
<td>Nurse Executive Advance Certification</td>
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<td>NLN</td>
<td>National League of Nursing</td>
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<tr>
<td>PAI</td>
<td>Political Astuteness Inventory (Clark, 1984)</td>
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<td>PhD</td>
<td>Doctor of Philosophy</td>
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<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>SDH</td>
<td>Social Determinants of Health</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER I
INTRODUCTION

Overview

In the United States, healthcare, nursing, and patient care are controlled by public policies and political processes and, therefore, nursing, healthcare, politics, and policy are inseparable (Ballou, 2000; Raines & Barton-Kriese, 2001). It is here then that nurse-guided advocacy, and more specifically, nurse-guided political advocacy becomes critical. This study focused on political advocacy in nursing and its unique importance in healthcare, nursing, patient care, and the health of our society as a whole.

The concept and practice of political advocacy in nursing is important, because "politics" and the formation of public policies do not occur without some form of human-initiated action. Human-initiated action is often triggered by the discovery that a problem or concern exists within society. The acknowledgment of a concern or problem typically leads humans to ponder how a newly discovered or ongoing problem or issue within society might be addressed, solved, or improved upon; the process for changing or developing a new policy is then initiated (Ballou, 2000; Phillips, 2009; Raines & Barton-Kriese, 2001). There are many historical examples of nurses who, upon discovering that a societal problem existed, functioned as a political advocate to promote, develop, or improve a public policy to address a problem or issue, for the good of a particular population in society or society at large.
In Victorian England, Florence Nightingale, after assessing the unsanitary conditions in the infirmaries and the inequitable treatment of the sick poor, initiated public policy reforms to improve the British healthcare system (Cook, 1914). She was able to accomplish her task more easily due to the public outcry that was precipitated by her widely published newspaper accounts, which made known to the public the horrible conditions and human suffering she had witnessed in graphic detail. She was especially incensed with the unfair treatment that those deemed “lower class” received (Conger & Johnson, 2000). She was relentless in her admonition that all patients should be treated “equally” even if those patients had no ability to pay for their care. Not only did the poor receive negligible care, but nurses themselves and the work they did, were looked down on by the upper class of Victorian England, as nursing was thought to be “unsuitable work” for ladies. Even though Nightingale was a member of the upper class of Victorian England, she politically advocated for both nurses and patients. As a result, she not only improved the treatment of the poor, but took the first steps in solidifying nursing as a reputable profession when she established the world’s first school for nurses on July 9, 1860 (McDonald, 2006). Other nurses were to follow in her footsteps.

Like Nightingale, Lillian Wald, Margaret Sanger, and other early nurse activists promoted health, prevention of disease, advocated for patient's rights, and reformed public policies for the poor, the oppressed, and the vulnerable throughout the first half of the 20th century (Conger & Johnson, 2000) through political discourse. However, in the latter part of the 20th century, there was a noticeable drift of nurses and the nursing profession away from activism and the socio-political arena (Conger & Johnson, 2000). Some researchers believe this may have been due to a change in practice venues from homes to hospitals, since most patients were cared for at home in the early part of the 20th century (Reverby, 1995). However,
beginning in the 1950s, patient care gradually shifted from home-based and community-based care, to care given almost exclusively in hospitals. As a result, nurses’ “workplace” shifted from homes and communities to hospitals (Reverby, 1995). It is important to note that as a result of the shift in practice venues, most nurses not only worked in hospitals, but they worked in hospitals almost exclusively governed by physicians. Some believe this shift in practice venues resulted in a loss of autonomy for nurses as they were forced to become a part of the physician-dominated biomedical model, or be jobless, since there was no longer a demand for community and home-based nurses (Reverby, 1995).

The change in focus from home and community-based care to hospital care changed the nursing profession’s focus from community/societal health and prevention needs to a primary focus on the needs of individual patients (Reverby, 1995). It also resulted in a change in the profession’s allegiance. Nurses, who had previously felt a moral duty to society at large, now felt a moral duty to the physician and to the hospital that employed them (Lynaugh & Fagin, 1988). Although care has not shifted from hospitals back to care given at home, population-related health issues and healthcare reform have started to garner more attention, as the link between socioeconomic factors, prevention, health, and wellness have become better established. This has been perpetuated due to a variety of reasons: insurance rates continue to rise, rates of chronic health conditions have continued to increase, and new medical/health related information is continually being discovered (Kim, Tanner, Foster, & Kim, 2015).

As a result, some nursing researchers have suggested the use of political advocacy as a tool that nurses can use to promote public policy development, healthcare policy reform (ANA, 2001), and social justice in society (Ballou, 2000; Hall-Long, 2009; Reutter & Kushner, 2010). Even so, we must ask, does our current healthcare system really need public policy reform
relating to healthcare and, if so, why? In addition, if the answer is substantiated by evidence, why then are public policy development and healthcare reform a nursing responsibility? Furthermore, when nurse/patient ratios are already stretched to the breaking point (Heinz, 2004), some may ask, don’t nurses already have an abundance of responsibilities? Is political advocacy truly a responsibility of the nursing profession and, if so, why? In addition, is there substantial evidence that political advocacy truly aligns with the historical tenets of the profession?

More importantly, even if the evidence reveals that political advocacy aligns with professional nursing’s historical, philosophical, and foundational tenets, and may have been a part of nursing’s history, what is its ethical and moral relevance in contemporary nursing? Furthermore, if contemporary moral relevance can be proven, how do current nursing mandates address the topic? How does nursing’s responsibility to society, to the individual patient, and to the profession itself relate to public policy? Are nurses really the most qualified healthcare professionals to participate in the public policy reform that is needed and, if so, why?

If the evidence bears witness that political advocacy is needed and nurses are the most qualified profession to guide healthcare policy, how do nurses gain insight into the experience needed for this type of work? It is here then that we must delve into the work of practicing nurse advocates to gain a deeper understanding of political advocacy in action, in order to learn (a) what life experiences prepared them for their work?, and (b) what does this type of advocacy look like in practice, from the standpoint of nurses who serve as political advocates in the field?

Through dialogue with practicing political advocates and recorded narrative using in-depth, semi-structured interviews with open-ended questions, an examination was conducted to reveal how political advocacy is understood and interpreted by nurses who function in this capacity. Listening to their stories, as well as examining their ongoing activities, will help the
profession gain conceptual understanding of not only what political advocacy in nursing *is*, but what the practice of political advocacy *looks like* in nursing praxis. In addition, examining the perspectives of nurses currently practicing as political advocates will also provide valuable insights into what classroom pedagogical interventions, clinical/practicum experiences, and professional practices will enable nurses to be effective political advocates in their field.

**Professional Nursing Mandates State Expectations but Lack Guidance**

Although the current mandates of the nursing profession contain multiple passages which confirm nursing's commitment to both political advocacy and activism, they offer very little guidance on what specific political actions or behaviors nurses are to engage in. Passages contained in the ANA’s *Nursing: Scope and standards of practice* (ANA, 2010b) and the ANA's *Nursing's Social Policy Statement: The Essence of the Profession* (2010c) stated that nurses are expected to advance public policy and the healthcare delivery system for the well-being of individuals, society, and the nursing profession in their practice, but did not state how nurses are to accomplish this task. Additional passages stated that nurses are required to "promote social justice" (ANA, 2010b, p. 9) for society (which includes individuals and vulnerable populations) and participate in activities which promote healthcare for all as a “human right” (ANA, 2010b, p. 4). However, the document did not offer any specific steps that the average nurse was expected to take or state activities in which they were required to participate. These requirements were reiterated within the official mandates formulated to guide nursing education as well.

*Essential V.* of the American Association for Colleges of Nursing's (AACN) *Essentials of Baccalaureate Nursing Education* (2008) required baccalaureate-level nursing programs to address the moral and ethical responsibility of all nurses to strive for "social justice," which implies advocacy. In addition, *Essential V., 11.* stated that baccalaureate-prepared nurses are
expected to “Participate as a nursing professional in political processes and grassroots legislative efforts to influence health policy.” (AACN, 2008, p. 21). This passage implied that BSN students should be educationally prepared to be effective political advocates and social justice advocates (i.e., political knowledge), participate politically (i.e., political activism), and have the embodied political awareness, skills, and understanding (i.e., political astuteness), which enables them to participate effectively in political and legislative processes which impact health and social policy (AACN, 2008). However, is political and social justice advocacy a primary focus of contemporary baccalaureate nursing education? More importantly, does the National Council Licensure Examination (NCLEX) contain questions that relate to political and/or social justice advocacy?

The ANA’s Health System Reform Agenda (2008a) clarified the organization’s position that “health care is a basic human right” (ANA, 2008a, p. 1). Further in the text, the ANA reiterated their “support for a restructured health care system that ensures universal access to a standard package of essential health care services for all citizens and residents” (ANA, 2008a, p. 1). In addition, although many individual nurses may not agree with the various provisions of the Patient Protection and Affordable Care Act (PPACA, 2010), evidence of the American Nursing Associations’ support of the document can be found in the ANA Issue Brief entitled, “Health System Reform: Nursing’s Goal of High Quality, Affordable Care for All” (ANA, 2010a p. 1, ¶1) in which the ANA addressed the PPACA and stated that

[the new law roughly follows the key areas that ANA has set forth as necessary for effective health reform; the latest iteration of this policy was ANA’s Health System Reform Agenda (2008). It employs the following overarching categories: Access to care, Quality care, Cost of care, Healthcare Workforce. The law secures access to care for most of the 36 million people currently uninsured in the United States. It does so by expanding public coverage programs and strengthening consumer protections in private and public insurance plans.}
The ANA further stated that the organization was active in the development and promotion of the PPACA (ANA, 2010a, p.1, p[4]). Much like the ANA, the AACN has also stated their organization's agenda for directing public policy in this country and commissioned a Public Policy Work Group to focus on enhancing the AACN's agenda to enact public policy reform (AACN, 2006).

In addition, global support of political and public policy advocacy can be found in mandates written by The International Council of Nurses (ICN). The ICN is an international professional nursing federation which represents more than 120 national nurses' associations worldwide. The ICN’s primary goal is to promote health and healthcare policies globally (ICN, 2000). In their publication, “The Code of Ethics for Nurses,” the ICN stated that

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse also shares responsibility to sustain and protect the natural environment from depletion, pollution, degradation and destruction. (ICN, 2000, p. 2)

Further, the ICN viewed healthcare as a “right of all individuals, regardless of financial, political, geographic, racial or religious considerations” (ICN, 2001, p. 272). This includes ensuring that adequate care is provided within the resources available and in accordance with nursing ethics (ICN, 2001).

Additional guidance, laws, and regulations further guiding the profession are carried out by Boards of Nursing (BON) within each state and contained within each state’s “Nurse Practice Act.” The various Nurse Practice Acts are not mandates per se, but are laws and regulations enforced by the state in which each nurse is licensed (National Council of State Boards of Nursing, 2011a, 2011b). Although there is some conformity among the various Nurse Practice Acts throughout the United States, no two are exactly alike.
The Nursing Profession

Both the Institute of Medicine (IOM) and the World Health Organization (WHO) have stated the need for nurses to participate in health and social policy reform due to the unique training, qualifications, and trust of the general public that nurses embody (IOM, 2003; WHO, 2010). In addition, there is significant evidence to support the idea that both individual nurses and the collective nursing profession are viewed by society as the “most qualified' to advocate for health and social policy reform: (a) nursing is ranked as the most respected profession in the U.S. (Riffkin, 2014); (b) nursing is the largest group of healthcare professionals (McGinnis, Goolsby, & Olsen, 2009); and (c) nurses spend more time in direct contact with patients than any other healthcare professional (Page, 2004). All of these professional attributes are evidence of the unique qualifications that nurses have to serve as advocates to guide the development of effective health, public, and social policy (Ballou, 2000; Mundt, 1997).

Statement of the Problem

Professional ethical codes of practice (both nationally and globally), require nurses to address the macro-level needs of populations as well as the micro-level needs of individuals through sociopolitical advocacy, as evidenced in the Code of Ethics for Nurses with Interpretive Statements (ANA, 2015; 2001), the ANA’s Scope and Standards of Practice (2007; 2010b), the ANA’s Nursing’s Social Policy Statement: The Essence of the Profession (2010c), and the ICN’s publication The Code of Ethics for Nurses (2000). In addition, Essential V. of the AACN’s Essentials of Baccalaureate Nursing Education (2008) required baccalaureate-level nursing programs to address the moral and ethical responsibility of all nurses to strive for social justice, which implied political advocacy. However, research revealed that a majority of nurses do not participate in political advocacy for patients and populations who suffer from the effects of failed
healthcare policy (Ballou, 2000; Falk-Rafael, 2005; Spenceley, Reutter, & Allen, 2006).

Researchers do not fully understand why nurses do not participate (Ballou, 2000). Although individual, bedside patient advocacy is widely referred to in nursing scholarship, there is a literature gap relating to the work and/or life experiences of contemporary nurse/political advocates in practice (Ballou, 2000; Falk-Rafael, 2005; Spenceley et al., 2006). In order to help nurses learn more about the concept and practice of political advocacy, this study examined the life experiences of current nurse/political advocates. Their perspectives, understandings, and insights can help the profession and individual nurses gain understanding of both the concept and practice of political advocacy within the nursing profession.

**Statement of Purpose**

Several areas emerged in the literature that point to research needs in terms of examining the practice of political advocacy in nursing. Nurses who currently function as political advocates already possess and utilize the experiences needed. This study sought to contribute to the process of knowledge-building in this area by using narratives of nurse political advocates by examining their life experiences and their perspectives on political advocacy in nursing. This process contributes to the conceptual understanding of political advocacy and illuminates the factors relating to its practice within the profession. Solidifying nursing's historical commitment to social reform and political advocacy may offer some guidance in this area, but a contemporary view was needed from practicing professional nurses.

**Research Questions**

This study aimed to answer the following questions:

1. How do nurses who do political advocacy interpret professional nursing mandates which address social justice, health equity, policy advocacy, and ethical care?
2. What are the implications for advocacy praxis for nursing education and for the nursing profession?

**Significance of Study**

This study is significant because this was an under-researched area of nursing practice. Nursing mandates state that nurses have a moral, ethical, and professional responsibility to participate in political advocacy and policy-level development to promote effective health and social policy for healthcare, individual patients, and society as a whole (ANA, 2001, 2010b). This responsibility includes individual patients (at the bedside), vulnerable populations, and the broader contexts of society, as written in the guidelines of the *Code for Ethics for Nurses with Interpretive Statements* (ANA, 2001) and *Nursing’s Social Policy Statement: The Essence of the Profession* (ANA, 2010c). These guidelines are representative of a clear and concise mandate that nurses participate in political advocacy and politics (in general), as identified by Ballou (2000) in her work, *A Historical-Philosophical Analysis of the Professional Nurse Obligation to Participate in Sociopolitical Activities* in which she identified the *Sociopolitical obligations in the 1985 Code for Nurses* shown in Appendix A. Additional statements loosely relating to political activism, social mission, social reform, and moral obligation to the public are contained in numerous additional ANA documents which add further to the evidence (Ballou, 2000).

Nursing research also substantiates contemporary nursing's collective and individual lack of participation in political processes (Ballou, 2000; Falk-Rafael, 2005; Spenceley et al., 2006). Due to this lack of participation, little is conceptually known about this type of advocacy or the nurses who currently function as political advocates.
Sample

A purposive sampling of licensed RNs active in political advocacy were identified from contact information gleaned from professional nursing organization websites, referral by other participants and word-of-mouth. Potential participants were recruited via email (see Appendix B). One hundred seventy-eight invitations were sent out. Fifteen participants initially responded by email and expressed their interest in participating in the study. Inclusion criteria for participation was then discussed via both phone and/or emailed correspondence. Three participants worked in the Washington, DC/Virginia/Maryland region in various nursing/political advocacy roles, but primarily resided and spent their time in other states (Delaware, North Carolina, and Pennsylvania), and were unable to participate due to scheduling and logistical conflicts.

Once it was determined that the participant met the inclusion criteria for the study, a date, time, and place were negotiated for 12 participants. When the interviews were scheduled, the participants were given the researcher’s cell phone number in case they needed to change the appointment day or time and/or if they had any questions. One interview was rescheduled due to inclement weather and one was rescheduled due to a scheduling conflict. I was willing to interview nurses until data saturation was reached. A total of 10 nurses who were active in political advocacy as part of their nursing practice were interviewed. All of the participants were licensed Registered Nurses: eight were licensed in Virginia, one in Maryland, and one participant was licensed to practice in both Washington, DC and Maryland. All interviews were audio-taped using a digital recorder.

Two participants were scheduled to be the 11th and 12th participants, but data saturation was reached when the 10th interview was coded. Data saturation was reached when coding the
10th interview because no new themes or codes emerged. Data saturation can differ from one study to the other, but in general, data saturation is reached when there are no new data, themes, or codes emerging. Although this might still leave some ambiguity and uncertainty, data that meet the aforementioned criteria and are also considered rich (i.e., of good quality) and thick (i.e., of good quantity) are needed. When the 10th interview was coded, there were a total of 219 pages of narrative material containing 77,774 words. In addition, the interviews contained rich, vividly detailed dialogue from all 10 participants. The two remaining potential participants were subsequently notified that data saturation was reached and thanked for their willingness to be a part of the study.

**Limitations**

The study had a small sample size and lacked gender and racial diversity, which makes it difficult to offer generalizations that relate to the average nurse. In addition, the impact of the geographical location on nurses could lessen the ability to generalize the results. It is possible that nurses who resided or worked in an area with close proximity to our nation's capital and/or within Washington, DC, may have been more politically aware than nurses who resided in more distant locales throughout the country. Due to this, they may have had different life experiences, may have been more likely to participate in political advocacy efforts, and may have been more politically knowledgeable in general than nurses in other locales. Also, since there were/are no professional or universal definitions of *social justice, social justice advocacy, political advocacy,* or *advocacy* in nursing, it was difficult to determine what the terms actually meant to practicing nurses. It was possible that nurses residing near Washington, DC may have had a different understanding of *political advocacy, social justice advocacy,* and *advocacy,* in general, than those individuals living in other areas of the country. It is also possible that regional, religious,
cultural, ethnic, gender, and socioeconomic differences among practicing nurses in DC, Maryland, and Virginia, might have influenced their beliefs and, as a result, their understanding of the concepts of social justice and/or political advocacy may have been duly impacted as well.

**Delimitations**

This study was designed with specific limitations. Only experienced nurses were chosen for this study because the research suggested that most political advocates are mature, experienced, well-educated nurses, and, as such, are those most likely to participate in political advocacy and, furthermore, the most qualified to do so. Therefore, this study only included nurses (a) who participated in policy-level political advocacy as a major focus of their work, (b) had a current license to practice as a Registered Nurse in the United States, (c) had been a practicing RN for at least 5 years, and (d) were English-speaking (because the researcher only speaks English). This study also excluded doctors, students, and other healthcare professionals in order to keep the research focused on practicing registered nurses and firmly grounded within the nursing profession. Even so, there may be limitations due to those exclusionary decisions.

**Definition of Key Terms**

*Advocacy:* The process of persuading someone to at least consider one’s point of view, or the view of another (Ballou, 2000). Defending or maintaining a cause or proposal on behalf of the patient, client, or profession to achieve societal or other goals (Interprofessional Education Collaborative Expert Panel, 2008)

*Autonomy:* The right to self-determination of any individual. Professional nurses protect patient autonomy when they advocate for a patient’s right to make decisions about their own health (AACN, 2008, p. 27).
Cultural Competence: “Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt, Green, & Carrillo, 2002, p. 5).

Diverse populations: Diversity includes differences in individuals relating to race, color, ethnicity, national origin, immigration status, religion, age, gender, gender identity, sexual orientation, ability/disability, political beliefs, social and economic status, education, occupation, or spirituality (Giger et al., 2007; Purnell & Paulanka, 2003).

Ethics: The rules or principles that govern right conduct (Kozier & Erb, 1979).

Health Disparities: Health disparities are differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States (Giger, et al., 2007).

Health equity: The absence of unfair and avoidable or remediable differences in health among ethnic or social groups (Solar & Irwin, 2007), resulting in the attainment of the highest level of health for all people (Braveman & Gruskin, 2003).

Nurse: An individual who is licensed as a Registered Nurse in this country.

Nursing: For the purpose of this study, the profession of nursing.

Patient: The term refers to the recipient of a healthcare service or intervention at the individual, family, community, or population level (AACN, 2008).

Political tactics: Specific activities used by individuals or groups to gain access, persuade, or influence political leaders (Milstead, 2004).

Political strategies: Goal-directed plans using tactics suitable for the specific context to achieve access or influence political leaders (Ballou, 2000).
Policy-making: The process of bringing significant problems to the attention of political leaders, which can lead to policy development, reform, and eventual enactment of a new policy (Milstead, 2004).

Politics: Activities aimed at directing the allocation of resources (Mason, Leavitt, & Chaffee, 2013).

Service learning:

Service learning, as a critical pedagogy, is characterized by four qualities: a) an activity or service that responds to a need identified by the community members; b) a balancing of the service activity provided by students with the achievement of the student’s academic objectives; c) authentic community partnerships and reciprocal relationships between the school of nursing and the community; and d) structured time to reflect on the complexity inherent in the service issue, the context in which care is provided, the social meaning of the client or population served, and the link to academic objectives. (Gillis & MacLellan, 2010, p. 1)

Overview of Literature

There is limited literature that specifically addresses the concept and practice of political advocacy in nursing. This may be because there is no profession-wide or professionally accepted definition. The literature that loosely relates to political advocacy in nursing focused on the recommendations for its use as a means for nurses to promote policy to address the multitude of ongoing socioeconomic and healthcare-related issues that negatively impact the quality of health in this country. The following is a summary of those socioeconomic and healthcare-related issues, an overview of their interrelationship, and their dependence on social policy reform to guide them.

Although the US spends more money on healthcare than any other developed nation, the need for healthcare and social policy reform is urgent and can be demonstrated by the following statistics: (a) the US is ranked 43rd in infant mortality and 51st in life expectancy at birth out of 223 developed nations (Central Intelligence Agency, 2017a, 2017b; Lathrop, 2013; (b) the risk of
dying prior to the age of 65 is three times higher for individuals who are at the socioeconomic bottom, compared to those in the socioeconomic top (Adler & Stewart, 2007); and (c) health disparity is now being viewed as both a social justice and a civil rights issue (McGinnis et al., 2009; Navarro, 2009). See Appendix C for a list of health conditions with a correlation to poverty.

The psychosocial circumstances that exist in our society—poverty, homelessness, unemployment and lack of education—have all been shown to result in negative physical responses such as cardiovascular disease, premature births, and hypertension (Clougherty, Eisen, Slade, Kawachi, & Cullen, 2009; Steptoe & Marmot, 2002; Wadhwa, Entringer, Buss, & Lu, 2011; WHO, 2008). These psychosocial and economic factors that contribute to health disparity are now commonly referred to as the "social determinants of health" (SDOH). The WHO (2010) reported that health disparity is increasing at an alarming rate, predominantly due to these economic and social factors. In addition, the WHO has stated the need for nurses and other primary healthcare professionals to serve as advocates for health and social policy reform aimed at addressing this type of social injustice (WHO, 2008; 2010). The quality of our public policies is particularly important to nursing because policies have a significant impact on the quality of individual health, healthcare, population health, and nursing education, as well as the nursing profession itself.

**Health and Social Policies**

Policies are governmentally formulated legislative plans that use the established political process to address the healthcare needs and social needs of both individuals and populations (Ballou, 2000; Rains & Barton-Kriese, 2001). Due to this, nurses have a professional and ethical responsibility to promote the needs of marginalized populations by advocating for those policies
aimed at allocating funding to change the societal structures that perpetuate social injustice and health inequity. Nursing education which does not focus on public policy advocacy ignores the healthcare needs of society in general, the growing inequities of vulnerable populations, the issues and problems within contemporary nursing practice and the philosophical foundation of the nursing profession itself (Aroskar, 1995). Although some graduate programs do contain guidance on public policy advocacy, nursing research indicates that most undergraduate programs give little (if any) attention to public policy advocacy and/or fail to address the impact of policy on healthcare or the profession. Additional research indicated that not only are most undergraduate nurses not exposed to any facets of policy-making, they have a startling lack of knowledge of the economic inequities that exist and the impact on society’s most vulnerable populations, children, the elderly, the poor, the disabled, and minority populations (Cunico, Sartori, Marognolli, & Meneghini, 2012), which may function as an additional barrier to political and social justice advocacy (Martino-Maze, 2005).

**Barriers to Political Advocacy in Nursing**

Some research suggested that many nurses are not socially and culturally competent and are therefore unaware of the health disparity and injustice which currently exists in our society (Cunico et al., 2012). This research further implied that nurses may lack the social consciousness which inspires one to "care" or be emotionally motivated to advocate for others. Does stereotypical thinking, racism, or discriminatory thinking impact political advocacy within the practice of nursing (Martino-Maze, 2005)? What are some of the challenges in preparing nurses to become effective political advocates and how can we overcome them?

Some research suggested that nurses cannot freely advocate for others who are oppressed because they belong to an oppressed group themselves (Dong & Temple, 2011). In the first half
of the 20th century, nurses operated almost exclusively as private duty nurses in homes, basically functioning as independent contractors much like physicians (Ashley, 1976; Melosh, 1982; Reverby, 1995). A study done by the U.S. Department of Health and Human Services (2012) told us that “[h]ospitals remain the most common employment setting for RNs in the United States, increasing from 57.4 percent in 2004 to 62.2 percent of employed RNs in 2008” (U.S. Department of Health and Human Services, 2012, p. 3). As a result, the majority of nurses now function within the guidelines of the medical model and work in hospitals and other organizations which can hire and fire them at will. Furthermore, it has been suggested that nurses may not have the professional freedom to truly advocate for their patients or themselves, due to the fear of retribution from their employers (Bevis & Watson, 1989; Freire, 1970; Leonard & McLaren, 2002; Peter, Lunardi, & Macfarlane, 2004). Is it possible that this lack of professional freedom has driven a wedge between nurses and the care and advocacy they bestow on patients and society? How is this possible, in a profession which has long prided itself on its moral and ethical responsibility to care and advocate for others? We must examine the historical significance of ethical caring and advocacy in nursing and compare it to contemporary nursing’s view.

**Advocacy and the Ethics of Care**

Nurse historians have confirmed that Nightingale's legacy of political advocacy is a construct of ethical caring (Fiscella, Franks, Doescher, & Saver, 2002) and have reported increasing evidence establishing the relationship between social justice and health inequities within our culture (Farmer, 2013; Nixon, 2011; Rylko-Bauer & Farmer, 2016). To address this trend, many researchers have called for the profession of nursing to reinvest in political advocacy, social justice seeking, social activism, and empowerment (Barnes, 2005; Bathum,
Nevertheless, if the nursing profession continues to ignore the political and economic factors which contribute to poor health, can we still claim to be administering care that is “ethical”? Falk-Rafael (2005, p. 1) furthered this when she passionately stated that “[n]urses, whose practice resides at the intersection of public policy and health care, are ideally situated and morally obligated to participate in political advocacy to influence health policy in their professional practice.” Later, Falk-Rafael (2006, p. 2) strengthened her earlier argument and insisted that “Nursing’s fundamental responsibilities to promote health, prevent disease, and alleviate suffering call for the expression of caring for humanity and environment through political activism at local, national, and international levels. . .”.

These impassioned statements set the nursing profession’s ethical and moral bar high and may prove to be unattainable. At some point nurses must contemplate whether our role as society’s moral and ethical healthcare police will lead to either the destruction of our profession’s credibility and/or employability, or both? How can political advocacy be used in the nursing profession to not only promote social justice and ethical healthcare in society, but preserve our profession’s reputation, our credibility and nursing’s long-term survival? It is here then that we must look to practicing nurse/political advocates for their expertise and guidance in this endeavor. This study of nurses in political advocacy/policy development positions used grounded theory methodology to examine their understanding, practices, experiences, and recommendations.
Methodology

Grounded theory encompasses both a method of inquiry and a mode of analysis (Charmaz, 2005) that enables researchers to build mid-range theory through the development of concepts that emerge as a result of data collection and analysis. It is often used to find the meanings of human behavior and is useful in examining, explaining, and analyzing processes, especially social processes (Glaser, 1992, 1998; Glaser & Holton, 2004; Glaser & Strauss, 1967). Grounded theory was therefore an appropriate research method to use in this research. The concept and practice of political advocacy from the perspective of practicing nurse advocates using interviews and observations was used to examine their thoughts, actions, life experiences, and behaviors. Only nurses who participated in the process of political advocacy in their nursing practice were targeted for recruitment. Data collection, data analysis, and ethical considerations for this qualitative study were addressed.

Ten nurse participants were chosen using purposive sampling. Data collection and analysis occurred simultaneously and were ongoing. Social justice seeking was used as the theoretical framework to help frame and organize the data and relate them to current nursing practice mandates which addressed social justice. Triangulation, member checks, researcher reflexivity, bracketing and the use of memoing all strengthened the validity of this grounded theory study. The semi-structured interviews allowed the participants ample latitude to share their perspectives and understanding. However, due to the nature of qualitative research and the limitations and delimitations of this study, the findings may not be generalizable to all nurses.

Chapter Summary

According to nurse researchers, professional nursing has a philosophical and historical foundation based on advocacy and participation in the political process, in order to promote
health equity and social justice within society (Boutain, 2005a, 2005b, 2008). However, nursing research has revealed a paradigm shift in professional nursing practice from a primary focus on social reform and society's well-being, (in the early 1900's) to a primary focus on each individual patient's well-being, which began in the latter part of the 20th century (Reverby, 1995). This shift has also resulted in subservience to physicians and allegiance to employers instead of society.

The seeking of health equity and social justice in our society requires political advocacy and political participation aimed at addressing the policies and social structures within our society which impact health and societal well-being. Contemporary nurses are professionally and ethically mandated to political advocate and participate in the policy process in order to conform to the foundational philosophical ideology of the profession which requires caring, advocacy, and the promotion of health equity and social justice within society (AACN, 2006, 2008).

This study examined the perspectives of practicing nurse/political advocates in order to establish the importance of political advocacy to the profession and within nursing education. Through dialogue with practicing political advocates, their narratives were examined to convey how things looked to those in practice. The recorded narrative using open-ended, in-depth, semi-structured interviews served as the unit of analysis for this study. Examining and analyzing the prior life experiences and the ongoing activities and dialogue of nurses currently participating in political advocacy, activism, and/or policy-level development helped illuminate the ways in which these nurses were prepared, motivated, and/or inspired to act and gave voice to their valuable insight and perspectives (Boswell, Cannon, & Miller, 2005; Conger & Johnson, 2000).

In the following chapter, I discuss current literature relating to the concept and practice of political advocacy, as well as the ambiguity that exists relating to this particular type of nursing advocacy within nursing research.
CHAPTER II
THE MANY FACES OF ADVOCACY IN NURSING

Overview

In this chapter I examined nursing research to determine what is known about advocacy in nursing (in general), both from a historical standpoint and a contemporary one. I could find no professionally accepted definition of political advocacy or sociopolitical advocacy, and (according to several researchers), nursing advocacy at the policy level is nearly invisible (Antrobus, 2003; Boswell et al., 2005; Spenceley et al., 2006); I therefore looked broadly at those nursing activities and practices that were aimed at policy development or change, but have been labeled differently within the profession. Secondly, I examined the history of policy-making and political advocacy within society (in general) and then determined its relative importance in nursing. What power did//does politics have in healthcare, patient care, nursing, or society? In addition, I also sought to determine whether nursing research, mandates, education, and the profession itself had been politically influenced (or not). I then examined the philosophical and foundational tenets of the nursing profession and determined their relationship to political advocacy, healthcare, and contemporary nursing mandates. Lastly, I examined current research to determine the contemporary political behaviors of nurses in nursing education, practice, and in relation to healthcare and social justice issues overall.

Examining Nursing Advocacy

Throughout nursing's history, political advocacy has remained an ambiguous concept and has not been well-defined in nursing research, education, or within the nursing profession
Due to this, the terms *political* and *advocacy* were virtually non-existent within nursing research until the latter half of the 20th century. However, even though other terminology was used, there have been many actions of nurses that can only be described as political advocacy activities. However, due to this lack of clarity, there was a significant amount of nursing research in both historical and contemporary nursing science that closely related to the concept and practice of political advocacy, but was not referred to as such. Terms such as *legislative participation*, *healthcare advocacy*, *health equity advocacy*, *civic involvement*, *civic engagement*, *public health nursing advocacy*, *population advocacy*, *healthcare reform*, *social reform* and many more were used within the literature to describe the political advocacy endeavors of practicing nurses (Boswell et al., 2005; Conger & Johnson, 2000; Cramer, 2002; Gehrke, 2008; Vandenhouten, Malakar, Kubsch, Block, & Gallagher-Lepak, 2011; Winter & Lockhart, 1997).

As proof of the ambiguity, a search on CINAHL using only the term *political advocacy in nursing* (surrounded by quotation marks) produced no results. However, using SmartText on CINAHL (which summarizes text and pulls research with similar meanings), resulted in an overwhelming 593,211 articles from 1937-2016 (the complete range of the database), or 391,876 articles from 2000-2016 only. Research topics ranged from *advocacy for cancer patients* to *public policy advocacy*. While an in-depth study on all types of advocacy in nursing was beyond the scope of this paper, a broad look at nursing science to determine how the profession categorized various types of nursing advocacy and how it defined nursing advocacy (in general) was helpful. Secondly, examining the evidence which loosely related to political advocacy (as both a concept and/or a practice) in nursing to determine how this particular kind of advocacy was situated within the broader scope of nursing advocacy was critical because it helped to
establish political advocacy’s unique importance, influence, and impact on healthcare, the nursing profession, and on other types of advocacy, like patient advocacy.

The importance of patient advocacy relating to patient decision-making, patient-centered choices, patient needs, patient protection, etc., has been well-established in nursing science (Dubler, 1992; Foley, Minick, & Kee, 2002; Fowler, 1989; Grace, 2001; Hewitt, 2002; Sanchez-Sweatman, 1997). Even so, researchers posited that the definition of patient advocacy within nursing was confusing, with no profession-wide consensus about its meaning among researchers (Bu & Jezewski, 2007). Several nursing researchers have examined the broad concept of nursing advocacy and have attempted to identify and categorize the various advocacy practices nurses are engaged in as part of their professional practice.

Hanks (2007) sought to not only define the concept of advocacy in nursing, but also to examine both the existing associations and existing barriers relating to the concept of nursing advocacy within nursing research. The aim of his study was to promote nursing advocacy by overcoming barriers. In order to accomplish this task, Hanks’ concept analysis also included a literature search of articles relating to patient advocacy, nursing advocacy in practice, nursing practice subservience, and how nursing advocacy was viewed by practicing nurses. His literature review revealed that nursing advocacy was most commonly associated with (a) protecting patient’s rights (Foley et al., 2002; Gadow, 1990; Kubsch, Sternard, Hovarter, & Matzke, 2004) (b) serving as a patient informer (Chafey, Rhea, Shannon, & Spencer, 1998; Curtin, 1979; Kohnke, 1982; Watt, 1997), (c) providing patient empowerment (Chafey et al., 1998; Lindahl & Sandman, 1998; Smith & Godfrey, 2002), d) serving as a supporter (Kohnke, 1982; Watt, 1997), and e) advocating patient partnership (Gadow, 1990; Lindahl & Sandman, 1998; Snoball, 1996).
Hanks (2007) identified common barriers to nursing advocacy as (a) duty to employer vs. duty to patient (Jenny, 1979; Miller, Mansen, & Lee, 1983; Pullen, 1995; Robinson, 1985; Walsh, 1985) (b) lack of support (Millette, 1993), (c) lack of power (Hewitt, 2002; Miller et al., 1983), (d) lack of education (Pankratz & Pankratz, 1974; Penticuff, 1989), (e) time (Miller et al., 1995; Segesten, 1993), (f) threat of punishment, and (g) subservience to the medical profession (Hamric, 2000; Winslow, 1984). In all, 55 abstracts were found within nursing literature. Hanks used 36 of these abstracts within his concept analysis. Hanks did not report any finding within the literature relating to politically focused nursing advocacy, social policy focused nursing advocacy, and/or healthcare policy nursing advocacy within nursing practice. His article concluded with an acknowledgment of nursing advocacy as a vital part of nursing practice and he reiterated the need for more research into how barriers to nursing advocacy can be effectively managed in practice.

Hanks (2007) stated that nursing advocacy is a “new concept” to the nursing profession, having only emerged in the 1980s. Hanks (2007) offered Hamric (2000) to support his claim. However, in his later work Hanks (2013) acknowledged social justice for vulnerable populations as a dimension of nursing advocacy and discussed Nightingale’s social justice work in England. He referred to Nightingale’s writings in *Notes on Nursing: What it is and What it is Not* (1859) in which Nightingale described the actions, beliefs, and behaviors nurses were to follow relating to the seeking of social justice for vulnerable populations and guidelines for the nursing profession. Hanks further described the literature relating to advocacy in nursing science as “philosophical”, but lacking guidance to understand the barriers within the profession (Hanks, 2011, p. 176).

Complementary to Nightingale’s work, Ballou (2000, p. 173-174) divided the broad concept of advocacy in nursing into three categories: (a) micro-level advocacy for the individual
(protecting patient autonomy, informing the patient, etc.); (b) intermediate level advocacy within a nurse's practice venue or at the point of care-delivery; and (c) macro-level advocacy which extends beyond individual practice venues/institutions and is directed at broad societal health, populations, and sub-populations within society. Macro-level advocacy is focused on public policy change or the development of public policy at the state or federal levels, as well as public policies which directly impact the nursing profession on a state, national, or international level. Political advocacy on the intermediate-level is aimed at changing policies within an organization, division, or nursing practice venue (Ballou, 2000).

For example, if a patient asked a nurse to advocate on his/her behalf to change a hospital policy that limits the number of visitors each patient can have, a nurse could advocate for a policy change. However, this advocacy action would likely result in either a departmental or hospital-wide policy change which would impact a limited number of individuals. This type of nursing advocacy would be categorized as intermediate-level nursing advocacy based on Ballou’s definitions (Ballou, 2000). In contrast, macro-level advocacy is specifically directed at changing or developing public policies that affect large populations (not individuals), at the state or federal levels, as defined by Ballou (2000). This study focused on political advocacy on the macro-level. Furthermore, since the practice of political advocacy in nursing continues to be so vaguely defined within the profession, the term advocacy and those terms most closely associated with political and advocacy were examined for similarities and clues to their meaning, purpose, and importance in nursing. In addition, the purpose of advocacy which is political in society, healthcare, and nursing was explored. How is political advocacy different from other forms of advocacy in nursing?
One of the gaps in nursing science (both historical and contemporary) is the lack of evidence relating to the concept and practice of advocacy to influence, guide, and promote social policies, or political advocacy, specifically. The information gleaned from this investigation; together with the information obtained from the face-to-face interviews with current political advocates helps to develop a body of knowledge relating to this particular phenomenon. As a result, the clarity gained enables consistency and theory development relating to what the concept and practice of political advocacy within nursing actually is.

The Power of Advocacy and Politics in Society

The English word advocacy comes from the Latin root that means "to call to." The definition of advocate is a person who publicly supports or recommends a particular cause or policy. The general definition of advocacy can be loosely defined as pleading the cause or needs of another (Merriam-Webster, 2003). It is important to note that all advocacy has an implied goal, but those goals vary greatly depending on the particular situation. The goals of political advocacy to promote social justice are many and may not be a particular “thing” per se, but may be a relational “condition” or a “distribution” in society that would be considered “fair,” “just,” or “equal” (Rawls, 1971, 2001; Reisch, 2002). In A Theory of Justice, John Rawls argued that justice is dependent on “how fundamental rights and duties are assigned and on the economic opportunities and social conditions in the various sectors of society” (2001, p. 7). He further clarified his views of distributive justice by stating, “[a]ll social values . . . are to be distributed equally unless an unequal distribution of any, or all, of these values is to everyone’s advantage” (Rawls, 2001, p. 62). In Rawls’ view, everyone does not receive exactly the same amounts of something; some may need more to achieve this “just” state and some may need less. However, a society which is profoundly just, would be a society that has achieved this state of equilibrium.
through distributive justice (Rawls, 1971; 2001). Rawls clarified his stance by stating, “Thus, the principle holds that in order to treat all persons equally, to provide genuine equality of opportunity, society must give more attention to those with fewer native assets and to those born into the less favorable social positions” (Rawls, 2001, p. 100-101). Scholars have used Rawls’ theory to support social justice-promoting policies such as affirmative action (Reisch, 2002). It is in this way that advocacy for social justice-promotion is interrelated and dependent on the power of political advocacy in nursing to promote policies to address injustice, and why a social justice framework was used to examine issues throughout this study.

Although there may be disagreement about which issues are most important and how best to address them, I argue that political advocacy is but a tool and a practice that must be undertaken to guide policy, if one ever hopes to achieve health or social equity in society. An examination of political science literature (both in mainstream society and other disciplines) may add a greater depth of understanding of politics, political processes, policy advocacy and political advocacy. This information will add depth to the understanding of how these processes relate to nursing.

Gen and Wright (2013), in their study on policy advocacy organizations, loosely defined policy advocacy as intentional activities initiated by citizens acting individually or in a collective group, in order to affect the policy-making process. Similarly, although the reasons may vary, several researchers suggested that those who are being represented by the actions of an advocate may have less relative power in society or may be unable to effectively represent their own interests (Gen & Wright, 2013; Jansson, 2010; Schlozman & Tierney, 1986). The poor, minorities, children, elderly individuals and individuals that have a disability, are offered as
examples of some of the vulnerable groups within society that may have less relative power than the majority.

Sprechmann and Pelton (2001) posited that the practice of policy advocacy seems to always involve a deliberate process. Additional research revealed that policy advocacy usually includes influencing decision makers (Jenkins-Smith & Sabatier, 1993), influencing a social agenda (Schmid, Bar, & Nirel, 2008), or building political interest and/or motivation for action (Gen & Wright, 2013). Inevitably, the aim of any policy advocacy endeavor must always be to change policy (Gen & Wright, 2013; Reisman, Gienapp, & Stachowiak, 2007). Furthermore, since public policy is always developed for the general public, (versus an individual), one can assume therefore that policy advocacy is advocacy with the good of the public or some part of the public in mind.

The historical definition of politics is derived from the Greek word *polis*, meaning a city-state or community in which one lives. The definition of *politics* varies, but can be generally defined as actions aimed at guiding the allocation of some type of resource (Mason, Leavitt, & Chaffee, 2012). The historical definition of politics is based primarily on the work of Aristotle. The definition of *political* has a similar meaning and refers to actions relating to public affairs or the seeking of power in government. In *Politics*, Aristotle (1944) declared that "man is by nature a political animal" (p. 1253a). Aristotle believed that human beings within a society could create a "just life" using "politics" as the tool, practice, or means to negotiate a way for all human beings to achieve a just and equitable society; and as such, be able to live a reasonably good life (Aristotle, 1944). If the practice of politics includes negotiating to achieve a just and/or equitable life, how can the profession blend politics, nursing knowledge, and nursing science in order to achieve a more equitable society? How is nursing science influenced by society?
Taylor (2013) told us that many view true knowledge as apolitical, but he acknowledged that all scientific knowledge had the potential of being politically influenced within a society, including the science of nursing. The science of political philosophy and the human sciences (i.e., psychology, sociology, medicine, nursing, etc.) are forever intertwined, and in this way, they legitimize each other. Scientific discoveries or theories in one area of science are influenced by discoveries and theories in other areas of science (Atwood, Colditz, & Kawachi, 1997; Taylor, 2013). In addition, scientific evidence (in any area of science) is politically-influenced by the prevailing thought within a society at any given moment (Brenner, 1998; Cole, 1992). Scientific discoveries in all areas of science are scrutinized, accepted, or rejected based on a collective societal/political view that is ever-changing and varies among groups of people within society (Brenner, 1998). For example, Darwin's theory of evolution is accepted within scientific circles, but is still rejected by many in society because it contradicts religious doctrine and/or their personal religious beliefs (Miller, Scott, & Okamoto, 2006).

Nursing, much like other areas of science, is similarly influenced and impacted by societal views. Browne (2001) told us nursing science (for the most part) has been dominated by empiricism, which views politics and ideology as scientific contaminants of true knowledge. Johari (1987) told us that this is problematic for the nursing profession, since empiricism, as a methodology, focuses on what is actually experienced by the senses and does not consider societal influences or societal structures.

Contemporary evidence suggested a trend away from empiricism in nursing as a multicultural/transcultural approach has gradually been accepted by the profession (Holmes & Warelow, 2013; Leininger, 1995). Leininger (1995) was one of the first nursing theorists to identify the influence that cultural and socioeconomic factors have on a patient’s care. Known as
the founder of *transcultural nursing*, her “*Theory of Culture Care: Diversity and Universality*” (Leininger, 2011) was aimed at promoting a more patient-centered, holistic approach to overall patient care. This movement has been furthered by position papers by the World Health Organization (WHO, 2010) acknowledging the socioeconomic factors that influence health. As a result, the WHO developed a framework for action for nurses and other healthcare professionals to address them (WHO, 2010). Much like nursing, contemporary healthcare research (overall) seems to be supportive of a more holistic, socioeconomic approach to patient care, which includes political advocacy. However, one must ask, does political advocacy aimed at addressing socioeconomic factors align with the philosophical and foundational beliefs of the nursing profession? And, if so, where is the evidence?

**Foundational Philosophical Beliefs in Nursing and Their Relationship to Political Advocacy**

The scope of any professional practice is determined by examining its originating philosophical and foundational tenets, the history of its practice, and current: practice regulations, practice standards, codes of ethics, moral standards, societal opinions, and current political views (Dawson, 1994). One can assume that an individual who is a practicing registered nurse and is a licensed member of the nursing profession by both education and registration is expected and obligated to ground their scope of nursing practice within the boundaries of the nursing profession's philosophical and political practices and ideology. It is here then that an examination of both the historical and contemporary political advocacy practices of nurses and the foundational tenets of the profession is needed, in order to establish political advocacy’s conceptual relevance and importance within the profession.

After a review of historical and contemporary nursing literature, Ballou (2000) identified three prevailing ideologies that define what nursing *is*. These three prevailing ideologies:
morality, advocacy, and caring, are consistent with liberal ideology. Browne (2001) went further and stated that intentionally or not, nursing practice is founded on liberal ideology due to the following: (a) the focus on individualism in nursing science, (b) the profession's view that society is egalitarian, (c) the maintenance of politically neutral knowledge development, and (d) nursing research which is racially and ethnically neutral. Even so, others have argued that the liberal stance relating to racial and ethical neutrality in nursing research hinders the profession’s ability to advocate for vulnerable groups (Smedley, Sith, & Nelson, 2003) because it results in the lack of race-based or ethnic-based evidence, (which could be used to advocate for minority populations), and because it focuses on individuals rather than community and social structures.

Even so, based on her assessment of nurse’s sociopolitical responsibilities, Ballou (2000) concluded that “All RN’s are obligated by the social policy statement to a social contract doctrine based on fiduciary responsibility and justice” (Ballou, p. 178). Additional evidence of nursing's moral obligation to sociopolitical advocacy is linked to liberal ideology that exists within the scope of nursing practice: nursing practice as a moral endeavor, nursing practice as a caring endeavor, and nursing practice as an advocacy endeavor (Ballou, 2000). However, Ballou's study also revealed that there is an inconsistency between professional nursing's moral and philosophical foundation and actual advocacy endeavors in contemporary nursing practice. In addition, the ANA, (one of the foremost nursing organizations within the profession), has stated that the organization is both “bi-partisan” and “politically neutral” (ANA, 2014). Similarly, since no official political affiliation is stated on the NLN website, it is likely that the NLN is “bi-partisan” and “politically neutral” as well, since the NLN is a tax-exempt, non-profit 501(c) (3) organization according to the Propublica website (Propublica, 2015). As a result, according to the Internal Revenue Service’s (IRS) 2016 online publication, The Restriction of
Political Campaign Intervention by Section 501(c)(3) Tax-Exempt Organizations, which specifically states,


[a]ll section 501(c)(3) organizations are absolutely prohibited from directly or indirectly participating in, or intervening in, any political campaign on behalf of (or in opposition to) any candidate for elective public office. Contributions to political campaign funds or public statements of position (verbal or written) made on behalf of the organization in favor of or in opposition to any candidate for public office clearly violate the prohibition against political campaign activity. (IRS, 2016, p. 1)

Although there may be legitimate reasons for both organizations’ political stance, political neutrality does not align with the historical evidence of the profession’s liberal philosophical and foundational beliefs.

Bodenheimer (2005), in his article, “The political divide in health care: A liberal perspective,” analyzed liberal philosophical beliefs relating to healthcare. The liberal belief in healthcare as a “right” is based on two branches of liberal thought: (a) the perspective of John Rawls which views healthcare as a basic right (Rawls, 2001), and (b) the utilitarian view that comprehensive healthcare services will increase the general welfare of the greatest number of people (Mill, 1971).

Similarly, Ballou (2000) concluded that in order to fully conform to the philosophical and professional mandates in nursing, the practice of political advocacy and activism in nursing must be aimed at changing structures, laws, or policies within society which impede the profession’s collective mandates and obligations to achieve social justice and health equity within society. Professionally speaking, a lack of participation in political advocacy and activism (by any licensed RN), would be a violation of the collective political ideology and the current professional mandates that guide the praxis of the current profession of nursing.

Ballou further solidified her stance by stating that contemporary professional nursing may require a full liberal educational framework in order to comply with the social, ethical, and
political obligations of the profession (Ballou, 2000). Complementary to this, Pascarella (2005) asserted that liberal arts study is firmly grounded in the Socratic Method and an approach to learning that empowers individuals by providing students with a broad knowledge of science and culture within society and how that knowledge relates to the larger world. Pascarella added that contemporary liberal arts education focuses on helping students develop a sense of civic and social responsibility, knowledge of moral philosophy, and an ability to use critical thinking and problem-solving skills in real-world settings. McKie (2012) agreed and posited that liberal arts study strives to incorporate a higher purpose (telos), into the knowledge of a particular science discipline.

Likewise, the liberal arts foundation in nursing education seeks to blend the art of nursing: caring, morality and ethical behaviors with the “science” of nursing. As such, nursing practice is founded and guided by both science and the liberal arts. In the American Association of Colleges of Nursing’s “The Essentials for Baccalaureate Education for Professional Nursing Practice” (2008, p. 3), Essential I stated that “[a] solid base in liberal education provides the cornerstone for the practice and education of nurses.” Even so, is a liberal arts foundation sufficient preparation for political advocacy in contemporary society, or is more needed? What were the political practices of historical nursing leaders and is the practice of political advocacy still relevant in contemporary nursing practice, or have society’s needs changed?

As an example, Cook (1914) told us that Florence Nightingale, the founder of modern nursing, was able to use her nursing knowledge and medical statistics to advocate for policies that would reduce health disparity and economic inequity in the late 19th century. Prevention of diseases and health promotion were part of her work, but there were many other issues that she systematically addressed, that can only be described as social justice issues (Cook, 1914). The
“workhouse infirmaries” served as hospitals for the vast majority of the population, including the “sick poor,” who could not afford a fee-paying hospital. Many individuals who resided in the workhouses were physically disabled, intellectually disabled, elderly, mentally ill, poor, or homeless (Cook, 1914). According to Cook, very few residents were actually ill, but many had nowhere else to go.

Cook (1914) told us that the reform of these “workhouses” was one of Nightingale’s greatest social reform accomplishments. McDonald (2001) explained that the changes which were initiated by Nightingale, and the policies which were developed, served as the first public acknowledgment in England that it was the duty of the state to provide hospitals for the poor. Nightingale, with help from her friend, John Stuart Mills, (a democratic socialist), advocated for these public policies, which resulted in taxes being levied on the public to help take care of the poor. This resulted in the Metropolitan Poor Law being instituted in 1867, which was one of the first “socialized” healthcare policies. Although other healthcare policies would follow (McDonald, 2001), it would take a over 80 years for the National Health Services Act of 1946 to be fully implemented in the United Kingdom in July 1948 (Webster, 2002).

Boykin and Dunphy (2002) told us that these actions established Nightingale as a committed liberal reformer of the 19th century, who insisted on non-discriminatory practices relating to a patient's religion, ethnicity, and social class. Cook (1914) posited that Nightingale's views on why England's political leaders did not do more to improve social justice and healthcare issues were that England's public officials were not trained to interpret and understand medical statistics and therefore lacked the knowledge of medical and healthcare issues to do so (Cook, 1914; Nightingale, 1859). The result of such ignorance, according to Nightingale, was that public policies of health were "not progressive" (Cohen, 1984, p. 7, p. 2) and were obviously
written by officials who "legislate without knowing what they are doing" (Cohen, 1984, p. 7, p. 2). Through her actions (which can only be described as political advocacy actions), she was able to promote into law more social justice and healthcare policies than any of England's elected officials (Boykin & Dunphy, 2002; Cohen, 1984; Cook, 1914; McDonald, 2003). It is important to note that Nightingale was able to do all these things, even though she was a woman, at a time when women had very little power in society. Throughout the years, many other nurses would follow in Nightingale's political footsteps.

Similarly, Margaret Sanger, a nurse activist, led efforts which would eventually establish Planned Parenthood in the United States. Although some researchers now acknowledge that Sanger’s views were tainted with racism and ableism (Russo, 2008), Sanger was able to accomplish her goals for women’s reproductive health and birth control by using various political strategies which brought national attention to her cause. Sanger publicly delivered speeches and participated in numerous public demonstrations in support of birth control. In addition, she solicited donations for money which she then used to print and distribute flyers which educated thousands of women about various forms of contraception (Ballou, 2000; Falk-Rafael, 2005; Spenceley et al., 2006).

Much like Sanger, other nurses such as Lillian Wald, Jane Hitchcock, and Myra Breckenridge, all established numerous programs for individuals living in poverty (Bullough & Sentz, 2000). They developed housing and food programs for impoverished immigrants in New York City, rights for women, and labor laws which prohibited young children from working in unsafe conditions. Some of these nurse activists (such as Margaret Sanger) were so strongly dedicated to the reform of social and health policy that they were willing to be arrested and jailed.
in support of their cause. But where is the evidence of contemporary political nursing leaders who have been arrested for their cause?

Though many of these brave acts occurred nearly 100 years ago, society and the nursing profession continue to boast of their accomplishments (McDonald, 2001; Neuhauser, 2003). These foundational nursing leaders were able to transform an ethic of care into political advocacy and action. How were these nurses able to accomplish so much at a time when women in general had so very little power? More importantly, why do contemporary nurses appear to be less able to effectively address public policy changes today? Has the average, contemporary nurse become not only less involved in political advocacy, activism, and social justice issues, but less caring and/or less interested too? What has changed among nurses and within the nursing profession?

It is here then that Reverby (1995) reminded us that prior to the 1950s most patients were cared for at home. As healthcare improved and care shifted from home-based and community-based care to care given almost exclusively in hospitals, nurses were forced to follow suit. When nurses became employees of hospitals, they lost their autonomy and became part of the biomedical model in hospitals governed by physicians. As a result, nurses experienced on-going dominance and exploitation by physicians (Reverby, 1995). The change in focus from home and community-based care to hospital care also changed nurses’ focus from societal health and prevention needs, to a primary focus on the needs of individual patients (Reverby, 1995). In addition, nurses who once felt a moral duty to society in general, now felt a moral duty to the physician and to the hospital at which they were employed (Lynaugh & Fagin, 1988).

When nursing practice became primarily hospital-based, Ballou (2000) explained that nurses “settled in” and adapted to their new practice venues. Gradually, individual nurses
became less focused on society’s healthcare needs and more focused on the political hierarchy governing their own practice venue and the needs of the patients within their own demographic. Nurses who practiced in rural locations became more focused on the issues of rural patients. Nurses who practiced in urban practice venues were more focused on the problems of city-dwelling patients. Over time, the average hospital nurse has gradually felt less responsible for the well-being of society, and as a result, has gradually become less interested in public policy (Ballou, 2000).

Since this process began, individual nurses have gradually become more distanced from the broad healthcare needs of society, both literally and figuratively. Ballou (2000) told us that the professional practice shift to hospital-based patient care has also resulted in a loss of the collective power of nurses in political advocacy and activism as a part of moral practice (Lynaugh & Fagin, 1988). Based on the evidence, a shift in practice venues may have caused nurses to drift away from their philosophical and political roots, but where is further evidence? What is the current political involvement of contemporary nurses?

**Political Representation and Professional Mandates in Nursing**

In the 2008 U. S. Presidential election, 70.4 million women and 60.7 million men voted. According to the Health Resources and Services Administration (2010) nurses are the largest group of healthcare professionals and there are currently more than 3.3 million registered nurses in the United States. To put this into perspective, recent statistics reveal that 1 in every 100 adults is a nurse (Feldman & Lewenson, 2000). However, even though large portions of the population are nurses and women outnumber male voters, there are currently only five nurses serving in Congress (ANA, 2016c) and all are female. Whether the lack of political participation
is gender-related (there are more female nurses than male) or primarily due to disinterest is unclear, but many nursing researchers suspect the latter.

Des Jardin (2001) believed that there is both a general disinterest in politics (in general) among nurses and a lack of political advocacy and activism (at the policy-level) profession-wide (Ballou, 2000; Falk-Rafael, 2005; Reutter & Duncan, 2002). Multiple studies revealed that most nurses do not participate politically (in general) and, therefore, they are not likely to participate in any political advocacy or policy-related activities (Ballou, 2000; Falk-Rafael, 2005; Reutter & Duncan, 2002). Researchers consistently reported that nurses, both individually and collectively, were only minimally involved in all political processes (Abood, 2007; Antrobus, 2003; Ballou, 2000; Boswell et al., 2005; Chafey et al., 1998; Mohr, 1996; Pence, 1994; Spenceley et al., 2006). While this may be the case, how does political advocacy align with the professional and/or mandated responsibilities of the profession?

Matthews (2012) told us that the first school dedicated to the training of nurses in the United States opened in 1873. He went on to explain that 2 decades later, nursing administrators came together to form a professional nursing organization that would establish standards for nursing practice and education. This organization was initially called the American Society of Superintendents of Training Schools for Nurses, but in 1952 the name was changed to the National League for Nurses (NLN). In 1896, nursing alumni came together to attempt to form standardization in ethics, education, training, and practice. This group was initially called the Associated Alumnae of Trained Nurses of the United States and Canada but was renamed the American Nurses Association (ANA) in 1911 (ANA, 2009; Matthews, 2012). In the United States, the two foremost professional nursing organizations continue to be the ANA and the NLN, respectively (Matthews, 2012). Although their main mission is to advocate for the nursing
profession, both agencies have also made commitments to politically advocate for healthcare as part of their mission (ANA, 1998, 2010; Matthews, 2012; NLN, n.d.; Robertson & Middaugh, 2014).

Contemporary professional guidelines from both the ANA and the NLN are numerous, such as the “Code of Ethics for Nurses with Interpretive Statements” (ANA, 2015; 2001), “Nursing’s Social Policy Statement” (ANA, 2010) and the “Standards of Clinical Nursing Practice” (ANA, 1998); all serve as evidence of nursing's professional obligation to political and social justice advocacy. In addition, gender-related health inequity (Drevdahl et al., 2001; Tyer-Viola & Cesario, 2010), race-related health inequity (Drevdahl et al., 2001), and marriage equality (American Academy of Nursing (AAN), 2012) are but a few justice-related concepts that are addressed in nursing science and would fall under the umbrella of “social justice” in nursing (Drevdahl et al., 2001; Reutter & Kushner, 2010). All offer further proof of the profession’s stance which acknowledges the importance of addressing social justice-related health inequity in nursing. Even so, Ballou (2000) referenced numerous studies as evidence of nursing's lack of sociopolitical involvement (Andersen, 1994; Chafey, Rhea, Shannon & Spencer, 1998; Mohr, 1996; Pence, 1994).

The NLN, on their “Advocacy Teaching” web page stated that "Nursing is social justice advocacy” (NLN, n.d.). In addition, in 2014, the NLN’s Public Policy Committee created their first “Public Policy Advocacy Toolkit” (Robertson & Middaugh, 2014). This resource delved into all areas of the political process, including how to communicate with elected officials and how to approach both in-person advocacy and advocacy through the media. The NLN appears to be supportive and encouraging of nurses becoming political advocates for healthcare and the nursing profession. Even so, no official and/or professionally mandated nursing definition of
advocacy, political advocacy, and/or social justice advocacy can be found among nursing literature. While the “Public Policy Advocacy Toolkit” may be full of helpful information relating to advocacy directed at public policy, does the average nurse even know it exists, or where to find it? For that matter, is the average nurse even a member of a professional nursing organization?

Research reveals that a majority of nurses are not members of any professional nursing organization (Abood, 2007; Antrobus, 2004; Ballou, 2000; Boswell et al., 2005; Chafey et al., 1998; Mohr, 1996; Pence, 1994; Spenceley et al., 2006). The NLN lists their membership at 40,000 individual memberships and 1,200 organizational memberships on the NLN website (NLN, 2015). The Union Facts website lists ANA individual membership at 163,011 for 2013 (Union Facts, 2014). Together, the combined individual membership is 203,011 for both agencies for the year 2013 and, as such, represents less than 1% of all nurses in the United States. Many researchers believed that nursing can never be a cohesive political force if nurses do not participate in the professional organizations that serve as the political advocates for public policy, the profession, and the healthcare needs for individuals and society (Ballou, 2000; Bekemeier & Butterfield, 2005; Conger & Johnson, 2000; DiCenso et al., 2012; Falk-Rafael, 2005, 2006). Do nurses perhaps view participation in professional organizations as an optional part of their practice and/or do they view membership in a nursing organization as unimportant? Furthermore, what work do these nursing organizations actually do?

On the ANA website (ANA, 2016a) we learn that developing useful policy is one of their core functions for the profession. When a policy issue is brought to the attention of the ANA, the policy experts at the ANA thoroughly research the topic, collaborate as a team, and then present their opinion in published Issue Briefs located in the Expert Policy Analysis tab on their website.
(ANA, 2016a, Section 2). The Issue Briefs contain concise information on each issue and offer suggestions to nurses as to how each problem can be addressed. Some of the Issue Briefs contain information relating to a specific rule, regulation, or policy to be voted on. Some have links to the Federal Register (Federal Register, 2016). The Federal Register is an online journal where nurses (or other citizens) can find detailed summaries of proposed regulations to be voted on by our elected officials in upcoming legislative sessions, and the address and contact information with which to make a comment. However, other Issue Briefs on the ANA website, such as the “Nursing Licensure Portability Issue Brief,” do not link to the actual regulation being voted on (ANA, 2016a, Section 2, ¶2).

While the Issue Briefs are all very informative, there are only two Issue Briefs which give nurses the information needed so that they are able to (a) take action, (b) identify the policy being voted on, (c) submit comments and/or questions about the proposed policy, (d) take specific actions to change the policy, and/or (e) examine all information relating to the issue. There are currently 13 Issue Briefs posted on the ANA website as shown in Appendix D (ANA, 2016b). However, effective participation in political advocacy requires professional nursing organizations to give specific instructions relating to the actions individual nurses should take to effect policy changes. In addition, participating in political advocacy requires individual nurses to be aware of the inequity and disparity that exists, cognizant of their responsibility to promote social justice (as a member of the profession), and inspired and/or motivated enough to participate. But what if nurses do not feel motivated enough to participate? Milstead (2004) strongly posited that policy making is not an option for a professional nurse, it is a necessity of the profession and a physical demonstration of ethical caring.
Ethical Caring, Social Justice, and Health Equity

Research confirmed that meaningful construction in nursing practice is grounded in the ethics of caring and performed by means of existential advocacy in the professional context (Murphy & Aquino-Russell, 2008). The ethics of caring in nursing originate from both ethical traditions and existential philosophy. According to Gadow (1990), the ethical elements relating to existential advocacy differ slightly from the ethics of caring and principle-based advocacy or the protection of patient's rights. Gadow described existential advocacy as a broad way of thinking about one's overall moral obligation to patients and society-at-large. In contrast, feminist research which emerged in the 1960s and 1970s focused primarily on nurses’ moral and ethical obligations and the promotion of universal healthcare.

Nearly 40 years ago, feminists proclaimed the need for universal health care as a “basic human right: “We believe that health care is a human right and that a society should provide free health care for itself. Health care cannot be adequate as long as it is conceived of as insurance . . . Health care for everyone is possible only outside of the profit system” (Boston Women's Health Book Collective, 1971, p. 192). However, despite much societal support of "health care for all" as a "basic human right," universal health care coverage continues to be unattainable in the United States. In addition, the number of people in poverty in 2014 in the United States is 2.3 percentage points higher than in 2007 (the year before the most recent recession), with the largest portion of impoverished individuals being those “native-born” and those residing in the South (DeNavas-Walt & Proctor, 2015). Based on the DeNavas-Walt and Proctor study (2015) conducted for the United States Census Bureau, in 2014 there were 46.7 million people living in poverty in the United States. What is being done in healthcare to address this trend? And, more
importantly, why is it occurring? Sadly, based on the evidence, it is primarily due to what is known as structural violence (Farmer et al., 2004; Nixon, 2011; Rylko-Bauer & Farmer, 2016).

Farmer (2013), an anthropologist, physician, and political/social justice advocate, posited that the poor are not poor because the natural world has deemed it so. He argued that the poor remain poor because of the action or inactions of other human beings (Farmer, 2013; Rylko-Bauer & Farmer, 2016). Farmer deemed these inequitable societal situations to be a form of "structural violence" (Farmer et al., 2004). The term structural violence was first used by Johan Galtung (1969) in order to describe the unequal distribution of power within a society, which typically results in an uneven distribution of resources.

Even though most healthcare professionals would probably agree that the poor deserve good medical care, Farmer (2013) chastised health professionals for their lack of political advocacy to challenge the moral integrity of a healthcare system which does not acknowledge that the ones who need care the most are the ones who typically do not receive it. Farmer (2013) stressed that nurses and physicians must become more involved in the political system and must question the inequitable political and social structures which offer the best care to the healthiest, the wealthiest, and the most intelligent, and the worst care to the poorest, the sickest, and the least intelligent. One of Farmer’s greatest skills as an advocate for the poor was his ability to reframe most health problems as systemic global problems (Farmer, 2013). Farmer (2013) critiqued our well-meaning, charity-based, healthcare/social justice missions, which help the impoverished, but simultaneously promote their on-going dependence on others for their survival.

Similarly, Kidder, in Mountains Beyond Mountains (2009), argued that Farmer believes that sustained change can never happen until well-meaning individuals connect the global with
the personal and the political. Farmer (2013) questioned how healthcare professionals can claim that they truly care about the poor and the sick if they do not care enough to change the political and socioeconomic factors that create the conditions which enable illness and disease to flourish.

What has nursing research done to identify or address structural violence and its impact on health?

In 2008, Jean Watson a well-respected nursing theorist, studied poverty, disease, and suffering, and subsequently identified these factors as the outward manifestations of social injustices such as racism, structural violence, and cultural incompetence. Watson questioned how the United States could justify spending billions to defend our country from terrorism, but spend miniscule amounts of money (in comparison) to provide basic healthcare and social services (Watson, 2008). Like Watson, many other contemporary nursing researchers now acknowledge nursing’s moral allegiance to society’s well-being and social justice issues and recommend advocacy which addresses socioeconomic factors as a way to accomplish this goal (Barnes, 2005; Clingerman, 2011; Falk-Rafael, 2005; Watson, 2008).

Notably, Bekemeier and Butterfield in 2005 undertook a critical review of the concept of social justice in the three national nursing documents which guide the profession: the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015; 2001), *Nursing’s Social Policy Statement* (ANA, 2010c), and *Nursing: Scope and Standards of Practice* (ANA, 2007; 2010b). Although Bekemeier and Butterfield (2005) were able to find numerous references to nursing’s historic role in broad social policy reform, the framework for carrying them out was inconsistent and ambiguous at best. They confirmed that the documents strongly reinforced nursing advocacy directed at individual patients, but stated that the documents failed to address nursing models
directed at broad societal, system, or policy changes aimed at the health of populations and offered little to no advice to nurses on how to change them (Bekemeier & Butterfield, 2005).

Unfortunately, the authors concluded that nowhere within the texts were nurses encouraged to change the societal systems that helped to perpetuate socioeconomic injustices and the resulting poor health outcomes (Bekemeier & Butterfield, 2005, p. 156). They furthered their stance by critiquing the statements relating to the “seeking of social justice” within the documents to be “non-compulsory”, “passive”, “vague”, and “weak” (Bekemeier & Butterfield, 2005, p. 156). If the guiding documents of the profession do not offer clear and specific guidance to contemporary nurses relating to the practice of political and social justice advocacy, how can the nursing profession and individual nurses alike have the guidance needed to be effective?

Bu and Jezewski (2007) echoed the sentiment, after reviewing 220 articles in their concept analysis of advocacy. They argued that even though nurses may support the concept of advocacy, nurses have not fully addressed or embraced advocacy in nursing education and nursing practice. They posited that the very definition of “patient advocacy” within nursing was confusing, with no profession-wide census about its meaning among researchers.

Advocacy for population health is typically addressed in nursing education as a facet of a community/public health nursing course and/or clinical rotation. However, there is a distinct difference between public/community health and population health. As Radzyminski (2007) pointed out, public health focuses on the relationship between the state government and the health of citizens. In contrast, a hallmark of population health is the acknowledgement of the patterns created by social factors and the interactions between these factors (Fawcett & Ellenbecker, 2015).
Many of the social factors which affect health, such as income and education level, are not typically addressed in public health nursing practice (Fawcett & Ellenbecker, 2015; Kindig & Stoddart, 2003) or public health/community nursing education courses. Although the profession has offered evidence to support the connection between the social factors and the level of health of individuals, and agreed that advocacy is a foundational mandate of the profession, nursing as a whole has not been able to bring about sweeping public policy and/or social policy changes in this country. If the single greatest social determinant of health is poverty, what has the profession of nursing done to address it?

As Bekemeier (2008) boldly pointed out, nursing praxis which focuses solely on the health of individuals, is a silent agreement to focus on “the health of the few” while ignoring “the illness and death of many” (Bekemeier, 2008, p. 51). In addition, population health includes the health delivery system, while public health does not. Other elements of population health focus on research agendas, policy reform, and resource allocation for populations instead of individuals.

The preamble to the World Health Organization's Constitution, written by the United Nations, establishes the right to both health and healthcare for individuals. This declaration, rightly named the “Universal Declaration of Human Rights,” of which the United States is a signatory, states that everyone has the right to medical care (United Nations, 2012). The International Covenant on Economic, Social, and Cultural Rights, signed in the United States in 1977, also established the right to healthcare (Vierdag, 1978). Even so, from both a national and global perspective, healthcare continues to be a commodity that is sold to the highest bidder, according to Farmer (2013).
There is much research relating to the professional responsibilities of nurses to impact socioeconomic and health policies to address the needs of vulnerable populations (Falk-Rafael, 2005; Gebbie, Wakefield, & Kerfoot, 2000; Glass & Hicks, 2000; Reutter & Duncan, 2002), and most especially those who live in poverty. The economic and social factors which impact an individual's health are now commonly referred to as "the social determinants of health" (SDH) (WHO, 2008). These factors are the cumulative compilation of the environment, conditions, and situations, into which individuals are born, raised, schooled, work, age, and eventually die.

Socioeconomic factors have great influence on the range of potential behaviors, lifestyles, and educational level an individual is able to afford. According to Adler and Newman (2002), socioeconomic disparities are now the most fundamental cause of health disparities. In addition, recent data suggest that individuals who are better educated live longer and have less disease (Olshansky et al., 2005; Zimmerman, Woolf, & Haley, 2015). Likewise, health factors have a direct effect on higher education attainment (Basch, 2011), which further supports the interconnectedness of socioeconomic factors, education, and health outcomes. See Appendix E for additional health disparity statistics.

While no one questions the idea that individuals who make poor food choices and engage in unhealthy practices like cigarette smoking or unprotected sex contribute greatly to their own unhealthy outcomes (WHO, 2010), no one can deny that there is little that an impoverished individual with limited resources can do to improve them. For example, a nurse can teach the benefits of a balanced diet with lots of fresh fruit and vegetables, but if a single mother cannot afford to buy them, patient teaching does little to fix the problem. Although individual behavior contributes to health and disease, who will advocate for policy to change the socioeconomic factors which impact those behaviors?
The Robert Wood Johnson foundation completed a comprehensive analysis of how the health of a nation is influenced, (both positively and negatively), by socioeconomic conditions. The report, *Overcoming Obstacles to Health*, declared socioeconomic factors and their influence on health disparities in the United States, as powerful as medical care or genetics (Fawcett & Ellenbecker, 2015).

There is no denying that poverty is one of the major determinants of poor health (Marmot, 2002; National Center for Health Statistics, 2013; Navarro, 2009; Wilkinson & Marmot, 2003), but what are contemporary nurse’s attitudes and actions toward socioeconomic factors such as poverty? Furthermore, how is poverty’s effect on health addressed in nursing education? In addition, what evidence exists within current nursing research relating to the actions within practice that nurses should take to politically advocate; in order to initiate change in social policies which impact poverty?

Davis and Chapa (2015) acknowledged that there is an increasing awareness of socioeconomic factors within nursing practice and healthcare in general, and offer a model for nurse practitioners to translate knowledge into actions which will promote effective change. They substantiate the importance of their framework, with the following question: How can nurses assist patients in improving their health, if nurses do not address the societal, economic, environmental, cultural, and religious influences which perpetuate them?

Although any nurse can translate knowledge into actions which lead to policy changes, Chapa and Davis’s framework (2015) was aimed at nurse practitioners. The authors also suggested that nurses in community and home health settings may be more uniquely positioned to address the Social Determinants of Health (SDH), due to the fact that the environment and/or situation in which an individual resides is more likely to be viewed by nurses who practice in a
community setting. The opposite is also true: the environment/situation in which an individual patient resides is not likely to be viewed by a hospital-based nurse. This implies that hospital-based nurse may not truly realize the magnitude of the environment in which an individual patient may reside, simply because they never see it or never have an opportunity to experience the environment first hand. One has to wonder if this issue may have also contributed to the general trend away from political advocacy in nursing: if nurses do not personally visualize the extreme poverty and/or dangerous situations in which some patients reside, how can they ever be inspired or motivated to not only care, but to care enough to politically advocate to change public policies?

Poverty not only negatively affects the health of an individual; it has a compounding effect due to the fact that poor health negatively affects other socioeconomic factors as well. Poor health also has a negative impact on any possible education and employment opportunities an individual might have (Basch 2011; Conti, Heckman, & Urzua, 2010; Hass & Fosse 2008). Individuals who chronically miss work due to illness are not likely to be the one chosen first for a special project or a performance raise. The compounding negative effects of poverty are far-reaching and are often transgenerational, as shown in Appendix C. Poverty is not only the strongest correlating factor in relation to quality of health; it is also the single-most important determinant of social injustice (Basch, 2011). However, as Bekemeier (2008) pointed out, there is still much critical analysis that must be done in nursing science relating to the Social Determinants of Health (SDH) as an obstacle to health and how nursing education should prepare students to address these obstacles through political endeavors. Nurses will need to shift their focus in order to influence and participate in policy decisions that address population health (Bekemeier, 2008).
The historical foundation of nursing coupled with the fact that nursing represents the largest health segment of healthcare workers (both nationally and globally) places contemporary nurses in a unique position to politically advocate for the poor and socioeconomically disadvantaged. What knowledge, skills, or actions do nurses need to take in order to participate in the political arena? And, even if nurses learn the skills and actions required to participate in the political process required, how can nurse educators better motivate nurses to actually use their newfound political advocacy prowess in the legislative/political arena to bring about policy level changes?

It is here then that a nursing advocacy assignment for vulnerable populations was developed by Jones and Smith (2014), who are professors at a small liberal arts college in the Pacific Northwest. Jones and Smith designed the assignment to encourage and promote social justice advocacy and health policy advocacy among nursing students in an online RN-BSN program. The Vulnerable Population Advocacy Assignment was focused on helping students identify and develop an awareness of issues impacting vulnerable populations. Promoting participation of nurses in policy formation is also a goal of the assignment. Although the course helped nurses to learn the process required for identifying the needs of vulnerable populations and the corresponding policy which relates to it, the authors did not address the steps, process, or actions required for the nurses to effectively advocate for an actual policy change in the political arena. Perhaps the students were unaware of the tremendous power of politics in nursing, healthcare, and society in general.

As evidence of this, Halstead, Rains, Boland, and May (1996) posited that one does not advocate if one does not acknowledge that a problem exists. They further concluded that in order for nurses to justify spending their time on political advocacy and activism, individual nurses
must have in-depth knowledge of the complex issues and problems that impoverished individuals face. To that end, Halstead et al. (1996) formulated six abilities that are characteristic of politically aware, senior-level baccalaureate nursing students. They are (a) the ability to analyze health policy, (b) the ability to analyze global trends in healthcare, (c) the ability to understand how political processes shape healthcare delivery, (d) the ability to influence political process, (e) the ability to advocate for health-promoting policy changes, and (f) the willingness to participate in political activism to promote improvements. Political awareness will help nurses gain an in-depth understanding of the resulting effect that societal problems have on the poor (Sword, Reutter, Meagher-Stewart, & Rideout, 2004).

Yun and Weaver (2010) posited that attitudes toward poverty can usually be divided into three categories: (a) individualistic explanations, (b) structural explanations, and (c) stigmatizing explanations. The individualistic explanations category specifically related poverty to the personal deficits of individuals: poor health behaviors, drug use, and poor financial management, etc. The structural explanations category related poverty to the socioeconomic structures in society which limit the opportunities of individuals: unemployment, lack of education, low wages, etc. The stigmatizing explanations category related to specific stigmatizing statements which reduce individuals (in a particular group or situation) from a whole and usual person to a tainted, unvalued, and socially unaccepted one. For example, a stigmatizing statement would be, “Welfare makes people lazy.” But, how can nurse’s attitudes toward the poor be assessed?

It is here then that Wittenauer, Ludwick, Baughman, and Fishbein (2015) surveyed the attitudes of hospital nurses’ toward poverty. Wittenauer et al. used a convenience sample to survey 117 registered nurses in a small community hospital located in a Midwestern state in the USA that serves a blend of rural and urban areas. The nurse-participants completed the *Attitudes*
Towards Poverty Short Form (ATP) (Yun & Weaver, 2010). The ATP short form has been used previously and demonstrated acceptable reliability and validity evidence in Yun & Weaver’s 2010 study on 319 undergraduate social work students at a mid-size university in Canada. Wittenauer et al. (2015) then used regression analysis to examine the associations between the nurses’ age, education, and years of experience, political views, and financial security. Within the sample, 18% of the nurses self-identified as liberal, 31% of the nurses self-identified as conservative, and 51% self-identified as moderate. Almost half of all the nurses surveyed were over the age of 50 (45%) and 64% had more than 10 years of nursing experience. The highest scores were found in the stigmatizing explanations category, followed by the individualistic explanations category. The lowest scores were found in the structural category. This suggests that most nurses were more likely to agree with stigmatizing statements than statements which placed blame on structural factors or personal deficiencies. There was a slight difference relating to the education level of the nurses surveyed. When compared, nurses who had a baccalaureate degree or higher, were more likely to attribute poverty to structural explanations than their lesser educated peers.

Similarly, Vleim (2015) conducted a survey among 44 nursing students in a Midwestern baccalaureate program also using the ATP in a pre-course and post-course design. The students participated in the course, “Childrearing Families: Wellness and Health Promotion,” during the first semester of their junior year. The course included an online poverty activity which addressed issues such as unemployment, health issues, and lack of financial resources and food. There was also a service-learning component in which nurses interacted with poor children at a local elementary school.
Although some students declined to state their political ideology, of those who answered the question, there was an even split between liberal and conservative self-identification. Pre-test scores revealed that a majority of nurses held stigmatized views of the poor pre-course. However, post-course, there was a statistically significant difference in mean scores when comparing pre- and posttest measures relating to structural explanations of poverty. In other words, more of the students attributed the reasons of poverty to structural explanations (instead of stigmatized statements), after completing the course. This study indicated that when nursing students begin to interact with those living in poverty and recognize them as people rather than as a stereotype, they have the potential to assume a more structural view of poverty.

Noone, Sideras, Gubrud-How, Voss, and Mathews (2012) reported similar findings of nurses’ attitudes toward the poor pre- and post-intervention using the ATP. Noone et al. found a positive correlation between positive attitudes toward the poor and liberal political views. This correlation has also been reported by Yun and Weaver (2010). Noone et al. also found a correlation between conservative political views and negative views of the poor. Noone et al. strongly believed that the correlation between political ideology and attitudes toward the poor needed to be examined and explored further, since the profession of nursing is firmly based in liberal political ideology which embraces the attainment of health equity and social justice for all. More nursing research in this area is needed to better equip nurse educators with the knowledge and skills needed to assist students who may have conservative viewpoints, in order for them to have a deeper understanding of nursing’s liberal philosophical and foundational tenets which are wholly supportive of social justice-related issues. Although nurses have the right to their own personal beliefs and can vote for whomever they choose, the dichotomy that exists between rigid conservatism and nursing’s tenets should be addressed plainly and
succinctly. Those with negative or stereotypical views of the poor (who are interested in becoming nurses), should be either educated to the inaccuracy of their views and (if their views still appear rigid and unbending), perhaps those students should be required to take additional courses that will enlighten them or (in some instances) perhaps they should be discouraged from applying.

**Nursing Education and Political Advocacy**

The Institute of Medicine (IOM) report, *Who Will Keep the Public Health? Educating Public Health Professionals for the 21st Century* (2003) revealed the scarcity of nurses and/or other health professionals who are competent in health policy development. Numerous researchers have theorized that greater knowledge relating to current health policy will help prepare nurses to become political advocates and activists in the development of new policies (Byrd et al., 2012; Clark, 1984; Primomo, 2007).

DiCenso et al. (2013) conducted a study of nursing students' political knowledge after the intervention of a health policy practicum. In this qualitative study, the researchers reported the results of the students' written self-assessments, which recorded the self-perceived political knowledge the students had obtained from the practicum experience. The students stated that they had (a) learned how government and health policy work together, (b) they had a broadened understanding of policy issues, (c) they learned how governmental policy makers and nurses can better work together, and (d) they learned how to better communicate with governmental policy makers.

A study entitled, *Political Astuteness of Baccalaureate Nursing Students Following an Active Learning Experience in Health Policy* (Byrd et al., 2012), was similar to the previous study. This study however, only included baccalaureate nursing students. The learning
intervention was a series of public policy learning activities over 3 years of their nursing education. There was a pretest administered before the learning experience and a posttest administered afterward. The focus of the student's learning was "political astuteness" and their learning was evaluated using an instrument called the Political Astuteness Inventory (PAI) (Clark, 1984).

Based on the results of the self-assessments, the students perceived that they had learned some of the skills needed for policy making. The researchers offered no information regarding specific activities that were included in the students' practicum learning experiences with policy makers, other than to say that the students had worked on policy projects with elected officials (Byrd et al., 2012).

The authors offered no suggestions relating to specific content that should be included in nursing curricula to promote either political awareness or political advocacy skills in students. While the researchers did acknowledge that the introduction of a tool to measure political astuteness in nursing students was helpful in measuring students' sociopolitical knowledge base, the study by Byrd et al. (2012) did not report if, or to what extent, nurses actively participated in political advocacy or activism post-course. So, the question remains: did the policy practicum promote the political advocacy behaviors of the students in their future nursing practice? If so, where is the evidence?

Cohen et al.'s (1996) theory of political development is clear: an individual or group must complete Stage 1 or the “buy in” process, before they are able to recognize the need for a change and the importance of political advocacy or activism. Cohen et al. (1996) described a four-stage process of nurse’s political development. They describe the first stage of political activism as the “buy in” stage, which included an increased awareness of nursing issues, learning
political language, and minimal participation in political activities. In Stage 2, deemed "self-interest," the nurse moved from awareness to activism. Stage 3 included more complex and sophisticated political action, including campaigning, election strategies, and public relations. In the fourth stage of political development, nurses identified health policy ideas that benefitted the larger public good.

Cohen et al.’s (1996) theory relating to political development may have merit, but how can one be inspired to politically advocate within the profession when a majority of nurses do not accept socioeconomic factors as an explanation for poverty? This realization further supported the need for more research on the relationship between (a) nurses’ attitudes, political ideology, and behaviors toward vulnerable populations; (b) the knowledge, educational preparation, political skills, and political actions needed to change socioeconomic policies, and (c) the motivating factors which promote political action/activism in nurses. What are the specific steps and/or actions nurses need to perform within their practice which will directly result in the improvement of social and economic policies that impact health and wellness (Brinkman & Brinkman, 2005; Brown & Tarlier, 2008)?

Woodward, Smart, and Benavides-Vaello (2015) completed a study focused on identifying factors that promoted political development within the nursing profession. Their research revealed three primary factors that support civic engagement among nurses: (a) political education in the nursing curriculum, (b) active psychological engagement, and (c) collective influence. The authors pointed out that even though there was a wealth of information determining the factors needed to improve political participation among nurses, there was little research relating to how that knowledge could then be best incorporated into the educational
preparation nurses need to be able to participate as effective policy advocates in practice and/or specific competency measurements.

Some nursing researchers theorized that political competence conceptually relates to those factors that influence nurses’ involvement in political advocacy and the skills needed to influence the policy process and/or become politically involved (Byrd et al., 2012; Clark, 1984). Others argued that the concept of political competence also includes an awareness of health policy issues, an understanding of the legislative and policy process, political knowledge, and skills such as knowing who policy makers are and how to communicate with them as skilled political advocates (Byrd et al., 2012; Primomo, 2007).

Rains and Carroll (2000) used a pre- and posttest within their study to attempt to measure the political competence of students and reported that graduate students significantly increased their political competence after completing a designated course in health policy. Rains and Carroll reported that the most significant change in scores when comparing the pre- and posttests was within the category designated "political knowledge," which increased more than the scores in the other categories of (a) political skills, (b) political motivation, (c) political interest, and (d) understanding of political context (Rains & Carroll, 2000). As in previous studies, there was no mention of the students’ advocacy/activist behaviors post-study or descriptive details relating to the political behaviors the nurses exhibited; the actual political skills the nurses used in practice; or the policy-roles the nurses undertook within their careers post-intervention. A list of political competency studies is available in Appendix F.

It is here then that two studies attempted to explore the practices of nurses who function in policy roles as part of their professional nursing practice. Winter and Lockhart (1997) interviewed 11 politically active nurses to determine how they became involved in policy as part
of their practice. The most significant correlation seemed to be the relationships the nurses had with politically active mentors. These mentors ranged from family members to former teachers. The nursing student interviewees suggested that policy-savvy mentors within nursing education might help future nurses become more active in this area.

In the second study, Gebbie et al. (2000) interviewed nurses who had political careers as part of their practice to determine what factors influenced their entry into politics. Participants distinguished three main factors which contributed positively to their entry into politics: (a) personal experiences with role models who are politically active, (b) exposure to politics in education, and lastly (c) an employment experience that stimulated their interest. Gebbie et al. (2000) concluded with the recommendation of several important factors for promoting the political activities of nurses: (a) knowledge of health issues, (b) knowledge of unmet needs, (c) an understanding of the factors which will motivate nurses to get involved, (d) knowledgeable mentors, (e) education in the political process, and (f) involvement in professional organizations. They believed that this combination could help the profession progress to becoming better political advocates for health.

Gaps in the Literature

Multiple researchers offered suggestions and strategies to teach political advocacy skills; however, if these skills and abilities are being learned, are nurses using these political advocacy skills in practice? If so, where is the evidence? Although there is no denying that political knowledge is a supportive dimension of political advocacy, there is little research which states that nurses who are politically competent are more likely to participate in political advocacy and activism. The lack of research relating to the actual activities, behaviors, and perspectives of nurse/political advocates continues to be an area that has been neglected in nursing research and
therefore very little is known. Based on the evidence, very few studies touched on the life experiences of nurses who are currently employed as political advocates (Gebbie et al., 2000; Winter & Lockhart, 1997). More nursing research examining the life experiences, practice experiences, and academic preparation of current policy-level nurse/political advocates may help us to better understand what is needed in nursing education to advance the practice of political advocacy in nursing and help us to better understand what inspired them, what motivated them, and what academically prepared them to function as political advocates.

Chapter Summary

A review of the literature relating to political advocacy has helped bring clarity to the concept of political advocacy and highlighted the importance of politics within science and society. Based on the evidence, the profession of nursing has both a historical and a philosophical foundation based on (a) morality, (b) caring, and (c) advocacy. Nursing advocacy encompasses advocacy for (a) the environment, (b) the individual patient, (c) society at large, (d) specific populations of vulnerable individuals, and (e) the nursing profession (Boutain, 2005a, 2005b, 2008; Drevdahl et al., 2001; Fahrenwald, Taylor, Kneipp, & Canales, 2007; Falk-Rafael, 2005; Reutter & Duncan, 2002).

Nursing science, both historical and contemporary, acknowledged the importance of political advocacy as (a) a professional responsibility (ANA, 2010; Bekemeier & Butterfield, 2008; Nightingale, 1859), (b) a caring responsibility (Bevis & Watson, 1989), (c) a social justice responsibility (Belknap, 2008), (d) a moral responsibility (Boswell et al., 2005), (e) a patient advocacy responsibility (Bu & Jezewski, 2007), (f) an ethical responsibility (Davis & Chapa, 2015), and (g) a responsibility to society (Boswell et al., 2005; Conger & Johnson, 2000; Cramer, 2002; Gehrke, 2008; Vandenhouten et al., 2011; Winter & Lockhart, 1997).
Professional nursing mandates, both nationally and globally, require contemporary professional nurses to address social injustice, health inequity, health disparity, and socioeconomic disadvantage in society (ANA, 2010c). However, evidence revealed that the majority of current nurses are (a) not members of any professional organization (DeLeskey, 2003), (b) not involved politically (Rains & Barton-Kriese, 2001), and (c) may not be aware that certain needs exist within society (Ballou, 2000; Bekemeier & Butterfield, 2005; Falk-Rafael, 2006).

Research revealed that attention to political advocacy in nursing may be addressed through (a) transcultural nursing research (Watson, 2008), (b) embodiment of the philosophical beliefs of the profession (Ballou, 2000), (c) curriculums firmly grounded in the liberal arts (Bodenheimer, 2005; Browne, 2001; McKie, 2012), (d) practice focused on ethical caring (Aroskar, 1982; Fowler, 1989; Smedley et al., 2003; Tronto, 1993, 1995, 2001, 2010), and (e) participation of nurses in professional organizations (Alotaibi, 2007; Ballou, 2000; Woodward et al., 2015).

Research revealed that various concepts and theories have been explored as a means through which to gain understanding of political processes within nursing: (a) political awareness (Dean, 1983), (b) political involvement (Conger & Johnson, 2000; Cramer, 2002; Vandenhouten et al., 2012; Winter & Lockhart, 1997), (c) political competence (Byrd et al., 2012; Clark, 1984; Primomo, 2007; Rains & Barton-Kriese, 2001), (d) political socialization, (e) political skill (Antrobus, 2003), (f) policy knowledge (Rains & Carroll, 2000), and (g) political ideology (Browne, 2001). Barriers to political/legislative advocacy have been explored and may be related to a lack of (a) skill (Antrobus, 2003); (b) motivation (Winter & Lockhart, 1997), (c) awareness (Dean, 1983), (d) understanding (Gebbie et al., 2000), (e) lack of autonomy due to practice
venues (Ballou, 2000), (f) political beliefs (Browne, 2001), (g) a lack of clarity relating to political advocacy within nursing mandates (Bekemeier & Butterfield, 2008), and/or (h) a lack of clarity relating to political advocacy within the nursing profession (Ballou, 2000; Bekemeier & Butterfield, 2008). However, there is very little evidence relating to the motivation, experiences, inspiration, preparation, and the actual day-to-day activities of nurse/political advocates.

Examining the ongoing work of nurse political advocates will enable us to learn not only the motivation for what their work is/was, but will also help us to learn how their work can be used as a tool to promote social justice. It is important to examine the concept of political advocacy as it is understood in the context of all those who practice it. According to Bogdan and Biklen (1998, p. 27) “It is multiple realities rather than a single reality that concern the qualitative researcher.” The concepts emerging from the examination of their political work will help enable the profession to prepare future nursing students who will become effective political advocates, as well as agents for social change, health equity, and good stewards of ethical care.
CHAPTER III

METHODOLOGY

Overview

This chapter describes the methodological framework that supports and guides this interpretive inquiry. A qualitative research design using a grounded theory approach was used. Within this chapter I justify, outline, and discuss the methods of design, theoretical framework, sample selection, data collection, and analysis used in this study. This chapter also includes a description of the ethical considerations necessary to the study.

Little is known about the activities and practices of nurse/political advocates from their perspectives. This study focused on the educational, professional, and life experiences of registered nurses who function as political advocates as part of their ongoing practice. In order to accomplish the goals of this study, I sought out nurse political advocates to learn as much as possible about their day-to-day work, their perceptions, their understanding, their educational preparation, and their life experiences which informed their political advocacy work. In addition, their recommendations for political advocacy in nursing education and practice give greater insight and understanding into how nurses can become better political advocates for healthcare, public policies, and the profession itself.

Research Questions

The original research questions for this study were

1. How do nurses who do political advocacy interpret professional nursing mandates which address social justice, health equity, policy advocacy, and ethical care?
2. What are the implications for advocacy praxis for nursing education and for the nursing profession?

**Methodology Selection**

According to Parahoo (2014), the selection of a research design should be made only after it is determined that it will be the best suited to answer the proposed research question. Quantitative research constrains findings to numerical data and therefore would not be suitable for this particular study (Burns & Grove, 2010). Since the overall purpose of this study was to gain an understanding of the experiences and perspectives of practicing political advocates, I utilized a qualitative research methodology as the most effective means of analysis (Holloway & Wheeler, 2013).

Specifically, grounded theory was used because it encompasses both a method of inquiry and a mode of analysis (Charmaz, 2003). Grounded theory helped to illuminate the meaning behind the experiences related by the participants and how these experiences led to their views on political advocacy in nursing.

**Setting of Research**

The research study took place in the Washington, DC Metro Region, Virginia, and Maryland. I conducted all interviews. Eight of the nurses were interviewed in Virginia, one in Washington, DC, and one in Maryland. Five of the nurses were interviewed in their offices or in conference rooms at their work, and the other five nurses suggested various public meeting places; one interview took place in a hotel suite, one interview took place in a room at a community center, one in a chapel/quiet room of a hospital, and one in the lobby area of a conference center.
Participant Selection and Recruitment

Due to the in-depth nature of qualitative study, Patton highlighted the benefit of a small, purposive sample to gain “information-rich” (Patton, 1990, p. 169) understanding about an issue or topic. Purposive sampling is used when a researcher needs to glean knowledge from individuals that have a specific level of expertise in a certain area. Purposive sampling is particularly useful where there is a lack of empirical evidence in an area of study. The initial contact information of those nurses who were active and/or served on political committees was gleaned from the professional nursing organization’s websites. However, there were some exclusion and inclusion criteria requirements.

Inclusion Criteria

1. Male, female, or transgendered.
2. Any ethnicity.
3. Adults aged 18 or over. (Rationale: you must be 18 in order to be a licensed Registered Nurse.)
4. Have a current license to practice as a Registered Nurse. (This was essential, since this study was focused on nurses who were currently active within the profession and therein held to the historical, philosophical, ethical, and professional standards of the profession.)
5. A minimum of 5 years’ work experience as an RN. This was essential in order to gain the perspectives of those nurses who had a greater level of expertise and experience in nursing that novice nurses do not possess.
6. Political advocacy (i.e., macro-level advocacy) (Ballou, 2000) needed to be a major focus of their practice. This included policy analysis, public policy development, or political advocacy for populations and/or the nursing profession as defined by Ballou (2000). This was
needed in order to gain the perspectives of those nurses who had expertise and experience in political advocacy endeavors (i.e., macro-level advocacy) (Ballou, 2000).

**Exclusion Criteria**

1. Any other healthcare professional
2. Novice Registered Nurses
3. Those nurses who did not have an active license to practice as a Registered Nurse. (They would not be held to the same professional standards as licensed, practicing RNs.)
4. RNs who did not participate in policy-level political advocacy as a major focus of their practice. (They lacked the expertise and experience in political advocacy that was required for this study.)

**Sample Selection**

A purposive, sampling of licensed RNs active in political advocacy were identified from contact information gleaned from professional nursing organization websites, referral by other participants, and word-of-mouth. Potential participants were recruited via email (see Appendix B). One hundred seventy-eight invitations were sent out. Fifteen participants initially responded by email and expressed their interest in participation in the study. Inclusion criteria for participation were then discussed via phone and/or emailed correspondence. Three participants worked in the Washington, DC/Virginia/Maryland region part-time (in various nursing/political advocacy roles), but primarily resided and spent their time in other states (Delaware, North Carolina, and Pennsylvania) and were unable to participate due to scheduling and logistical conflicts.

Once it was determined that the participant met the inclusion criteria for the study, a date, time, and place were negotiated for all 12 participants. When the interviews were scheduled, the
participants were given the researcher’s cell phone number in case they needed to change the appointment day or time and/or if they had any additional questions. One interview was rescheduled due to inclement weather and one was rescheduled due to a scheduling conflict. I was willing to interview nurses until data saturation was reached. A total of 10 nurses who were active in political advocacy as part of their nursing practice were interviewed. All of the participants were licensed Registered Nurses: eight were licensed in Virginia, one in Maryland, and one participant was licensed to practice in both Washington, DC and Maryland. Two participants were scheduled to be the 11th and 12th participant, but data saturation was reached when the 10th interview was coded. Data saturation was reached when coding the 10th interview because no new themes or codes emerged. Data saturation can differ from one study to the other, but in general, data saturation is reached when there are no new data, themes, or codes emerging. Although this might still leave some ambiguity and uncertainty, data that meet the aforementioned criteria and are also considered rich (i.e., of good quality) and thick (i.e., of good quantity) are needed. After the 10th interview was coded, there were 219 pages of narrative material containing 77,774 words. In addition, the interviews contained rich, vividly detailed dialogue from all 10 participants. The two potential participants were subsequently notified that data saturation was reached and thanked for their willingness to be a part of the study.

Methodology

There are four common approaches within qualitative research: (a) phenomenology; (b) grounded theory; (c) ethnography; and (d) historiography. Grounded theory is a type of inductive thematic analysis and was first used by Barney Glaser and Anselm Strauss in the late 1960s (Glaser & Strauss, 1967). The purposes for using an inductive approach are (a) to condense raw data into a brief summarized format; (b) to recognize and establish links between the research
objectives and the findings developed from the data; and (c) to develop a theory relating to the experiences or processes which are revealed during data analysis (Thomas, 2006).

Unlike quantitative design methods which typically focus on answering “how many?” qualitative research seeks to answer the what, the why, and the how (Ritchie & Lewis, 2003). Qualitative research methods also allow for the examination of data which have multiple realities and are therefore never finite, but continuously evolving. The evolutionary component of qualitative studies makes them particularly useful for examining human behavior in both social settings and in professional practice endeavors. In addition, qualitative research methodology can provide an in-depth look into the social dimension of a participant’s experiences and the participant’s perspectives relating to those experiences. For this reason, qualitative methods are especially helpful when seeking understanding in political science, psychology, sociology, education, and nursing.

Inductive analyses are useful in applications that involve the prediction, the forecasting, or the promotion of a particular behavior. Glaser and Strauss (1967) posited that the inductive process that grounded theory provides is especially useful to (a) offer an explanation of behavior, (b) enable the prediction of a behavior, (c) advance theoretical perspective, (d) promote practical applications, and (e) to further additional research on related behaviors or phenomena (Glaser & Strauss, 1967). Since the promotion of political advocacy in nursing practice is the focus of this research, inductive analysis was appropriate for this study.

Inductive enquiry is an important feature of grounded theory study and provides not only a means of generating new theory and new understandings, but requires researchers to identify the research problem from the research participants’ perspectives (Elliott & Higgins, 2012). A major assumption of grounded theory is the realization that we do not know all there is to know
about a phenomenon or process, and that the best way to gain theoretical understanding is to remain grounded in the words and experiences of participants. This method allows research participants to describe their experiences rather than attempting to predict or fit their experiences into an already existing model. The participants’ words and real-world experiences brought authenticity to the research. This also made the approach well-fitted for investigation into political advocacy in the nursing profession context.

The ultimate goal of grounded theory analysis is to create mid-range theory. Mid-range theory focuses on a particular part of the human experience and is therefore especially useful when studying experiences within disciplines and in clinical practice settings (Polit & Hungler, 1995). The grounded theory analysis was chosen for this study because it provides a productive means of generating nursing theory that is grounded in the philosophical beliefs and professional mandates of the profession (Elliott & Lazenbatt, 2005). This qualitative study attempted to generate grounded theory in order to learn what experiences or preparation empowered, motivated, or prepared nurses to become political advocates in practice settings.

**Data Collection**

Prior to the beginning of data collection and analysis, approval was received from the University of Alabama’s Institutional Review Board (IRB) as shown in Appendix G. Based on McNamara’s suggestions, (2009) this study used standardized forms for all steps of the consent process. The standard forms provided only basic identification information (date, time, location, characteristics of the respondent, etc.). No actual interviewee names or other personal identifying information was noted on any of these documents. Before the interview began, the participants received disclosure information, terms of confidentiality, and consent forms. I then informed the potential participant that only pseudonyms would be used in the study and that I would not reveal
details about where the participants worked, where they lived, any personal information about them, and so forth, so their identity would be kept confidential. Time was allotted for the participant to ask questions relating to the study, their privacy, and/or consent. When all questions were answered to the potential participant’s satisfaction, they were instructed to sign the consent form if they still wanted to participate or decline with no penalty. See Appendix A for the Recruitment Letter, Appendix G for the IRB Application Appendix H for the Interview Protocol; Appendix I for the Participant Informed Consent Form, Appendix J for the Demographics Information Form, Appendix K for the Field Notes Template; Appendix L for the Memoing Template; and Appendix M for the Member Check Questionnaire, Appendix N for the List of Concepts and Themes (that emerged from the data), and Appendix O for the Researcher’s Journal Entry. After the consent forms were signed, but before the interview questions began, the participants were given the Demographics Information Form (see Appendix J) to complete. After it was completed, the interview process began. The Compilation of the Demographics Information Form Data is displayed in Table 1.

Table 1

Compilation of the Demographics Information Form Data

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</tr>
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</tr>
<tr>
<td>Special focus Institution</td>
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<tr>
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<td><strong>Highest Nursing Degree Obtained</strong></td>
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<td><strong>Carnegie Classification of Graduating School</strong></td>
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Table 1 (con’t)

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<th>Variables</th>
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</tr>
<tr>
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<td>8</td>
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<td>Yes-APRN-CNS, NEA-BC, FACHE</td>
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<tr>
<td>Yes-FACHE</td>
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<tr>
<td>Area of Participants’ Residence</td>
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<tr>
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<tr>
<td>Suburban</td>
<td>40</td>
<td>4</td>
<td></td>
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<tr>
<td>Rural</td>
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<td>5</td>
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</table>

Note % = percentage n = number of participants who responded in this category, μ = the mean
NEA-BC = Nurse Executive Advance Certification
APRN-CNS= Advanced Practice Registered Nurse, Certified Nurse Specialist
FACHE=Fellow of the American College of Healthcare Executives

Interviews

Semi-structured interviews with participants were conducted face-to-face and recorded with a digital voice recorder. The interview questions for participants are listed in the Interview Protocol (Appendix H). The interview times ranged from 1-2 hours. When the interviews were complete, the participant was given information on how the researcher could be reached if participants had any additional questions. The participants were also informed that they might be contacted after the typed narrative of their interviews was received for a brief member checking process to clarify their words. The participant was then told that the researcher would inform them of the conclusion of the study as well as the results of the study.
The initial interviews occurred face-to-face from February 2017 through May 2017. Follow-up and member checks occurred via phone and through email beginning in February 2017. Interviews were digitally recorded and archived using a compressed MP3 digital format and stored on CD ROMs. All data obtained during each interview, (including the interview transcript, field notes, and the CD ROMs), were assigned a pseudonym, coded, and placed in a three ring-binder, so they could be easily organized, catalogued, and retrieved. The binders were stored in a locked file box for safety. Memos and field notes were also a part of this research process and were categorized and stored with the other written documentation that was part of the study.

**Data Analysis of the Interviews**

The process of data analysis, using open coding, in vivo coding and holistic coding, was aided by a Coding Paradigm for theory-building posited by Strauss and Corbin (1990). Their model is depicted in Figure 1. This process can be applied to any area of inquiry.

![Figure 1. Strauss and Corbin (1990) Coding Paradigm.](image)

Figure 1. Strauss and Corbin (1990) Coding Paradigm.
Interviews were transcribed as they were completed. Transcriptions were checked for accuracy, member checked (if needed), then coded. All coding was done manually. New transcripts were compared to previously coded transcripts to look for themes, similarities, differences, and saturation. After the member checking process was complete, the entirety of the raw narrative data, field notes, and memos was used to identify and formulate grounded theory through reasoning and conceptualization using a constant comparative process (Glaser & Strauss, 1967).

**Open Coding**

As each transcript was analyzed, I began collecting indicators. Indicators are words, phrases, statements, observations, or experiences that are being described. Open coding, according to Corbin and Strauss (2008), requires the researcher to analyze the data and disassemble it into pieces in order to more closely examine the data and to find similarities and differences within the data. For example, several of the participants mentioned the abstract concept of “good eye contact” in their words. Other participants mentioned the importance of “being a good listener”, and others mentioned the importance of “tactfulness.” As the indicators were sorted and analyzed, it became clear that “good eye contact,” listening skills,” and “tactfulness” all fell into the broad category of “communication skills.” When pronouns were used, the actual name being referenced was coded (example: her-Susan, they-nurses). Every word in each transcript was reviewed, but not all words were coded. (For example: filler words like “and,” “the,” or “however” were discarded.) Words were only counted once even if they were a part of a metaphorical phrase. (Example: “It was sad. I mean really sad. Probably the saddest thing I had ever experienced and I have experienced a lot of sad things.” “Sad” Word Count: 1).
Holistic Coding

Segments of the data were then compared to each other to identify similarities and differences using holistic coding (see the Holistic Coding of Political Advocacy Interviews in Table 2). Holistic coding is especially useful in qualitative studies with semi-structured interviews and multiple participants according to Saldana (2016). Holistic coding is a preparatory step for more detailed coding of the data. It is a time-saving coding method, which enables researchers to code massive amounts of data into coded chunks of text (Bazeley, 2007; Saldana, 2016). Holistic coding is a first step to help a researcher get a general idea of a meaning of a passage or vignette. Holistic coding was used to help identify concepts and relationships within the data. Once identified, these concepts were then placed into categories (example: “Leadership in nursing is important. “Leadership is important in healthcare.” Code: “leadership”). Data analysis following each interview helped guide question formation for the next interview, and also assisted in determining when data saturation had occurred.

In Vivo Coding

In vivo coding involves using an actual word or phrase from a section of transcription and using that to formulate themes (Given, 2008). An example of the in vivo coding process that was used is shown in Table 3 using excerpts from the actual transcripts. All of the themes that emerged during the coding process were categorized. The List of Concepts and Themes is shown in Appendix N. The major categories which emerged are represented in the Model of Political Advocacy in Nursing Praxis shown on page 101.

Grounded theory emerges from, and is connected to, the social world that the theory is being developed to explain. The researcher makes decisions relating to initial collection of data based on their present understanding relating to the phenomenon. The constant comparative
process starts with identifying a phenomenon of interest and identifying concepts, principles or processes which relate to it.

Table 2

*Holistic Coding of Political Advocacy Interviews*

<table>
<thead>
<tr>
<th>Interview Excerpts</th>
<th>Holistic Codes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“And then I got pregnant, had a child, and then I worked in a family practice setting for about a year and a half, which was fabulous nursing. I loved working there because the patients were not your patients, they were your family.” - Susan</td>
<td>Happiness, Belonging</td>
<td>Job Satisfaction, Acceptance, Professional Experiences</td>
</tr>
<tr>
<td>“I’ve been to the Virginia Nurses Association meetings and the local ones here in Lynchburg. I’ve gone to the, you know, Virginia DDNA meetings. I’ve done that, and I’m not feeling inspired, you know, and that’s a problem and I think it’s because there’s no one out there with an inspiring message.” - Jill</td>
<td>Uninspired, Frustration</td>
<td>Professional Dissatisfaction, Indifference, Lack of Motivation</td>
</tr>
<tr>
<td>“I think that I’ve always been loud and opinionated.” - Jill</td>
<td>Outspoken, Opinionated</td>
<td>Assertiveness, Stubbornness</td>
</tr>
<tr>
<td>“I was about eight when I read &quot;To Be A Slave&quot; by Julius Lester, and that was the... uhm... descriptions of... by people who lived it, what it was like to be a slave. And...I was transformed. I still can't really...uhm... think about how that was without crying.” - Sarah</td>
<td>Empathy, Ethnic Racism</td>
<td>Emotional Connection, Personal Experience, Cultural Competence</td>
</tr>
<tr>
<td>“And each area has their own challenges so even if you’re teaching the same content you have to present it in the way that that person understands it.” - Catherine</td>
<td>Geographical Differences, Individualizing Instruction</td>
<td>Cultural Differences, Ethnic Differences, Learning Styles, Pedagogical Flexibility</td>
</tr>
</tbody>
</table>
Table 3

*In Vivo Coding of Political Advocacy Interviews*

<table>
<thead>
<tr>
<th>Interview Excerpts</th>
<th>In Vivo Coding</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“And what we found is that we have gained more members since then, because people have a voice and can vote. Ah, and so I think it was the right decision to make. So that to me was a huge advocacy for our profession.” -Susan</td>
<td>Advocacy</td>
<td>Professional advocacy</td>
</tr>
<tr>
<td>“In fact, somebody flat out told me the goal was to indoctrinate kids so that they would not feel comfortable outside of the Jewish circle, so that Judaism would like, continue.” -Sarah</td>
<td>Indoctrinate</td>
<td>Religious abuse</td>
</tr>
<tr>
<td></td>
<td>Would not feel comfortable</td>
<td>Emotional abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>w/Injustice</td>
</tr>
<tr>
<td>“In general, I think that adults with disabilities are one of the most neglected groups of individuals within the population, within our country, really.” -Jill</td>
<td>Adults with disabilities</td>
<td>Discomforting</td>
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<tr>
<td></td>
<td></td>
<td>Uneasiness</td>
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<td></td>
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<td>Othering</td>
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<td>Bearing Witness</td>
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<td>Neglected groups of individuals</td>
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<td>Disparity</td>
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Validity

Establishing validity is necessary because not doing so diminishes the integrity of the research study. Several strategies have been identified in the literature to improve the validity of research (Kolb & Hanley-Maxwell, 2003). Because validity is an area of concern in qualitative research methodologies, researchers need to account for the information provided in the study and address both internal and external validity (Kolb & Hanley-Maxwell, 2003). Internal validity can be improved upon by using both field notes and memoing. This helps ensure that no observations, thoughts, or reflections are forgotten (Creswell, 1998, 2003). The third piece, triangulation of the data is achieved by confirming your findings with available literature.

Reflexivity is the process of examining one’s internal beliefs as a researcher. Researchers should be continuously reflecting, exploring, and documenting their relationship with the study and the topic, through all stages of the research process, including the coding and data analysis phase (Conrad, Neumann, Haworth, & Scott, 1993). Memos are the actual write-up of theoretical ideas about codes and their relationships as the data emerge during the actual analysis process. Data analysis and memoing are a simultaneous process that is interwoven throughout the coding process. Ideas are fragile and fleeting and should be written down as they are acknowledged. Reflexive bracketing is a method used in qualitative research to help lessen the effects of any preconceptions the researcher might have. Reflexive bracketing and memoing hunches and presuppositions are a helpful way of acknowledging preconceived ideas relating to the topic being studied and were a method I used within the study to reduce researcher bias and subjectivity (Ahern, 1999; Tufford & Newman, 2012). Dependability can also be increased by triangulation, a process in which researchers use evidence-based research to strengthen or corroborate their argument or findings.
Before I began interviewing, admittedly, I thought that the participants would likely tell me about some special course, training program, skill, or competence they had acquired. I thought that perhaps some might even have relatives who are elected officials. I reflected on these thoughts and others throughout both the data collection and analysis phase. I used bracketing throughout the study to help mitigate and neutralize any preconceived notions I had about political advocacy, social justice advocacy, or advocacy in general by acknowledging my beliefs and biases early in the research process and suspending them which is a process that Creswell and Miller (2000) recommended. To further reduce bias, I followed an interview protocol in which everyone was asked the same list of questions and I intentionally spoke very little, because I did not want to appear to “lead” the participants. Additional questions were used to clarify answers, but everyone was asked the same set of questions from the interview protocol initially. I viewed my research role simply as the facilitator through which the participants could “speak their truth.” Any additional questions were aimed at clarification or elucidation of details, but were intentionally phrased in such a way as to discourage leading or suggestion (Parahoo, 2006).

Guba and Lincoln (1994) offered four additional criteria to increase the validity of qualitative research: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability. The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Credibility was addressed in this research study through member checks in which the participants had the opportunity to verify their narratives and share their thoughts on the results of this study, as well as their thoughts on the Political Advocacy in Nursing Praxis Model, which will be discussed more fully in Chapter V. Transferability refers to the degree to which the results of qualitative research can
be generalized or transferred to other contexts or settings. The idea of dependability, on the other hand, emphasizes the need for the researcher to account for the ever-changing context within which research occurs. Dependability is important because it is a mechanism that researchers can use to establish the consistency and repeatability of the research. In other words, it is a level of assurance that another researcher, using a similar group of participants, questions, and data gathering, would have either the same (or a very similar) conclusion. To ensure dependability, I adhered to the interview protocol as closely as possible and described all of the steps within the research process in great detail.

Confirmability of the research refers to the degree to which the results could be confirmed or corroborated by others. Confirmability can also be increased by post-interview member checks to clarify the participants’ words, together with ongoing memoing of the researcher’s thoughts and reflections relating to the data. This process reduces the potential for bias or distortion. It was important to make sure that the data reflected the participant’s views, not my own, as discussed in the Researcher’s Journal Entry shown in Appendix O. This was an ongoing process throughout the data analysis, to reduce the risk of the data being influenced by the researcher’s bias. Confirmability was also obtained in this study using post-interview member checks, which allowed the participants to check their transcripts for accuracy and completeness and make corrections, if needed. My interpretations of their statements were included in their member checks, so that the participants had the opportunity to correct or clarify my interpretation of their statements, as well as their own.

**Timeline of the Study**

The timeline for this research study began after IRB approval in August 2016 through July 2017. Data collection began in February 2017 with the initial interview of the first
participant and ended in July 2017 with the final data analysis. Data analysis was an ongoing process that began in February 2017 with the transcription and coding of the first interview. Memoing began in February 2017. The coding process, including holistic and in vivo coding began in February 2017 and was ongoing through July of 2017. The first draft of the final report was written in August 2017.

**Ethical Considerations**

The primary ethical responsibility in any study is the protection of the research participants and, therefore, should always be the researcher’s primary focus. Ethical considerations include privacy of the research participants’ personal information, identity, and the security of all documentation. It is the responsibility of every researcher to abide by ethical standards that will protect their participants from any harm. I have used the following as a guideline:

- I will seek informed consent.
- I will respect the confidentiality and anonymity of my research respondents.
- I will ensure that my participants will only participate voluntarily.
- I will do my best to remain impartial, truthful, and will resist the temptation to influence any of the results throughout the study.
- I will keep accurate, well-organized, and secured documentation of all facets of my research study.
- I will keep a journal which will give me a space to reflect on my thoughts and feelings and a pace to put my ideas down, so they do not taint or bias the study in any way.
- I will ensure that interviews are conducted at a neutral site of the participant’s choosing.
- I will ensure that each participant is given the opportunity to review and correct their narrative for mistakes and clarification through member checking.
- I will ensure that each participant is given the opportunity to review my interpretation of their narrative for clarification through member checking.
- I will ensure that each participant be given a transcript of her interview.
- I will prohibit all relatives, and former or present colleagues and/or classmates from participation in the research in order to mitigate any bias.
Strengths and Limitations

Qualitative study has strengths and limitations. The strength of qualitative study is that it offers a real-life perspective from the individuals that are experiencing the phenomenon. Qualitative study offers insight into human behaviors, perspectives, and processes that are not possible in quantitative studies. One of the most promising strengths of this study is the possibility of promoting the understanding and actions of nurses and nursing education, relating to the concept and practice of political advocacy.

Possible limitations of this study relate to the inability to make generalizations that relate to the average nurse, based on such a small sample. In addition, the impact of the geographical location on nurses could lessen the ability to generalize the results. It is possible that the nurses who reside in areas with close proximity to our nation's capital maybe more politically aware than nurses who reside in more distant locales. Due to this, they may be more likely to participate in political advocacy efforts and/or may be more politically knowledgeable. Also, since there is no universal definition of social justice, there are many varying interpretations of what social justice actually means. It is possible that individuals residing within close proximity of our nation’s capital might have a different understanding of social justice than those in rural or less politically involved locales. It is also possible that regional, cultural, ethnic, gender, and socioeconomic differences among individuals might influence their beliefs and, as a result of those beliefs, their understanding of the concept of social justice may be duly impacted.

Delimitations

There are many other issues/problems which relate loosely to political advocacy in nursing. I considered studying political competence and/or the political skill of nurses but rejected the idea since political competence itself does not always preclude nursing practice work.
in political advocacy. I also consider studying what factors motivated or inspired nurses to become political advocates, but this was presumptive and assumed that there was one factor or one person, thing, etc. that inspired or motivated them to become political advocates, which may or may not have been true.

In addition, participants in this study were only those nurses who (a) had participated in policy-level development and/or political advocacy as a major focus of their work, (b) had a current license to practice as a Registered Nurse in the United States, (c) had been a practicing RN for at least 5 years, and (d) were English-speaking (because I only speak English). This study also excluded doctors, students, and other healthcare professionals, in order to keep the research focused on practicing registered nurses, and firmly grounded within the nursing profession. Even so, there may have been limitations due to those exclusionary decisions.

**Researcher Positionality**

I am a former public health nurse, and previously attended nursing school in the Northern Virginia region. Like most nurses, I have participated in micro-level political advocacy (Ballou, 2000) for individual patients as a part of patient care. I have also participated in intermediate-level advocacy (Ballou, 2000) as a nurse/case manager. Admittedly, my interest in political advocacy has been further motivated as the parent of a severely intellectually disabled child with multiple, chronic medical conditions. As the parent of a disabled child, I have experienced healthcare inequity first hand in various forms by healthcare professionals and others who (in my opinion), may not have valued my son’s life and health as much as they would have, if he was a “normal,” healthy child. From the time he was very young, the difference in their behavior (when caring for my son, Jordan), was markedly different than the way they treated my first-born child who was born healthy. I now have three additional healthy children who have been and continue
to be treated differently (and better) than Jordan on a regular basis. Early on, fighting for the best care possible for Jordan became a routine event with physicians, hospitals, school officials, therapists, dentists, etc., many of whom repeatedly demonstrated their indifference. It forced me to learn as much as I could about disability law, disability funding, etc. If I had not, in many situations, he may not have had any semblance of decent care or educational equity. One particular event occurred during an especially heated IEP negotiation with administrators at my son’s school. In IEP (Individual Education Plan) meetings, various school personnel typically attend. On one such occasion, a pediatrician’s order for therapy twice a week for Jordan (who was about 5 years of age and could not sit up at the time) was presented during the IEP meeting. After review, the principal stated that the order was “excessive” and he would not approve it, even though the school therapist agreed with my son’s pediatrician. When I asked the principal why he thought therapy twice a week would be excessive for my son, his answer had nothing whatsoever to do with the impact on my son’s health. Instead, the principal stated that there were many other needs at the school, including a need for new P.E. equipment for the “normal” children, and he simply could not justify spending so much money on only one child. For a moment I was silent, as I gathered my thoughts. How could I make him see that he was not placing the same value on my son as the other children? Then I asked him: “Do you have children of your own?” He replied, “Yes, I have four sons.” I posed the following question to him: “If someone gave you $100.00 to spend on your children and three of your sons wanted to spend the money on football equipment, but your fourth child needed the money for therapy because he was sickly, severely disabled, and could not even sit up by himself, which of your children would you spend the money on?” Seemingly embarrassed, and with a reddened face, he quickly signed the IEP which allowed Jordan to receive therapy twice each week while at school.
(For the record: my only option was to have the school pay for his therapy, as they do not allow private practitioners to practice on school grounds.) After the meeting, he did apologize to me, and he thanked me for “opening his eyes” and helping him to understand.

Since then, I have participated in numerous voluntary advocacy campaigns aimed at educating politicians and others regarding the need for increased funding for disabled individuals at the state level. However, I have never been formally employed with duties focused primarily on political advocacy, policy-level advocacy, macro-level advocacy, and/or health/public policy analysis at the state or federal levels. I am currently employed by a state agency whose focus is on developmental and behavioral health administration. As part of my duties, I help educate and train other caregivers and parents on how to be more effective advocates at physician visits and other setting within the community.

**Chapter Summary**

Everything in society is controlled by public policies. Public policies and their resulting effect on all aspects of society have a monumental effect on quality of health and the nursing profession itself. It is imperative that nurses gain understanding and become better able to participate in public policy development. Insight into the practice lives and experiences of political advocates in the field will help the nursing profession gain greater understanding of both the concept of political advocacy itself and the practice of political advocacy as a possible tool that can be used by nurses to impact the profession as well as the future of healthcare in the United States (Pelc, 2009). When nurses exercise their political power to influence policy, they strengthen the credibility of the nursing profession as social change agents (Pelc, 2009) and adhere to the foundational tenets of the profession to promote health equity and social justice. Exploring the perspectives of nurses who are currently active in political advocacy processes
using semi-structured interviews, will provide thick, rich dialogue that will be invaluable to both
the nursing profession and nursing pedagogy.
CHAPTER IV

FINDINGS

Overview

This study sought to explore nurses’ understanding of the concept and practice of political advocacy and their interpretations of the professional nursing mandates that relate to social justice, health equity, policy advocacy, and ethical care. Their experiences and perspectives also help shed light on any similarities or relationships which might exist among the concepts. Their recommendations for nursing education and practice were also explored. Their recommendations for political advocacy in nursing education and practice help us have greater insight and understanding into how nurses can become better political advocates for healthcare, public policies, and the profession itself.

Through data analysis and synthesis, a model of nurse/political advocates’ understanding, perspectives, and practices emerged. The Model is centered on the phenomena or “practice” of political advocacy itself. Political advocacy in nursing will be depicted throughout this chapter through the lens of practicing nurse/political advocates. This chapter begins with short biographies of each participant. The participants’ conceptual understanding of political advocacy and social justice advocacy are then presented, followed by the major concepts that emerged which depict the Model of Political Advocacy in Nursing Praxis and are presented using the words of the participants.
The Participants

Catherine

Catherine has an Associate’s Degree and has been a licensed Registered Nurse for 12 years. She identifies as Caucasian, is a licensed Registered Nurse in Virginia, and lives in a rural part of the state, but travels to urban, suburban, and rural areas for her work. She is currently employed as the Director of Nursing for an agency that provides services for individuals who are intellectually and/or physically disabled. However, many of the individuals are dually diagnosed with co-morbid conditions such as chronic health conditions, mental illness, and behavioral disorders. As part of her current position, she serves as a teacher/trainer for RNs, LPNs, and unlicensed employees who function as direct caregivers for the individuals the agency provides services to. She also serves as the agency’s liaison with state-level decision makers who regulate, license, and oversee licensed providers. In the past, Catherine has worked in oncology, hospice, palliative care, and geriatrics.

Darlene

Darlene has a Master’s of Science in Nursing and a Doctorate in Education with a specialization in curriculum instruction. She is currently licensed in the state of Maryland and has been a licensed Registered Nurse for 20 years. She identifies as African American and currently works as an Assistant Professor at a Historically Black College or University (HBCU) as designated by the Carnegie Foundation (Carnegie Foundation for the Advancement of Teaching, 2011). The university is located in a large metropolitan city. She is also the chairperson of the baccalaureate nursing education program and serves on multiple committees across campus. She also teaches and serves as a student advisor. She has been in her current position for about 10 years. Prior to teaching at the university-level, Darlene taught nursing
courses at a local community college. She has also worked in nursing case management and also for the Department of Juvenile Justice. Darlene is a member and is active in several professional nursing organizations: Blacks in Higher Education, Chi Eta Phi Nursing Sorority, and Sigma Theta Tau Nursing Honor Society, as well as the American Nurses Association.

**Jill**

Jill has been a licensed Registered Nurse in Virginia for 12 years and identifies as Caucasian. Her highest degree obtained is a Master’s of Science in Nursing with a specialization in Nursing Administration. She attended the same doctoral granting university in Virginia for both her undergraduate and graduate degrees in nursing. She is currently employed as a Medical Quality Assurance Director and has held that position for the past 3 years. Prior to this position, she was the Medical Quality Assurance Coordinator for the same agency for 1 year. One of Jill’s primary functions is maintaining the agency’s compliance with regulations, policies, and reporting systems put in place by governmental regulatory agencies within the Commonwealth of Virginia. Although she is not a direct caregiver, she shoulders the responsibility for the health and welfare of the individuals the agency supports. Jill is also responsible for nurse’s training, direct care employee training, data collection, and risk management within the agency. The individuals the agency supports have a variety of mental, physical, and intellectual disabilities. The political facet of her role within the agency includes advocacy for state-level regulatory policy development and/or revision. In addition, she is also a political advocate for Medicaid expansion in Virginia and she routinely advocates for revision of Medicaid reimbursement rates that she describes as being “too low” to provide quality care.
Susan

Susan has been a nurse for over 50 years and identifies her race as Caucasian. She initially graduated from a diploma program, but later went back to school to obtain her BSN. However, she did not finish the BSN program at that time because she was the primary support for her family and, due to the scheduling requirements of the program, she could not juggle participation in a full-time clinical practicum and full-time employment simultaneously, so she switched her major to Health Care Administration. After graduating, she worked for several years as a nurse before she decided to go back to school to obtain her BSN. It took 11 years for her to complete the Bachelor’s program and when she graduated she immediately went into the Nurse Executive Master’s program. She later switched to a DNP program and graduated a few years later with her Doctorate of Nursing Practice degree. In the late 1960s, a friend she had worked with previously in a hospital setting called her up and asked her if she wanted to help “open up” a new hospital. Susan said “yes” and cites the experience that followed as being “one of the most amazing experiences” of her career. Together, she and her friend, the Director of Nursing for the new hospital, helped write all of the hospital’s care-related policies, hired the staff, and opened the hospital.

Sara

Sara has been a nurse for 36-1/2 years and identifies her race as “other.” She spent the early part of her life in San Francisco during a time when there was a significant amount of social and political unrest. Sarah’s mother was a special education teacher who later went back to college to become a nurse. She describes her mother as being a very “left-wing liberal.” Her father was a political science major. Her former nursing experiences include working as an acute care nurse at the Veteran’s Administration and working as a public health nurse. She is currently
an instructor. Much of Sarah’s political advocacy work in the last few years has been focused on state and federal policies that impact healthcare and/or the promotion of universal healthcare in the United States. She is currently active in a political study group on the Affordable Healthcare Act (ACA) and another group called “10 Actions-100 Days.” Her state-level political advocacy work has been focused primarily on regulations and policies that impact medication administration. Sarah states that many of the state-level regulations and policies that impact medication administration are “poorly written,” “vague,” and “difficult to interpret.”

**Helena**

Helena is an Associate Professor in graduate nursing at a university in the Washington, DC/Metro region and identifies her race as Caucasian. She stated that if there was another degree that she might have ever sought, it would have likely been in Anthropology because she has always been interested in other cultures. Besides teaching, she also develops community programs that promote interprofessional engagement of healthcare professionals with aging adults through the use of stories, narratives, and the arts. She is passionate about helping healthcare workers understand the capacity for older adults to enrich communities with their gifts. Her work with interprofessional groups brings healthcare professionals together with geriatric physicians and case managers, where they can discuss practical issues relating to unsuccessful hospital discharges, re-admissions, and the like. Helena has significant experience in grant writing.

**Barbara**

Barbara has a Doctorate in Education and has been a Registered Nurse for 51 years. She currently is an Advocacy Consultant and Contract Lobbyist who represents multiple clients. She gets all of her clients by referral from other clients, word of mouth, and through friends. She
never advertises. Most of her clients are non-profit organizations. When asked about the challenges of her work she states, “It’s helping my clients enhance their advocacy skills and empowering them to make the changes that need to be made in the work that they do.” Barbara also has significant experience in grant writing.

**Rachel**

Rachel has been a licensed Registered Nurse for 18 years and identifies her race as Caucasian. Although Rachel initially obtained her nursing degree through a diploma program, she has gone back to school several times throughout her career to continue her education. Her highest degree obtained is a Doctorate of Nursing Practice in the Executive Leadership Track. She has a Bachelor’s Degree in Philosophy and a Master’s of Science in Health Administration as well. Rachel shares that she initially graduated from nursing school during a nursing shortage and worked in a hospital for almost 1 year and then went into public school nursing. She really liked being a school nurse but stated that she could not stay in school nursing because the salaries are so low. In the years following, she has worked in a children’s/adolescent hospital that serves individuals with complex medical needs, and has held positions as nurse manager, clinical coordinator, and risk manager. She currently works in the litigation department of a large healthcare system. Rachel has held primary leadership roles in several professional nursing organizations throughout her career. Most recently she completed a 7-month training program offered by Emerge, an organization that trains Democratic women to run for office.

**Mary**

Mary has been a Registered Nurse for 10 years and has a Bachelor’s Degree in Organizational Management. She identifies her race as Caucasian. Mary started her career in the accounting field, worked for a while, then decided to go back to school. She then graduated with
a Bachelor’s degree in Organizational Management and worked for a manufacturing company. Mary then worked as a Float RN for a community services agency where she worked for a wide range of age groups including adolescents, geriatric, acute care, and others. She currently works for a Community Services Board. Her position entails a wide range of responsibilities. She must ensure that staff members are well-trained in all facets of care. She also oversees medication administration, physician appointments, and functions very much like a nurse/case manager. Many of the individuals whose care she oversees are intellectually disabled. Some have multiple co-occurring conditions such as mental illness, chronic diseases, anxiety issues, sensory deficits, and multiple communication problems. Many of the individuals are completely non-verbal.

Various forms of advocacy are a large part of her work. She participates in micro-level advocacy for individuals at physician appointments, within the community, with therapists, and within the agency. She has also participated in town hall meetings and, when the need arises, she also helps patients and other individuals prepare to speak to elected officials at town halls (and other venues), about how proposed state funding cuts will negatively impact their lives.

Jane

Jane has been a Registered Nurse for more than 50 years and has a PhD in Nursing and Bachelor’s degrees in both Behavioral Science and Nursing. She identifies her race as Caucasian. She has multiple advanced practice credentials and currently lives in a suburban area. Her first nursing degree was an Associate’s Degree and she attended a college in New York City. She currently teaches graduate students at a university. Jane’s state and national-level leadership roles in professional nursing organizations are numerous. She is an author and has been published in numerous peer-reviewed nursing magazines. She also currently serves as a peer reviewer for three professional nursing magazines. In addition, she is currently a board member.
on a hospital oversight committee that focuses on patient safety and quality care. She has also participated and testified at hearings on health policy and participated in numerous healthcare and nursing profession-related policy briefings.

Political Advocacy and Nursing

One of the primary goals of this study was to gain perspective and understanding relating to political and social justice advocacy from practicing nurses. Since there are no profession-wide definitions of either political advocacy and/or social justice advocacy, it is important to determine their meaning from the participants. When the participants were asked about their understanding of political advocacy, the participants’ views and understanding had some basic similarities, but there were many variations among the participants, some more subtle than others. Barbara described political advocacy as a “tool”:

It’s a tool that nurses can use to speak on behalf of themselves as practitioners so that they can practice to the full extent of their training and education, and on behalf of the clients they serve; and that's political advocacy. (Barbara)

Jane viewed political advocacy not only as “what” nurses do, but also included that it is “how” nurses do it. She viewed political advocacy as a means of helping policymakers “understand the realities of healthcare.” “Political advocacy is how you as a nurse speak up, speak out and speak with policymakers to help them understand the realities of healthcare” (Jane).

When Catherine was asked for her understanding of political advocacy in nursing practice, Catherine stated her views simply and concisely. She viewed political advocacy as the means for “influencing change” and as a change agent that can make “what is wrong right”.

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When Jane was asked what she thought had changed relating to nurses’ political involvement in recent years (if anything), she shared her views on what she described as “more autonomy in practice”:

Nurses having more autonomy in practice, nurses having more advanced practice roles under their belt. And . . . being accepted as being educated . . . being seen as more than just a right hand of the physician. I think the public appreciates it . . . certainly, I mean the Gallup poll, the number one in trust for 15 years! Uhm, I think the public accepts that we speak on their behalf. (Jane)

Darlene described political advocacy using figurative/metaphorical language: “Standing up for something you truly believe in and have a passion for. To make change happen, even when other people don’t support you, [but] you see the need” (Darlene). When Darlene was asked about her perspective of nurses who don’t “speak out,” she said, “If it’s in you, it’s in you. You’re gonna speak out regardless.” Sarah, too, expressed the importance of not “giving up” in the face of adversity. “Like, what you see and feel is—is . . . just because no one is listening to it, it doesn't mean it's not valid” (Sarah).

Mary’s views on political advocacy differed slightly. She viewed political advocacy as “advocating for change” and as a means to “assist someone with making a change,” which implied more of a collaborative effort between the nurse and the patient, society, etc.

Helena viewed political advocacy via the lens of legal reform:

I suppose, looking at laws, regulations, policies that affect the public . . . legal regulations that affect either how we practice or the care we’re able to provide, or the issues that arise for the people we care for. So I think, in terms of political advocacy, being more involved with policies and laws . . . whether it’d be state or national laws . . . but also within just the department level. Examining those things . . . the rules, regulations . . . um . . . policies that are intended to guide healthcare. . . . And, um, so I would think political advocacy would be trying to address those, and, uh, either supporting or trying to amend or change current policies. (Helena)

Jill believed, too, that nurses are gradually becoming more politically “active” and more politically “engaged”. Additionally, she thought it was a particularly “vulnerable time” now
(more than ever before), for the quality of care for individuals with disabilities to be negatively affected in some way.

I think it's changed. I think it's definitely changed. I've gotten more politically active, like more politically engaged. Um, I think it's also because I've gotten older, too, um, but also because my career has made me become a little more politically involved. . . . It's such a vulnerable time right now, for the people that I work with and for the agency that I work for. (Jill)

Rachel agreed that the political interest and involvement of nurses has changed recently, but she believed it had changed among the general public, too, and not just among nurses. She said that recently, local political meetings have been “filled to capacity” with “standing room only.”

Similarly, Sarah saw political advocacy as a means for nurses to have a voice with those who have political power. She felt it would help the perspectives of nurses and patients to have “equal footing: in the “political power structure”. Throughout this chapter, although there were similarities of thought, the participants described 35 different definitions of political advocacy throughout the 10 interviews, which are shown on the next page in Table 4.

Table 4

Nurses’ Understanding of Political and/or Social Justice Advocacy

1. A tool that nurses can use to advocate for themselves.
2. A tool that nurses can use to advocate for their practice.
3. A tool that nurses can use to advocate for the clients they serve.
4. The act in which a nurse helps policymakers better understand the realities of healthcare.
5. A means for nurses to influence change.
6. A means for nurses to make what is wrong right.
7. A means for nurses to promote practice autonomy.
8. A means for nurses to promote advanced practice roles.
9. A means for nurses to promote nursing scholarship.
10. A means for nurses to speak on behalf of the public.
11. A means for nurses to stand up for their beliefs.
12. A means for nurses to support issues they are passionate about.
13. A means for nurses to promote change.
14. A means for nurses to assist someone to make a change.
15. An act not associated with traditional politics.
Table 4 (con’t)

16. A means for nurses to advocate for issues that are going to impact the lives of individuals.
17. A means for nurses to advocate for change.
18. The act of examining laws that affect the public.
19. The act of examining regulations that affect the public.
20. The act of examining policies that affect the public.
21. The act of examining legal regulations that affect nursing practice.
22. The act of examining legal regulations that affect the care nurses provide.
23. The act of examining issues that impact the individuals that nurses care for.
24. The act of being involved in departmental, state or national policy development
25. The act of examining policies that guide healthcare.
26. The act of amending, supporting or changing current policies.
27. A means to set large scale policies in place that will impact everyone.
28. A means to push policy making forward to align with cultural and social norms.
29. A means to have a strong voice and actions at the seats of the table of those in power.
30. A means to help establish nursing’s perspective on an equal footing with the market.
31. A means to help establish the patient’s perspective on an equal footing with the market.
32. A means to help policymakers prioritize resources.
33. A means to address societal disparities (gender, environmental, cultural, financial, educational, etc.) and promote health and societal equity of all individuals, groups and society at large.

Sarah was the only participant that communicated the need for input from all different types of nurses (LPNs, LVNs, CNAs, etc.), and not just RNs, so as to have a more realistic view of what is necessary for the best outcomes.

A lot of people don't include aides in their definition of nurse, which is a problem I have with the ANA. They [policy makers] need input from all nurses. . . . And they [policy makers] need it [input] from people who are wiping bottoms. Policy makers need to know that it is not possible to do that in two minutes. (Sarah)

Although Susan did not share how she defined political advocacy, she did share some of her thoughts relating to nurses’ responsibility to help policy makers to “understand” the nursing profession. “We're not getting out there and telling our story. We're very humble, but we really need to get out there! We [nurses] need to talk about what we are doing and help them [elected officials] to understand.” (Susan)
Rachel did not share her definition of political advocacy either, but instead chose to share her views on why nurses do not become politically involved. She believed nurses lack an emotional connection to the issues. “Behavior is moved by emotion, not necessarily by facts and figures. Facts and figures don’t really do it, and so, if you can touch somebody’s heart and you connect with them emotionally, that can motivate a change in behavior” (Rachel).

**Nursing Mandates**

Participants’ understanding and interpretation of professional nursing mandates which addressed social justice, health equity, policy advocacy, and ethical care were also explored. Participants were specifically asked what their understanding of *The Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015; 2001) and *Nursing’s Social Policy Statement* (ANA, 2010c) were. Several of the participants were aware of the aforementioned nursing mandates and stated that they were familiar with the content, or the booklets themselves, but did not share their thoughts relating to a specific passage contained in the mandates. Catherine viewed the mandates as guiding documents that “define the nursing practice” and described them as “the code in which we work in” [*sic*]. Jane chose to relate the concept of social justice to what she described as nurses’ “innate” desire to be “socially just” and to be “an advocate for social justice.” Jane also shared how she, as the former director of an accelerated BSN program, exposed nursing students to professional nursing mandates. Jane stated that both books, *The Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015; 2001) and *Nursing’s Social Policy Statement* (ANA, 2010c) were used in her school’s nursing program as “textbooks in the transitions course.” Rachel’s view differed from Jane’s. She thought nursing mandates had little “influence” on practicing nurses and she did not believe social justice can be taught; that it must be something you care about personally.
They [nurses] probably knew them [nursing mandates] in school. So you know, knew it and forgot it. But, even if they [nurses] did, remember them [the mandates] I don’t think that they [the mandates] would influence them [nurses] one way or the other. I mean, either they [nurses] care about social justice or they don’t. “Social justice--that can’t, that can’t be taught. Either it’s innate within you and it’s something that you care about or because of personal meaning and purpose. (Rachel)

Sarah, who has a Bachelor’s Degree in nursing and is currently working on her Master’s, when asked about *Nursing’s Social Policy Statement* (ANA, 2010c) stated that she was wholly unfamiliar with the document. Like Sarah, Mary stated she was not familiar with *Nursing’s Social Policy Statement* (ANA, 2010c). Darlene, who is a nurse educator, shared that she is familiar with both nursing mandates and has exposed nursing students to their content in class. Even so, she believed that the nursing mandates may not be as important in the profession as they once were.

I have, you know, I’ve read them but . . . I mean, you know, they [nurses] should be. I mean, those are our Bibles. But, I don’t know . . . I think honesty is absolutely critical and I think that caring for others is in a way, you know, like the goal of the world to me. It’s like, okay, so here’s what’s important. And those are probably the two things that are the most important for me of all the things in my whole life. I have, you know, tried to do those things and to operationalize those. So, can I quote the code? Not anymore. I took ethics one time but no, I can't quote the code anymore. (Barbara)

Helena did not share her opinion relating to the mandates or their influence. Susan shared that she was familiar with their content but believed that nurses “still have to do the work.” Jill stated that she might have read the Code of Ethics “a couple of times” in her career, but she viewed it as a very basic document that suggests that nurses should provide “good care” and should do no harm. The participants’ views relating to the concept of social justice (in general) was also explored. When Rachel was asked about her understanding of social justice, she replied,

Gender disparities, culture disparities, it’s equity of things that are important to life, you know, whether it’s food or water or housing or education, child care, all of these things. It’s caring for vulnerable populations. It’s acknowledging the fact that there is extra work that needs to be done for vulnerable populations that despite, you know--the American command, we cannot all pull ourselves up by our own bootstraps, that there is social work to be done. (Rachel)
Barbara’s understanding of social justice related to caring. Although caring can be broadly interpreted and she did not define exactly what she meant by “caring,” her statement included the passage “the least among us,” which implied caring acts the vulnerable in society, in general.

Susan shared her views on the interconnectedness between social justice and political advocacy, arguing that “you can't take them apart.” Catherine’s words initially revealed the negative connotation that is sometimes associated with the words social justice, when she said, “Social justice. I don’t really like social justice, that word social justice.” Then she stated, “. . . To me, justice is when we learn from what was wrong and make it right.”

Barbara believed “the world would be a different place” if more nurses would be “active,” and would participate in activities such as “writing letters” and “meeting with policy makers” to share their opinions and their expertise.

We do need more nurses talking about, um, social justice things, and acting on those things. And we do have some who are very active, and, you know, writing letters, and meeting with policy makers, and telling what they think, and serving as experts with them. And that's probably, if we had more of that, I think the world would be a different place. (Barbara)

**Major Concepts Within the Model of Political Advocacy in Nursing Praxis**

The participants were a wealth of information and enthusiastically offered not only factual information relating to their advocacy work, but also shared their perspectives of what had prepared them, what had helped them, and what had hindered them. All of these factors the participants described: their beliefs, their values, their skills, their personal and practice experiences, their opinions, their observations, etc. were all coded as “indicators.” The only words not coded were filler words like and, but, the, etc. The next step of the coding process involved separating and categorizing all of these individual one-word indicators and multi-word...
phrases into categories. This was an on-going process as each interview was completed. The following conceptual categories slowly emerged: (a) Pre-Conditioning Factors, (b) Conditioning Factors, (c) Cognitive and Psychological Motivators, (d) Action Strategies, (e) Professional Facilitators, (f) Professional Barriers, (g) Communicating a Proposed Plan to Policy Makers, (h) Public Policies; and (i) Health and Social Equity (which is the goal); and (j) Regrouping. All of the categories ultimately became a part of the Model of Political Advocacy in Nursing Praxis shown in Figure 2. The categories are discussed more fully in the paragraphs which follow.

![Model of Political Advocacy in Nursing Praxis](image)

**Figure 2. The Model of Political Advocacy in Nursing Praxis.**

**Pre-conditioning Factors**

The following three categories or sub-concepts were identified as pre-conditions:

- Personality Traits, Parental/Familial/Educational Influence, and Personal Beliefs. A pre-condition or antecedent is defined by Merriam Webster (2003, p. 52, 4a) as “A preceding event, condition or cause.” Pre-conditions were unique to each nurse. Certain personality traits might
contribute positively to political advocacy practices more so than others (based on the participant’s perspectives); however, personality traits cannot be measured, compared, or predicted. However, the possession of the following personality traits was mentioned most frequently among the participants: resiliency, self-confidence, self-esteem, and assertiveness, and were placed in the Personality Traits sub-category. The traits were recognized as those that are most beneficial when communicating with people, meeting new people, influencing others, presenting information, and lobbying elected officials. However, to what degree they helped (or not) was impossible to determine.

Jill described how she has always just liked to “change things” and “figure things out.” “And I've always just like to figure things out, and I've always wanted to change things. I think it's probably just maybe a personality thing” (Jill). Sarah claimed she was born questioning the authority of any one person, to control the destiny of another person. “I learned to question authority with my mother's milk [laughs]” (Sarah).

Although no questions were asked to attempt to determine the participant’s religious or political beliefs, many of the participants freely shared their moral views and understanding relating to a variety of topics: social justice; social justice advocacy, political advocacy, their thoughts relating to vulnerable populations in general, the intellectually disabled, the elderly, those diagnosed with mental illness, homeless individuals and families, poverty, and many others. However, during the interviews, only a few shared their religious and/or their political affiliation. The participants shared experiences relating to their upbringing, their childhoods, their parents’ work ethic, values, moral standards, parenting style, political beliefs, religious beliefs, and other facets of their lives and their life experiences that they believed had impacted their political behaviors, their advocacy, and their nursing practice. The personality trait of
resiliency was a common theme throughout their stories, even though other words such as “perseverance”, “stubbornness”, “resourcefulness”, “toughness”, “grit”, and phrases such as “the ability to recover after adversity” and “never giving up”, were used.

Helena’s childhood resiliency was evident as she shared her experience of growing up in a “farm family” in which she was the eldest daughter.

You grow a lot of your own food. You can it [the food], so you have it in the wintertime. If something breaks, you figure out how to fix it. You don’t just throw it out and buy a new one. So, I think sometimes in my nursing career, I approach things the same way . . . you’re presented with this problem and you just--figure it out. And . . . if it should be done, how do we make it happen? (Helena)

Self-confidence was another personality trait that emerged in the participants’ words. The participants described how self-confidence positively contributed to their work and enabled them to be assertive when communicating, approaching someone, and when they were presenting their ideas for change. Self-esteem, initiative, enthusiasm, assertiveness, and courage were other personality traits that were identified by the participants which also contributed positively and helped enable them to have the confidence to do their work. Mary shared her views on how she believed self-esteem can help enable other nurses to “make a difference.”

Really, I think it goes back to the way that a person is raised and in the sense of having self-esteem and having the idea that you can make a difference and that you can play that role and also just having the courage and initiative to take it on for other people. (Mary)

An individual’s personal beliefs are a culmination of their political beliefs, their culturally or ethnically related beliefs, their religious beliefs, and their morals and values. Darlene grounded her effectiveness as a political advocate to personal ethics that were reinforced throughout childhood by her father.

Persistence, dedication, commitment to your students . . . commitment to myself, commitment to my family . . . that is how my dad raised me [and] all his girls. He was very focused and driven. You know, he always said, “a little work is not going to kill you.” He’d say, “Stand up for yourself! Say it, but be respectful.” (Darlene)
Sarah shared a little about her religious background and her childhood religious experiences, which had had a profound influence on her personal beliefs, her current religious beliefs, and her advocacy work.

So, at some kind of ceremony, I remember throwing a Bible across the room, and people in the room were like "GAH!" gasping. But it was how I felt! And I felt very much like I finally knew the goal. In fact, somebody flat out told me the goal was to indoctrinate kids so that they would not feel comfortable outside of the Jewish circle, so that Judaism would like, continue, and I was like "That's nauseating!", you know? (Sarah)

Jane believed her moral compass, her upbringing, and her faith, all played a role in her advocacy work. “I have to say that my own upbringing, uh, my belief in Christianity, and my own moral compass certainly played a role” (Jane).

The sub-category Parental/Familial/Educational Influences included the following types of experiences and/or factors, which became indicators: parental influence/role modeling, the influence of other adults, political exposure, political involvement in school (K-12), civics learning, childhood political experiences, early political interest, and geographical location of their residence (either in childhood or adulthood). Jane shared her thoughts on how she believes foundational childhood experiences influence adult political beliefs and behaviors.

Uhm, I really believe that, uh, role models going back to growing up, what did your parents do? Did your parents vote? Did they think that it was important? What did you hear in school? Did you have a civics class or history class, and were you encouraged to vote? Was Election Day more than a day off from school? Was it discussed? What does it mean to be an American? So I think it's very, very basic going back to elementary school and the values that you saw around you, uhm, that helped shape how you feel about being politically active or even just going out to vote. (Jane)

Sarah stated that she was “political, long before my peers.” The emotion could be heard in her voice as she expressed her desire to represent those individuals she described as the “disenfranchised.” It is likely that her residence in California (Oakland and San Francisco) played a part in the shaping of her political belief system.
A big part of it for me was I wanted to be the face of someone who was human in the medical system . . . for people who were disenfranchised. So, I already was political way before I went to nursing school . . . and uhm, my high school graduation, I was . . . uhm . . . you know the little sayings in your yearbook? Mine was "Speaks Politics". Uh-hmm, so I’ve kind of been like at this a long time! (Sarah)

Barbara shared a story about her parent’s political beliefs and involvement, which might have influenced her own political interest, beliefs, and behaviors, although it would be impossible to accurately measure. She also shared a story about her early political activism, which began when she was a child.

Well, when I was growing up, uh, I was raised in Pennsylvania, my dad had an undergraduate degree in economics from the University of Chicago, very conservative. And he was a Republican, like a Nelson Rockefeller Republican. When he was 85, he became a Democrat because he couldn't stand the Republican Party anymore, what it had become. But anyway, my mother was a member of the union, she taught K thru 6th art. And in Pennsylvania, it's a union state, and she belonged to the Pennsylvania State Education Association. So, the conversations at the table . . . she was not active politically, but she had that union. You know, worker's rights. And my dad would be . . . they, both of them were socially liberal, they believed in social justice. I mean, social justice issues were very important to them, but the conservatism came in on the fiscal side. You know, the role of the government primarily. And I remember those conversations as I was growing up, so I think about that a lot, and then I was always kind of involved in school activities, and I did lead a little bit of a revolt against the food, the cafeteria at one point when I was in school. Got in a little trouble doing that, so I think it [political activity] started early. (Barbara)

The stories the participants shared were filled with information about their individual personalities and personal strengths; their childhood and adulthood struggles (emotional, financial, etc.); the various life skills they had acquired throughout life; the impact of their family’s religious beliefs, their ethnic background, their personal beliefs (which became another sub-category), their familial affluence, family history (as well as the impact of the geographical location where they grew up); and their parents’ career choices, political behaviors, work ethics, and moral convictions. All of these factors seem to have impacted their personal and professional lives, as well as their political advocacy behaviors, based on the data. Whether there were any similarities amongst the participants relating to any of these pre-conditioning factors (or not), and
to what degree any particular aspect of their Personality Traits, Parental/Familial/Educational Influences, or Personal Beliefs (all Pre-Conditioning sub-categories) had impacted or influenced their political activity is not known. However, Jane believed that it would be an “injustice” to “stereotype who’s politically active and who’s not” based purely on personal behaviors, personality traits, or other factors.

I think it's doing an injustice to try and stereotype who's politically active and who's not. I would say that people that are outspoken, they are probably more often categorized as being the people that are politically active, but there are plenty of people behind the scenes that help move policy forward and aren't out there beating their chests and making broad statements. (Jane)

**Conditioning Factors**

Eight of the participants described intimate personal experiences and/or experiences they had personally witnessed which they believe motivated, influenced, or inspired their advocacy work or nursing practice in some way. The experiences the participants described are those they had personally experienced, those a close family member had experienced, and/or those experiences they had personally witnessed through direct and/or intimate contact with the individual or group who had experienced the need, injustice, etc. The emotional connection that many of the participants described seemed to be related (in varying degrees) to the intimate personal experiences and/or the intimate bearing witness experiences the participants described in their interviews. Their experiences seem to have helped the participants establish an emotional connection to the issues, problems, and situations they were exposed to. Instead of participating in a learning assignment which had required them to read a case-based story to learn about social injustices, healthcare inequity, or the issues facing vulnerable or marginalized groups; the participants had felt them, seen them, heard them, intimately witnessed them, and, in many cases, experienced them personally. Gleaned from the data, the life experiences the participants described fell into two distinct themes or sub-categories: (a) Intimate Bearing Witness
Experience with Injustice and (b) Intimate Personal Experience with Injustice, which were then categorized broadly as Conditioning Experiences with Injustice and labeled accordingly in the Model of Political Advocacy in Nursing Praxis.

An *Intimate Bearing Witness Experience with Injustice* is an intimate experience in which an individual has been bodily present during an unjust act and/or bodily present to witness the results of an unjust act, such as racism, marginalization, inequity, disparity, neglect, injustice, abuse, or stigmatization of an individual and/or group of individuals. This experience can be a childhood experience, a personal experience, a professional nursing practice experience, a student nurse experience, or a volunteer work experience. The experience can occur at any time from childhood through the present and might include multiple exposures to an unjust act or the ramifications of an unjust act.

An *Intimate Personal Experience with Injustice* is an intimate personal/bodily experience in which an individual has been the actual victim or focus of an unjust act such as racism, marginalization, inequity, disparity, neglect, injustice, abuse, or stigmatization. The experience can occur at any time from childhood through the present and might include multiple exposures to the unjust act.

**Intimate Personal Experiences With Injustice**

All of the following experiences are personal experiences the participants described which included some facet of injustice, inequity, marginalization, stigmatization, extreme need, a perceived need, and/or an anticipated need which was felt on an intimate level by the participant. Three of the participants described experiences which had occurred in early childhood and/or throughout their childhood and into their adult lives. For Sarah, both of the experiences she chose to share were childhood experiences that greatly impacted her life as well as her nursing
practice and advocacy work. With emotion in her voice she described some of the difficult events that occurred in her childhood.

My mother, despite being admirable, was abusive, and uhm . . . my parents split over uhm . . . something that happened with my brother that was abuse, and my father and I sided against her. She said, ‘If you side with him, then I'm leaving’, and she did. And that was some of what I was reflecting on, on the way down, because I think that I took on a . . . “This is how he should be raised” and . . . I was unsuccessful. Uhm, my dad was pretty neglectful, and . . . my brother didn't turn out okay. And . . . looking back on that . . . you know . . . a few years ago, I got back in touch with him, and looking back on that, I now see that it was impossible that I could've been successful, I was twelve. (Sarah)

During her interview Sarah also shared that she was “born Jewish.” She also shared some facets of her extended family’s history and their tragic reason for immigrating to the United States, which Sarah stated was to “escape the Nazis.” She went on to say that many of her family members “lost their lives during the Holocaust” and that she was made aware of her family’s history as victims of the Holocaust from “a very young age.”

My mother is . . . uhm . . . Her grandfather, uhm . . . came to escape the Nazis, and she is related to the only [name withheld] that are still alive. Every . . . Every other branch was exterminated. And so . . . I grew up knowing that. And I grew up, uhm . . . having those faces of the grave and deaths in my nightmares...” (Sarah)

In elementary school, Sarah remembered teachers and school administrators going “out of their way” to make her feel “welcome” by putting up Hanukkah decorations. And yet, she claimed that she always felt “different” from her classmates. “So I've . . . I’ve always had that, and I've always known that no matter what we look like, if the Nazis came back, it wouldn't matter. We wouldn't be considered white” (Sarah).

Sarah’s explains how she struggled during her childhood, first in Oakland, then in San Francisco:

I have this huge chip on my shoulder about people who didn't have to know. That didn't have to struggle or . . . had things given to them . . . or have to go to a high school where people got knifed, you know? And I, it's true, it's really true that I had to go to a school like that. I clawed my way out because education was my way out, and I was good at it. But I know, like, I know so many other people that didn't. And so, when people say,
“You know what? You just have to work hard!” It’s like “no, you don't”-- I mean, I know that, so viscerally. I’m like, “If you knew what I know, you could never say that.” (Sarah)

Although she dealt with being bullied and ostracized for being White and Jewish, Sarah realized now that the exposure she had to diversity functioned as an asset in her life. She explained how she lived in a mostly Spanish-speaking Latino neighborhood in San Francisco when “gay” individuals were “flocking to San Francisco.” She credited these experiences as the reason she was very comfortable with ethnic and sexual diversity and she explained that she didn’t see anything “strange or odd” about either. On the contrary, she viewed diversity in society as a positive and something that can strengthen society in general.

Much like Sarah, when Rachel was asked if there was anything that had influenced her work, she too chose to share a very personal experience that began in childhood and continued throughout adulthood. She described a multi-faceted struggle: religious abuse, emotional abuse, financial difficulties, and domestic difficulties. The emotional pain Rachel endured could be heard in her voice as she haltingly described the traumatic events she endured, which she described as her “truth.”

I was raised in a religious cult from the age of 5 to 24. I was not allowed to go to school after 6th grade. I’ve experienced poverty, welfare, food stamps, Section 8 housing, and . . . a lot of emotional-religious abuse. So . . . I came out of that at 24 and about 2 years later, no, no, no . . . 4 years later, I took my kid and left my husband. And so I’ve been a single mom for 17 years and it’s very difficult you know, raising her by myself . . . I fought through education, fought for quality childcare . . . At times I'd bring [my daughter] to the nurses’ station, she'd stay there in the morning until time for school and then I’d drive her there . . . I was raised extremely conservative [sic] and when I was old enough to realize that that meant that no one gets any help, you know . . . that's when I was like “No, that's not gonna work for me!” I needed help and I got help. You know . . . you can't deny people help, so . . . that's my truth. (Rachel)

Her tenacity was palpable. Rachel was a fighter; she was not a victim. She was resilient. She was passionate. More importantly, her life experiences seemed to have helped her establish an emotional connection and personal meaning not only to the issues she has experienced, but
perhaps her experiences with injustice have helped her develop a depth of understanding and awareness (in general), that has enabled her to be more empathetic to not only the particular forms of injustice which have negatively impacted her life, but those injustices that others have experienced as well.

Similarly, when Catherine was asked if there was anything or any experience that had influenced her work, she, too, described a childhood experience. She stated that much of her childhood was “difficult” and overshadowed by her mother’s mental illness and the stigma her family endured as a result. Her mother was diagnosed with schizophrenia and Catherine described how her mother’s illness waxed and waned throughout her childhood and how the instability of her mother’s illness forced her to assume more of an adult-like role within her family.

Yeah . . . I saw lots of things. Sometimes it was good, sometimes it was bad. Most of the time I acted more like a parent than a child. I had to . . . I had no other choice. It’s what’s pushing me in this way. What’s pushing me to try and change things. My mother was schizophrenic and my sister was just diagnosed four years ago with schizophrenia, too. My ex-husband has a traumatic brain injury. So, I’ve had a lot of dealings with the CSB and mental health institutions and their lack of funding and services for people. (Catherine)

Ironically, Jane’s words about policy helped me to better understand Catherine’s experiences and how the difficulty in obtaining services for her mother had possibly impacted and influenced her political advocacy work.

Again, I think it gets back to how it affects you. Policy doesn’t affect you until your health insurance claim gets denied or you have a parent that’s in the hospital, and you’re trying to deal through the red tape of insurance. (Jane)

Mary did not describe a childhood experience, but instead described an experience that ultimately resulted in a complete career change for her, and one that she described as a “life changing event” for her. Mary explained that before she was a nurse, she worked for several
years in business after graduating from college with a Bachelor’s Degree in Organizational Management. It was during this period of her life that her father became seriously ill and had to live in a nursing home for an extended period of time. Since she visited her father frequently, Mary ended up spending a lot of time in his nursing home observing the goings on.

It would be when my father became sick and he had to live in a nursing home for a long time. And you know, that was what prompted me to even go to nursing school. I just saw how people struggled to have a voice and . . . I mean that was a life-changing event for me. I just wanted to be that voice for him, you know? And so, you know, that was just what prompted me. And then I saw other folks that were in the home, how they struggled. They get put in homes and families walk away and they never see them again. I had somebody tell me, it was my dad's roommate, he said that his brother said one day, “Come on, let's go in the car for a ride.” And they lived in Kentucky. His brother brought him here to Abingdon, put him out in a nursing home and he never saw him again. And so . . . I thought to myself, “Who is helping this man?” You know? How is it even possible that somebody would do that, you know? Because, I didn't have that type of relationship with my dad! It was just heartbreaking to me, that a family could just walk away and leave somebody like that. And so, I mean, really, that's what prompted me to become an advocate, and . . . it just grew into a job. (Mary)

Darlene’s story about what social justice meant to her was very moving. With tears in her eyes she recounted an experience that had taken place years ago but had stayed with her. The poor treatment she and her daughter had experienced had left an indelible mark.

The world is not always just, it's not always fair, and the world doesn't evenly distribute healthcare or funds evenly. Years ago I had to take my daughter to the hospital late at night. I threw something on and I wasn't dressed up. It was very late at night. Probably two, three o’clock in the morning, but she was very sick so I took her to the E.R. They didn't know that I was a nurse. So, I'm sitting there like, you are going to do some more stuff right? Do a complete assessment? But no, they didn’t. They didn’t even do a head to toe exam! Yeah, they looked at her. But did they listen to her lungs? No. Did you do X, Y and Z? No. My daughter . . . she was very sick, so I ended up having to take her to another hospital. (Darlene)

Darlene, a professional nurse, with a doctoral degree, paused for a moment and looked down. Taking a deep breath, she looked back up at me, with tears in her eyes. As she continued I could hear the emotion in her voice as she slowly exhaled and bravely struggled to explain something
that she instinctively knew, an American-born person with lighter skin has likely never had to endure, and therefore, can never truly understand.

No, they never really examined her. So, at the end I did tell them that I was a nurse and I was going to follow the chain of command to the president and let them know . . . you know, that I am a nurse. But . . . you know . . . you have to be fair. You have to! If the president’s family comes in and gets an expert assessment and excellent care, versus somebody coming in that doesn’t look rich or wealthy . . . You know, you never really know who you're treating! But, you should still be fair and distribute it equally. You know that is part of what social justice is. What kind of society is this, for us to treat people so differently? Everybody should be respected . . . everybody! (Darlene)

**Intimate Bearing Witness Experiences With Injustice**

The bearing witness practice experiences with injustice that the participants described seem to have worked in much the same way as their personal experiences did, in that they seem to have conditioned the participants to establish an emotional connection to the issues, problems, and situations they were exposed to. Some of the experiences the participants described occurred when the participants were nursing students, others occurred when the participants were professional nurses. The important distinction between the intimate bearing witness experiences with injustice and the intimate personal experiences with injustice is that during these experiences the participants functioned as an intimate observer and were not themselves the “victim” or the individual who was personally experiencing the injustice.

Mary had an experience during a clinical rotation in a psychiatric ward that she felt inspired her future nursing practice. Mary said that most of her classmates did not see the benefit of taking care of psychiatric patients. The following is the experience Mary shared.

Oh, it was definitely my clinical rotation--when I did a six-week clinical rotation at the psychiatric hospital. Out of my whole class, I was the only person that was like, “Wow, this is awesome!” Everybody else was like, “Ugh, I cannot wait to get out of here.” You know? Because they looked at everyone--because they were in a mental institution, as—"crazy,” you know? And instead of looking at them as a person, an individual, everybody was just looked at as “crazy.” And they thought it was a waste of their time to do that rotation. And when I was there . . . it . . . it just clicked for me and I thought, who better
to put your time and effort into than to help someone get their life back together, and get back out in the community . . . to be a productive part of it! (Mary)

After Mary obtained her nursing degree, she was employed as a psychiatric nurse at a state-run psychiatric hospital for a total of 7 years and she says she “loved” her work there. Mary also shared her views on how she believed the media negatively influences society’s view of mental illness, which then functions as a barrier for individuals with mental illness.

I think the media, the movies and TV have mental health so negatively spotlighted that . . . it . . . it just skews how people look at it. It really does! So, when they [the public] think of mental illness, they're going to think of the most sensationalized things that they have ever seen, you know? On TV. And I'm not saying that those may not be true cases, but those are far and few between when you look at how many people are diagnosed with a mental illness. If people really knew that, they would be shocked. You know? They would. And, how many people live productive lives that have a mental illness? A lot! (Mary)

Jane described an experience that occurred when she was a student nurse. This experience was her first realization of the differences in healthcare that could exist within the same city, depending on in which part of the city you received care. She described the lack of basic supplies that existed in the hospitals and the overcrowded conditions the patients were forced to endure.

I remember as a student, my first med/surg rotation was at Lincoln Hospital in the South Bronx. It was a large 50-bed ward, and when we got there we were going to go do bed baths. And there were basins, but there was no soap. And there no washcloths, so we did bed baths using a towel and using an edge of the towel as a wash cloth. And one of the student's parents heard about this and donated a carton of soap, and we took up a collection among ourselves and bought washcloths. Even the very basics were missing, and that struck me accordingly, that you could live in different regions within the same city and have different levels of healthcare. (Jane)

Jane then described her very first job as a licensed R.N. in which she worked with indigent populations in the Bronx.

My very first job was working in New York City for the Department of Hospitals, and so I worked with indigent populations from the Bronx. I worked in hospitals without air conditioning in the summer, with sometimes five and six-bed rooms, and no private rooms. (Jane)
Helena chose to describe an experience that occurred early in her practice in which she worked very closely with homeless, inner-city families.

I probably got most involved, initially, because I came to [location withheld] to work in the inner city with, um . . . underserved families, and eventually, um . . . started working with homeless families. So, I had to do a lot of local advocacy as well as . . . sometimes, um, testifying before city officials on some of the needs of families. Um . . . because when you think of homeless people, many people think of single adults living on the street. And yet families have a whole different constellation of problems, different reasons that they come to homelessness, as well as different problems, um, within that system. (Helena)

Helena shared another experience that occurred when she was a student nurse working with Native Americans at an Indian health hospital in New Mexico.

The other experience I had was . . . um, my senior year. We had the option of doing a January term experience. And I went to Gallup, New Mexico to an Indian health hospital. And we were there three weeks and we rotated through one week. I was traveling out in a jeep with the visiting nurse, going to hogans and things out--way, way out in the rural areas. Um . . . another week, I spent in, um . . . one of the schools. They still had boarding schools. And there were clinics at the boarding schools to help address problems with children. And then the third week, I spent in the hospital--more in the clinics that they had in the hospital area. Um . . . that was . . . it was very . . . it was a great experience. And certainly very difficult to, um . . . to see, um . . . how the kinds of situations that, in some ways, were imposed by a larger community and, um . . . the problems that kind of evolved out of that. (Helena)

Although the experiences varied, the interviews were notably similar due to the raw emotions that emerged when the participants described their experiences. In some ways, it seemed as if the participants relived their experiences, as they described them. Though the stories and intensity varied, the emotions the memories evoked could be heard in the participant’s voices and seen in their facial expressions and gestures. Although it would be difficult to measure whether the impact of these experiences was positive or negative (overall) and difficult to determine the degree to which each participant’s personal life and/or professional life had been influenced, (or continued to be influenced), it seemed as though these experiences had
made a significant impact in each participant’s life. It is also important to note that while the influence of their experiences would be impossible to definitively measure, the participants themselves believed their experiences had influenced their nursing practice and their advocacy work in some way.

Helena shared her experience as a novice nurse in mother-baby care and her thoughts on how nurses tend to hyper-focus on certain aspects of care, which may be dictated by hospital rules, but ignore socioeconomic issues that may be just as important to a patient’s immediate well-being and ongoing health status.

Um . . . I got involved early on with mother-baby care when I first became a nurse. And it always amazed me that we insisted on putting the mother and baby in a wheelchair on the floor and wheeling them to the front door of the hospital, but we didn't really care whether they had food when they got home . . . um, whether they had support. And the same is true of someone with . . . who's had a heart attack. We put fifty thousand dollars into saving them and we even wheel them right out to the front door and make sure they get in a suitable, safe transportation home, but we don't have a clue whether they're going to be able to eat that night . . . or if they can get to the toilet, get transportation back to a physician or nurse practitioner! So, um . . . I guess whether it's social policy, whether it's nursing ethics, I think we're ethically bound to care about all aspects of health and wellness, and not just the illness part of care. (Helena)

Jill worked with individuals with intellectual disabilities every day and her desire to help them was easily observed, as she passionately shared her thoughts about adults with disabilities.

In general, I think that adults with disabilities are one of the most neglected groups of individuals within the population, within our country, really. I think it’s because it’s still just socially misunderstood. And I think that until people understand that, um, and see people as people we’re going to have a really hard time, getting equality much less equity—from not just healthcare but services in general. So I think that makes my job as a nurse very challenging. I mean, when we’re taking people [with intellectual disabilities] to the doctor and the professional doesn’t even look at the person that we’re supporting! So, even just basic conversation skills—we’re having to teach to people. Like telling them [healthcare professionals] to look at someone when they are speaking to them. We have to have that conversation! (Jill)
Susan did not tie her passion to a particular issue but shared her thoughts on how passion can impact and facilitate advocacy, and the importance of choosing an issue you care deeply about.

I believe in being passionate. I can't go and be an advocate of something that I can't support! So, don't put yourself out there doing something that you don't believe in just because somebody wants you to be the advocate. Don't do it! Advocate for the things that you have a passion for. (Susan)

I argue that Darlene’s experiences and the experiences of the seven other participants who had intimate experiences with injustice, promoted or created a heightened cognition or “state of being” for the participants which enabled them to be more keenly attuned to the needs of others. This heightened sense of empathic awareness is a type of “embodied awareness” and functions as a cognitive and psychological motivator. In addition, the participant’s words could possibly foreground the connection which exists between experiences, emotion, and advocacy and the part they play in all facets of the political advocacy process. In the next section, the specific personal and professional experiences, skills, etc. which had helped to facilitate the participants’ political advocacy behaviors are identified and categorized accordingly.

**Professional Facilitators**

The category of Professional Facilitators was gleaned from the data the participants shared as well, and can loosely be described as professionally-related experiences, activities or training that occurred within their nursing practice and/or education that helped prepare, enable, promote, assist, and (in some instances) support the participants to be better able to participate in political advocacy. Although everything in this category was gleaned from the experiences the participants shared, they were separated out and categorized to help illuminate career or professionally-related factors within the participants’ experiences that have been specifically identified by the participants as those that help facilitate or promote political advocacy activities.
Although some of the experiences/skills within this category have personal facets, they are categorized as professional facilitators because they are those that helped facilitate behaviors that fall within a professional nurses practice realm.

**Practice Experiences With Injustice**

Experiences with injustice have already been addressed in great depth earlier in the chapter. However, it is important to note that some of the experiences the participants described occurred during their professional nursing practice. As a result, Practice Experiences with Injustice is also included in the Professional Facilitators category within the Model of Political Advocacy in Nursing Practice.

**Participation in a Professional Nursing Organization**

Several of the participants shared their perspectives on professional nursing organizations’ importance to the profession and/or to political advocacy. The benefits of professional nursing organizations are many. Professional nursing organizations provide a forum for: emotional support to nurses, helping nurses problem solve, promoting collaboration, reflection, knowledge-sharing and interpersonal skill-building. All of the participants were members of at least one professional nursing organization. Other participants shared their views on why nurses do not join professional nursing organizations, which are explained more fully in the “Professional Barriers” section later in this chapter.

Susan shared her thoughts on how professional nursing organizations broadened her perspective on the nursing profession. “I think it [the experience] helped broaden my perspective of nursing and what the profession was all about, and how we [nurses] needed to have a voice . . . because the ANA and VNA is really the voice of nursing” (Susan).

Sarah thought it was important to find nursing peers who had similar advocacy interests. She suggested the use of professional nursing organizations as a platform to help you find people
whose interests “align” with yours. Jane believed that professional nursing organizations need to reach out to nurses more and share the results of their work accomplishments. She believed that membership should be viewed as a part of professional accountability.

This is what we’ve done. This is why we need your voice. You can add your voice, and you don’t have to physically come to a meeting. Um, I tell my students, once you get your master’s it is part of your professional accountability to be policy-savvy and to speak out and to belong to a professional [nursing] organization. Nurses just need to feel that their voice is important. That one voice spills on another voice, and if you don’t join in that chorus of voices, then you’re not heard. You can be part of that chorus and not be that single person beating their chest, just by joining that political organization or professional organization. You just need to take the first step. The results are multiplied thousands and thousands of times, and you reach multiple lives and make differences in lives that you don’t even know. (Jane)

Mary shared her views on the importance of nurse educators encouraging nursing students to become members of organizations that advocate for health. “I think that they [nurse educators] should really encourage nursing graduates to become members of organizations that advocate for whatever their interest is, whatever their specialty is going to be in, or whatever they feel passionate about” (Mary).

Barbara shared that when she was in school, the message was very clear that joining a professional nursing organization was expected, so she always did. She said she did not participate much when she was younger, but she assumed there was someone in the organization advocating for the profession. She did not seem to think that it happened that way now, based on some of the literature she had read.

Jane shared thoughts on how to encourage more nurses to become involved.

There needs to be more marketing, more reaching out. This is what we've done, what we can do. This is why we need your voice. You can add your voice, and you don't have to physically come to a meeting. You can attend an online meeting. Virginia Nurses Association has lots of committees. And many of those committees meet by conference call. (Jane)
Jill was very frank about her disappointment with professional nursing organizations and their lack of ability to not only inspire her personally, but their inability to convey an “inspiring message” to any nurse. “I’ve done that, and I’m not feeling inspired, you know, and that’s a problem and I think it’s because there’s no one out there with an inspiring message” (Jill)

**Professional and Personal Support From Mentors and Peers**

Mentoring experiences, whether they occurred in a professional, academic or a personal setting, emerged as a strong facilitator to political advocacy. Mentoring-related experiences were mentioned by all 10 participants, even though some participants used different wording, and described life experiences such as peer support and peer encouragement. Some participants described groups of nursing friends, personal friends, or co-workers that mutually inspired each other. Other participants described academic, leadership, or politically-related mentors. Darlene, a professor at an inner-city HBCU and a mentor to many of her students, described some of her students’ difficulty coping with the stresses of nursing school and the adversarial issues they were faced with as students, financial problems, family crises, time demands, etc., and the effort the students expended to maintain their grades.

You know, everybody’s not going to make that 75%, that grade of 75 and pass successfully, so what do you do, and can you live with it, if they don’t? As a nurse, you want to save everybody, you know? We try, we want to provide everybody with an education, soo . . . if they can’t be a nurse, give them the advice and the guidance to go into another discipline. (Darlene)

Darlene also shared her thoughts on having multiple mentors from all walks of life, not just nursing.

I think it’s important to have multiple mentors. You know . . . whether Caucasian, male, female, young, old . . . and it doesn’t necessarily have to be in nursing. It can be in education, it can be in various roles, but all of them [nursing students] should have multiple mentors. (Darlene)
Jane shared how much she learned from one of her former professors who, (in addition to being her teacher), was also her mentor and a “great inspiration” to her. When Barbara was asked if she had ever had a mentor or mentored another nurse, she stated that she has had “a number of mentors throughout her career” that have helped her through some “tough spots.” Other participants described similar situations in which they fluidly moved from mentor to mentee. Sarah shared that she, too, had had a lot of mentors throughout her nursing career that really influenced her practice and her life. One of Sarah’s mentors was especially perceptive of her needs and taught Sarah how to “prioritize the important.” Sarah had also been a mentor to other nurses and other healthcare workers. She felt that they mutually supported each other when “one of us is down and one is feeling stronger” and “mutually inspired each other” in their areas of interest. Jill, too, shared her thoughts on mentors and the value of what she has learned from them in her words.

Most of what I have learned has been from working with people. And it's not really come from textbooks. Um, it has just been mentors. Um guidance . . . someone to kind of like . . . bounce those ideas off of. Like “Hey, I'm thinking about this.” or “Okay, wait a minute. Maybe you should look at it from this angle, um, because you need to know that too, you know?” (Jill)

All 10 of the participants described experiences with mentors and the important part mentors have played in their lives and within their nursing practice and political work. Jane shared her views on the importance of focusing on policy in nursing education and the influence that her students claim her class had on them.

. . . And because I had your class, I knew that I could go and I could talk to him on this important issue. Or “I've joined this group!” or “Here's my picture holding this sign. I was at this rally.” So I really, truly believe that educators can influence, um, students and help them to be policymakers, and help them to get involved, and be bitten by that policy bug and to see that we can make a difference. And again, we can make a difference for our patients through changing policies. (Jane)
Darlene, like Jane, believed that mentorship is very important in order to help nursing students “problem solve and to give them guidance” on how to overcome the challenges they are faced with as students. She not only believed it was “important,” but she thought mentorship was “necessary” for their success and can really make a difference. “It’s so important. I think it’s necessary . . . you know . . . it takes a village to raise a child . . . and mentorship is so important” (Darlene).

Rachel believed that mentors have the ability to provide the emotional and professional support needed to nurses who may lack knowledge about certain leadership opportunities. She believed this support might enable nurses to feel the level of confidence they need to be brave enough to step out of their “comfort zone,” try new things, and become more involved. Rachel shared her thoughts about the intelligence, strength, and ability of nurses to lead, if they have a mentor who will support them, encourage them, and help “show them the way.”

If there were more mentors around that said, you know, you can do this, and this will help you to help such and such, and show them the way and have their back, that there would be more nurses doing that. (Rachel)

Overall, the participants said that mentors helped them to be able to reflect and helped them focus on what was important and what was not. Mentors also helped them navigate and evaluate educational, career, and political decisions and inspired them to think outside of the box, do more, and try things that might take them out of their comfort zone.

Like mentors, nursing peers and groups of peers offered a sense of emotional and profession-related support. The advantage of nursing peer groups is that they can offer a sense of mentorship, emotional, and professional support to nurses, that doesn’t require a professional, financial, or academic-related commitment. Susan explained,

And so, we just had informal meetings at each other's homes to plan how we would communicate our message and how we would take it to each one of the candidates. And
it didn't matter whether we were Republican or Democrats or Conservative, or Liberals. When we would sit around that table, we were educating them about nursing. Then when we left that table, we could vote and we could work for whatever campaign we wanted to, but we had to make sure that our message was clear and it was the same message, going forward: to advocate for nursing. (Susan)

Skills

The skills most frequently mentioned were: communication skills, policy skills, problem-solving skills, advocacy skills, grant-writing skills and empowerment skills. All 10 of the participants referenced a variety of different ways they communicated with policy makers, but only a few specifically named communication skills as being an important skill for their political advocacy work, but most of their dialogue contained some reference to communication or the interpersonal skills needed to engage with an elected official. Catherine described what she saw as her ability to “express a point” and thoughtfully shared her reasoning process for problem solving “without being abrasive” with policy makers.

I like to talk and I have no qualm with saying what I think . . . but I think I’m good at saying it without being abrasive. I think I’m able to express a point and give reasons. And, I’m able to hear other people too. **Listening and discussing problem solving ideas** . . . and not just having an opinion and shutting everybody else out. So . . . instead of complaining that they [policy makers] aren’t hearing me, I say, “This is what’s going on at this level and these are the things we need [to make it work] down here.” (Catherine)

Jill explained how much of the work takes place “behind the scenes” and how her participation was sometimes “indirect” and she supported others’ efforts to “go testify” and other times was more “direct” in which she met with senators or local legislators.

We've been able to work on getting some amendments sponsored. I was even able to help support some [healthcare] providers to go testify in front of the Senate Finance Committee. So, I've been able to really kind of see and participate directly and even indirectly in policy-making. (Jill)

Sarah described her perspective which related to the importance of “knowing who to talk” to and how to talk to them. She also shared that many times nurses only complained to their co-workers
which was so unproductive. Susan described the importance of fashioning your statement to policy makers so that its message is informative, easy to understand, and can be quickly shared with policy makers who have little time to talk. In addition to communicating with policy makers, Helena thought there was not enough time, focus, or importance devoted to the communication aspect of patient care in nursing education.

And I think of that as just--it’s where we put the importance of what we’re teaching people to do, that they’re not learning the dance, um, both with the person-- but-- the whole value of this blood pressure pulse and respirations just becomes the focus, rather than having them look at what local policies, um . . . what people are living within their home life and home conditions. (Helena)

Jane thought that sometimes nursing students were initially intimidated by elected officials, however,

Once the students figure out that they [elected officials] are just people, and by the way, we pay their salaries! They really do want to hear what it is that we have to say, because nurses have such a wonderful perspective on what's going on in healthcare. (Jane)

Like Jane, Jill thought that nurses had/have a unique perspective to share with others.

So, I think that [nurses] have to have that engagement on that political level because there’s this disconnect often times between what happens politically, and what happens down here [in society]. And so you have these two worlds that kind of turn and we have to be able to get them to meet together. (Jill)

Barbara believed that nurses had/have a great deal of power and influence and that sometimes policy makers needed to be reminded of this.

What I'd like to say to legislators all the time when they try and blow me off is, “Well, wait a minute! Do you know how many millions of us there are, or how many thousands of us there are? And whoever met a nurse who didn't have an opinion and didn't talk to you? And so it's just not that one nurse you're talking to, but that nurse lives in a home or a house. And so she's got a significant other, and she's got neighbors. And oh, by the way, she probably has parents, and aunts, and uncles, and a sister, and in-laws, and people that she talks to in the grocery line! We are influencers, so it's not only our own votes that we yield, but the people that surround us.” And then . . . all of a sudden, they want to listen to us! (Jane)
When Barbara was asked what best enabled her to do her work, she did not hesitate with her answer.

It’s interpersonal skills. It’s communication! That’s the bottom line! . . . That's why I always tell students that's what advocacy is, it's interpersonal relationships, it's communication, it's looking people in the eye and describing a problem, and seeking help, and pushing for solutions. (Barbara)

Jane stated that nursing school continues to be a great place for nurses to gain experience in the legislative/policy arena. Jane went on to explain that one of the assignments she gave her students required them to develop “talking points” they were then required to present to elected officials.

“In the policy class I teach, they [the students] write a policy brief. Uh, they will identify a current piece of legislation, and they write a policy brief on that current piece of legislation. It can be state or federal. The choice is theirs. Then they are asked, and it's a requirement, to contact a representative, a senator, an assembly person, again, state or federal, that is connected to that bill. It doesn't have to be the sponsor. It's just their own representative, and ask for, uh, some time to go and to speak to them. Now they've done their policy briefs, so they're experts on the subject now. And so I ask them to compose a list of questions that they want to ask this particular, uh, policymaker. And besides the question they want to ask, I want them to come up with some talking points that they've learned from writing the policy brief that they would like to share to educate that particular policymaker. They go and do that. That's a course requirement. (Jane)

The usefulness of problem solving skills was threaded throughout all of the participants’ words, due to the fact that political advocacy itself was aimed at improving a “problem,” issue, injustice, inequity, etc. in society that needed to be improved upon. In fact, solving issues and solving problems and/or problem solving, was implied and specifically stated in so many of the participants’ words, that re-posting all of them would be repetitive. Instead, I have bolded all of the instances when the participants specifically mentioned “problem solving” throughout this chapter and have chosen to share Barbara’s views on problem solving in this section.

Does it need a legislative fix? Does it need a regulatory fix? Does it need [development of] policies and procedures in their own institutions? So my approach usually is . . .
What problem are you trying to solve? And then let’s think about whether you really want legislation. (Barbara)

A few other participants mentioned the use of social media in their personal lives but did not state if it was used in their political advocacy work or not. Jill was the only individual who named a particular social media platform as a means for political advocacy and/or political activism.

Uhm, I started a Facebook group that’s called [name withheld], and I kind of admin that and then I was able to start a petition. I’ve been able to get some groups of [healthcare] providers from other agencies together and they’ve spent time in [name of city withheld] advocating.

Helena shared how she has used her grant writing skills to help her facilitate change in innovative ways. She used grant writing as a tool which enabled her to develop programs aimed at benefitting individuals within society.

But I suppose I found I could effect change most readily by . . . um, writing grants. And early on, I started writing grants to fund an adolescent program and then programs for young families in the inner city. And I found that, um . . . that gave me a real voice as a nurse, that if I could articulate what I felt people needed and could find the funding to do that--I could do pretty novel and innovative programs. So I suppose . . . for me, grant writing has been more effective in making change happen, at least with the populations that I was working with. (Helena)

Three participants described their participation in political campaigns. Two of the participants, both Rachel and Darlene, have been candidates in primary elections in the past and have therefore participated in their very own campaigns. Darlene initially became interested in politics when she was mentored by a nurse who was a State Delegate. Darlene’s mentor is now a member of the Senate and her mentor’s accomplishments have inspired Darlene to become even more politically active and involved. Since then, Darlene has participated in several political campaigns. Darlene also remained open to the idea of some day running for office again.
Rachel became interested in running for office after participating in the Emerge America program in the state in which she resided.

And I, you know, I told them a little bit about myself, how I completed the institute political leaders program and they said you should do our program. And Emerge is all over in several states. In several more states, especially this year, they are getting their own programs up and running and the mission of Emerge is to train women Democratic candidates. (Rachel)

Sarah shared that she applied to be a delegate in her district for Bernie Sanders, a Democratic candidate for the 2016 presidential election. Although disappointed that she was not chosen, she implied that it was not too devastating, because they chose her daughter instead.

Susan elaborated on some of the work she had done for a nurse who was campaigning for president in a professional nursing organization. She shared that “campaigning” was not easy work and could be quite expensive, as it was all usually “volunteer work.”

And in fact, [individual’s name withheld] who is the [organizational name withheld] President, I worked on her election campaign! I was her campaign chair for election the first time that she was elected and for the second time that she was elected. Once again, all volunteer work and money out of your pocket to get her elected, to help her go around the state, talking, going around the nation, talking, going to meetings and really helping promote her . . . . You know, you kinda have to have a little bit of passion or willingness to do this work. Because it's not easy work! It's volunteer work. It takes time, it takes energy, it takes money, and it diverts you from your family. It diverts you from all other social activities! (Susan)

**Action Strategies**

Action strategies are activities that are ongoing and occur simultaneously throughout the political advocacy process and therefore overlap. Action strategies were described by the participants in connection with other concepts they shared. The following action strategies were identified in the participant’s words: establishing an emotional connection between the change makers and the issue, linking evidence to the issue, and establishing relationships with change makers and gatekeepers.
Establishing an Emotional Connection Between Policymakers and the Issue

Although the experiences varied, the importance relating to the concept of “Establishing an Emotional Connection between Policymakers and the Issue” was mentioned by several of the participants. Four participants specifically mentioned the importance of in-person pleas to elected officials at town halls, the general assembly, and other venues where elected officials had the opportunity to interact with the public and/or the public had the opportunity to give a policy related impact statement. Rachel offered her opinion on the importance of stories to foster an emotional connection between people and the issues while campaigning. “Stories are important for everything. Stories are important when I’m campaigning, stories are important if you wanna change hearts and minds” (Rachel)

Jane shared how her students’ initial apprehension about the work they were required to do in her policy class, which required them to meet with a policymaker, slowly evolved into enthusiasm.

Uhm, and the students, at first, when they see the assignments the first week of school are very taken aback. “That is just so much work. Oh my goodness gracious!” But as we work our way through it and after they’ve met with their policymaker, they are just so excited that they’ve done this and they’ve made that first step. And I get e-mails all the time from graduates that say, “Just had to send this e-mail to you. I was thinking of you today. I was standing on the steps of the Capitol, and I just went to see legislators so and so, senators so and so.” (Jane)

Similarly, Mary shared her thoughts on the importance of recruiting and involving individuals that have been impacted by a particular policy (or lack thereof).

“It’s so easy for people who develop policy to develop it and not put a face behind what they’re doing. And if [they] can see that, if [they] vote to cut funding, it is going to affect this person’s life, and [they] are looking [the person] square in the face . . . I think it’s a lot harder for legislators to make those decisions knowing that there’s somebody back in this rural town that has told them, “Hey, this is going to hurt me!” Folks need a voice and without a little prompting and encouragement and help, nobody hears that voice. (Mary)
The other type of emotional connection involves the establishment of a connection between the nurse/political advocate and the issue. It was clear to see that the life experiences the participants described had helped to establish the intimate emotional connections the nurses had to the issues they felt most passionate about.

**Linking Evidence to the Issue**

According to Susan, having the skill to link evidence to the issue and doing thorough research beforehand were equally important. Susan went on to describe not only the importance of thorough, evidence-based research, but the benefits of anticipating the questions that may be asked by elected officials.

So do all of your research, so that when you're talking to somebody . . . you're not afraid that you're going to say the wrong thing or do the wrong thing. It's really having the confidence, it's really educating yourself and making it a part of fluent conversation, because they will ask you questions and start a why, why, why, "Why is that important? Why would I want to vote for that? Why do I need to do this?" So go and think about what their five whys might be and write the answers down. . . . I'm always going to make sure I know more about it than anybody in the room does, so that I can look like an expert, even if I’m not. (Susan)

In addition to the importance of evidence-based research to support your views, several participants described some of the interpersonal skills that can contribute positively to relationship-building with elected officials.

**Establishing Relationships With Policy Makers and Gatekeepers**

Susan also shared her thoughts on the importance of body language and social skills, such as memorization of elected official’s names and faces (before you meet with them), which can be accomplished by studying their on-line photographs.

It’s all so important [to do] before you go to the General Assembly. [Nurses] can look online and see who everybody is and can have pictures of them, so you can know who they are before you go there [the General Assembly]. You know . . . reaching out and shaking their hand and calling somebody by name is so important. (Susan)
Barbara believed it was not only important to recognize them, but to also have established a relationship with them “before you need them.”

And the other thing is when you're working with people who work in an area of influence, you need to get to know them before you need them, and I learned that early but I didn't vocalize it that much. And it's not just them. It’s their gatekeepers. It’s all the people who work with them. You've got to get to know all of them. So, you know, you have the eye to eye contact and, you know, that's the important thing. (Barbara)

A friend of Barbara’s who taught health policy at the graduate level shared how he slowly went about getting to know policy makers.

My [relationship withheld], who is older than I am and still working full time, he has taught health policy at the graduate level and that's one of the things that he uses. And last week we were talking and he tells me he has been going to the Boards of Supervisors’ meetings not to talk, but to watch people as they're working on budgets and he said, “You know, I’ve got to get to know them before I need them.” And he says “I'm just putting in a presence. I'm not talking to them, I'm just putting in a presence.” And I'm thinking, yeah, this is a guy who's really savvy about that process. (Barbara)

Barbara believed that nurses may not have much experience with individuals who have influence and may not be successful initially, but if they realized the importance of getting to know these people, and how to go about it, they could improve with time.

So, you know, nurses who work in a vacuum and don't necessarily schmooze with the folks who have some measure of influence are not going to be real successful when they do identify a change. Now, they might become that way when you say to them “This is the way it starts. You've got to get your butt in gear and get to know these people.” (Barbara)

**Professional Barriers to Political Advocacy**

The following sub-categories fall under the larger umbrella of “Professional Barriers to Political Advocacy”: (a) Lack of Professional Identity; (b) Lack of Autonomy/Initiative; (c) Lack of Participation in a Professional Nursing Organization; (d) Career-Related Responsibilities; (e) Skill Deficits; (f) Lateral Violence; (g) Male Dominance.
Lack of Professional Identity and Initiative

The participants shared their views on what they generally described as a lack of initiative and a lack of professional identity. Mary shared her frustration with those nurses who lacked initiative and therefore did not put themselves in situations where they could “make a difference.”

I think a lot of the nurses are coming out of school today and they lack that initiative that “get up and go” about them. And instead of questioning things and putting themselves out there, so that they are in situations where they can make a difference, it’s easier to sit back and let somebody else do it. (Mary)

Darlene thought that some of the new students just did not have the same passion required for nursing. She thought many of them viewed nursing as merely a way to obtain a job and a paycheck. “For some students, you know, it’s for the money, the livelihood. I want you to come here because it’s what you have a passion to do” (Darlene).

Susan had a similar view and voiced her dismay with nurses that viewed the profession as “just a job,” or a “paycheck.” Susan described how her mentor helped her understand that nursing is not just a job, it is a profession that practicing nurses should contribute to. Barbara had similar thoughts about nurses who only see nursing as a paycheck. “And we used to call those the ‘refrigerator nurses.’ You know, in nursing, they just, it's a pay check--and that's it. And it's a fact of life” (Barbara).

Jill thought part of the problem was that the profession of nursing had sent a confusing message to the public and had failed to define nursing’s professional identity. She said it frustrates her and she felt that there was a lack of leadership and inspiration within the profession as well. In addition, she thought that nursing had especially failed the younger generation with its “nursey speak” and “researchy speak” and she was longing for an improvement in both of those areas.
. . . I follow like people on Twitter and Facebook and I’m bored. I’m bored of nursey speak and researchy speak and I’m bored of some of these things and there’s a disconnect I think in the generations with what’s being said. (Jill)

Jane thought that there was also a lack of professional unity of thought and therefore no single organization existed that spoke from the viewpoint of all nurses. She believed the ANA was the primary organization that loosely spoke for the profession as a whole and one of the only nursing organizations who employed lobbyists. “Uh, another barrier is that we have so many professional organizations but really don't have an organization that speaks from the viewpoint of all nurses. . . And so we kind of splinter ourselves off” (Jane).

Another category which began to emerge in the data related to what nurses viewed as either a declining allegiance to patients or a divided allegiance to patients.

**Lack of Autonomy/Divided Allegiance**

Several participants remarked on the lack of autonomy which existed in nursing (sometimes due to retribution by employers) and the skewed thinking of some nurses who now demonstrated more allegiance to their workplace and insurance companies than patients. Jill shared her frustration with the profession in general, which she felt has not done enough to be seen as “equal team members.”

I think that we're not seen as equal team members but I also think that we haven't given any reason to be seen as equal team members sometimes. . . . A registered nurse who's working in a hospital as a bedside nurse, should be able to advocate and develop a model where she can bill independently for her services. And I think that if we can establish that kind of a billing business model, I think over time--you'll begin to see a shift in our profession, and we will see nurses who value themselves more. (Jill)

Sarah thought that many nurses did not push for changes in policies or voice their concerns because nurses who were confrontational ran the risk of retaliation by their employer. Helena corroborated this by narrating this incident.
If people were paying nurses directly, or if nurses were paid directly by the patient, they would have more responsibility to the patient. This way [currently] their allegiance is to the hospital and they feel they’re working for the hospital. When, in fact, patients are paying for their insurance. They’re paying their bills to receive care. But unless we get that direct transfer--and that’s where I think nurses--everybody sees insurance as the big payer. And we don’t pay attention to the fact that it’s really people we’re caring for. Anyway, I’ve mentioned [this idea] different times in student groups. And they [say] “That couldn’t work.” . . . It’s like they have no concept of the fact that they’re caring for the patient! (Helena)

Jill shared her views on the dominance of physicians and their lack of knowledge relating to who nurses are and what nurses can do.

. . . I think nursing has done itself a huge disservice and this is one of my biggest frustrations with being a nurse, is that we have allowed the American Medical Association to run healthcare for 200 years, and it has annihilated our ability, pardon me, to be effective advocates to know who we are as nurses. And they [physicians] tell us who we are and what we can do and they don’t understand. I mean, for the 15th year in a row, nurses have been voted the most trustworthy profession, you know, so if there’s anyone who is more well-positioned to advocate for the healthcare needs of people, it is most certainly a nurse! And so, I feel like that is the one thing that we as nurses have fallen flat on our faces about is our apathy and our lack of understanding of the importance of political advocacy and that level of engagement. (Jill)

**Lack of Participation in Professional Nursing Organizations**

Jane believed that many nurses do not join professional organizations because oftentimes “professional lives become overshadowed by personal lives.” She also believed that nurses new to the profession might have both financial and time constraints that prohibit them from joining a professional nursing organization and might only see membership in a professional nursing organization as an added expense. Darlene had similar views and believed that money was a primary issue that discouraged nurses from joining professional nursing organizations.

Well, I can speak for myself uhm . . . and what I've heard from other colleagues, it’s the money. Some like for instance, the fee is . . . and this is a nursing organization. The fee is like almost 300 dollars. For a year. If you don't have it, you don’t have it. (Darlene)
Career-related Responsibilities

Career-related responsibilities are those related to (a) time constraints related to heavy nurse/patient workloads which contribute to exhaustion, excessive overtime due to staff-shortages and staff-turnover; (b) financial constraints due to student loans and excessive debt; and (c) family responsibilities due to childcare issues and illness with immediate and/or extended family. Susan believed that nurse educators were/are trying to educate nursing students to understand that being a part of a professional organization is a responsibility to the profession, but that many nurses were (and continue to be), overwhelmed by career and family demands.

But I think when nurses get out of nursing school, all they're trying to focus on is their practice and then maybe they're focusing on their family and they're focusing on different things, and they just don't see the value that the profession or organization has. And they'll say they don't have the money for it, which is ridiculous. I mean $40 a year, I think any nurse probably can muster that up. (Susan)

Sarah’s views were very different from Susan’s. She was not a “fan of the ANA” and resented the ANA’s push to professionalize nursing. She stated that for many nurses, it was/is, an unrealistic stance, when many nurses have felt (and continue to feel) that the only thing employers are worried about is how many tasks they can do in a given time period.

So, like, I never have been a fan of the ANA. Because, they're all about professionalizing the nurse. So, my view is that nursing work for the vast majority of nurses is labor, it's not professional. It's supposed to be professional, in school it’s professional. We have professional responsibilities, but we're not treated as professionals. And when you get out of school, the jobs that most of us have is ‘How many of these tasks-- can you get done in this amount of time?’ It’s not “I am sharing my knowledge base with the public.” That's what we all want to do, but that is not what you get paid for. (Sarah)

Jane believed there were many possible reasons nurses did not join professional nursing organizations, but she believed that one of the reasons stemmed from a general lack of understanding about the work the organizations do for nursing.
There's the lack of understanding of what their organization does. There's a lack of understanding about what the lobbyists do or can do, uh, and the cost. So I think professional organizations need to do a better job of getting that information out there to nurses. (Jane)

Overall, a lack of participation in professional nursing organizations discourages interaction with peers, limits opportunities for collaboration with peers, limits the opportunities for mentee/mentorship experiences, and reduces the opportunities for interpersonal and communication skill-building.

Skill Deficits

Although the participants did not specifically address all the skills that are lacking in someone who is not an effective political advocate (they were asked to describe their experiences, not those of someone else), by taking the skills the participants listed as facilitators and looking at the opposite, a list of probable skill deficits was developed. They are poor communication skills, poor problem-solving skills, poor listening skills, poor presentation skills, and a lack of policy knowledge.

Lateral Violence

Much of Darlene’s day-to-day work involved ongoing advocacy to change and/or develop policies to address the various issues that impacted the nursing faculty and nursing at the inner-city HBCU (Historically Black College/University) where she was employed, such as scholarship programs, funding for tutors, funding for childcare assistance programs, and funding for continuing education for the staff. Addressing these issues often required advocacy for policies at the university level and at the state level. The other issue that Darlene shared was an example of what is now referred to as lateral violence.

Another issue that has been a challenge for me . . . initially going into my administrative position was the lack of support. When you have a situation where one person appoints you, and there was some administration transition, so then the other person may not
necessarily support you. So that was a challenge to um, learn the role and continue to teach four courses . . . um, it wasn't easy. When you don't have that support and the person wants somebody else in your position you know, it was really difficult. I remember crying every day. I would sit out in the parking lot and cry because this position was what I wanted to do, but I felt so unwelcome. (Darlene)

As she described the incident, I could see the emotion on her face and the tears in her eyes. It was obvious how much the series of events had upset her and had left her wondering how nurses can be effective political advocates for society and for the profession, when we do not support and uplift each other.

**Male Dominance in the Political Arena**

Susan was the only participant who described her views on the importance of learning how men interact with one another, so that nurses can learn the types of interpersonal contact they respond to best.

You know, you develop those skills of how to interact with people and how to approach people and a lot of it in the beginning is observation. It's watching how other people work and recognizing that the general assembly is still predominantly male. And so, it's understanding how they deal with each other. (Susan)

**Overview of the Emerging Theory**

The 10 nurse participants in this qualitative, grounded theory study have all participated in policy advocacy in their practice. Each participant shared her thoughts relating to the concept of political advocacy. Using a grounded theory methodology, 10 major categories emerged from the data analysis of the nurse participants’ understanding, perspectives, and lived experiences with political advocacy in nursing. The Model of Political Advocacy in Nursing Praxis was gleaned from the data obtained from the narratives of the participants in this study and is a visible representation of the political advocacy process that practicing nurse/political advocates use. The Model of Political Advocacy in Nursing Praxis contains the following categories: (a) Pre-Conditioning Factors, (b) Conditioning Factors, (c) Cognitive and Psychological Motivators,
(d) Action Strategies, (e) Professional Facilitators, (f) Professional Barriers, (g) Communicating a Proposed Plan to Policy Makers, (h) Public Policies; (i) Health and Social Equity, (which is the goal); and lastly, (j) Regrouping.

Chapter Summary

Based on the data obtained from this study, the concepts which seem to have had the greatest impact on the participant’s participation in political advocacy are at the lower half of the center column: Pre-Conditioning Factors, Conditioning Factors, and Cognitive and Psychological Motivators. These categories seemed to garner the most influence (overall) on the participant’s political advocacy behaviors, based on the data. These categories carried the most “weight” and are shaded darker to depict their importance.

Action strategies are the next section and are unique because they occur simultaneously and are ongoing, as policies are revised or expanded. Policy revision may be needed if the issue or problem changes (improves or worsens), public sentiment changes, and/or if newly occurring events add to the evidence. For example, recent mass shooting events in the United States have swayed the public’s opinion, as well as the opinions of some elected officials, who until now would not entertain the idea of any gun reform laws. As a result, it is likely that nurse/policy advocates will be regrouping and revising their appeals to include the newest victim/witness statements and the latest data will be added to their presentations to strengthen their argument and its influence. Professional Facilitators are listed on the left side of the Model.

The Professional Facilitators were those factors that the participants felt had positively contributed to the political advocacy process, based on their experiences. The right side of the Model of Political Advocacy in Nursing Praxis contains the Professional Barriers, or those things that had played a negative role, and/or were in direct opposition to the Facilitators that were
previously stated. For example, the Action Strategies section (in the center column) is positively impacted by the Professional Facilitators and negatively impacted by the Professional Barriers.

Action Strategies can be triggered numerous times by the category, Communication of a Proposed Plan to Policymakers (if there is a need to revise the proposed plan), but also assist and enable the Communication of a Proposed Plan to Policymakers (which is a necessary and often ongoing activity to convince and/or influence policymaking decisions), which is why the arrows go both ways. Public Policy development is the next category. Public Policy is the nurse’s plan or course of action which will enable and/or help promote the seeking of Health and Social Equity, which is the goal or outcome of the Model of Political Advocacy in Nursing Praxis. Some of the participants shared that oftentimes legislation will “go to committee” to be changed or edited and sometimes (depending on the proposed changes) there will be a need for “Regrouping” in order to support or defend an additional change and/or to argue against an unwanted change, as previously explained using the recent school shootings as an example. Regrouping can ultimately trigger all stages back to the Action Strategies, if new information is needed or if a proposed plan needs to be changed based on newly obtained evidence.

The concluding chapter will present an analysis of how the conceptual categories relate to one another and a substantive theory regarding nurses’ understanding of political advocacy in nursing, which is visually depicted within the Model of Political Advocacy in Nursing Praxis. More information about the significant conceptual findings within the theoretical model and their implications for the nursing profession, research and education will be discussed more fully in Chapter V.
CHAPTER V
DISCUSSION, IMPLICATIONS, LIMITATIONS, FUTURE RESEARCH,
AND CONCLUSIONS

Overview

The goal of political advocacy in nursing practice is the achievement of social justice for all and/or the state of health and social equity in society wherein everyone has their basic needs met in order to be healthy, safe, etc. Marmot (2008, p. 1) put it best: “Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death.” Public policy is defined as a system of laws, regulatory measures, courses of action, and funding priorities concerning a given topic promulgated by a governmental entity or its representatives. Individuals and groups often try to shape public policy through education, advocacy, or mobilization of interest groups. (Evans, 2008, p. vii)

As such, (in theory), public policy advocacy can be used by nurses to improve the lives of individuals, groups of individuals, and/or society at large. The definition of political advocacy, gleaned from the participants’ words is the act or process of communicating a proposed plan to policy makers (and others) in order to influence their beliefs, thoughts, actions, and decisions relating to a particular issue or problem before, during, and throughout the public policy making process. It is my hope that the Model of Political Advocacy in Nursing Praxis will serve as a framework for helping nurses and nurse educators to have a deeper understanding of the various concepts, skills, and actions that contribute to the political advocacy process within the profession.
The goal of grounded theory is to build theory based on the study of the phenomena. This goal was achieved by constructing a model which depicts the process of political advocacy through the perspectives’ of practicing nurses. This study also contributes to nursing’s collective understanding of not only the meaning of political advocacy by practicing nurses, but the use of political advocacy as a mechanism for influencing, promoting or developing public policies that are aimed at achieving health and social equity individually and collectively.

In addition, this study also adds empirical evidence to nurse’s professional dialogue relating to the practice of political advocacy as a foundational and ethically-supported nursing responsibility. It also will provide a mechanism for promoting social justice and universal healthcare within nursing practice. The majority of published discourse which has examined the political facets of nursing practice has focused on nurses’ lack of political interest and/or nurses’ lack of political competence. The use of grounded theory to build knowledge on the lived experiences of nurses makes this study unique because it provides a snapshot of what is actually occurring in nursing practice, not what we think might be happening. Gaining a greater understanding of nurse’s behaviors and actions, (as well as the context in which they occur), will help contribute to a greater depth of understanding of political advocacy practice within the profession now, and in the future.

This study grounds political advocacy within professional nursing’s scope of practice and reveals identified factors which help facilitate the political advocacy process and those that function as barriers to hinder the process of political advocacy. It will also provide practical recommendations for nurse educators. The goal of the Model of Political Advocacy in Nursing Praxis is Health and Social Equity. The eight core concepts contained within the Model are (a) Pre-Conditioning Factors, (b) Conditioning Factors, (c) Cognitive and Psychological Motivators,
(d) Facilitators, (e) Barriers, (f) Action Strategies, (g) Communicating a Proposed Plan to Policy Makers, (h) Public Policies; (i) Social and Health Equity (the goal); and (j) Regrouping. For a detailed visual representation of the theoretical model, please refer to Figure 2 in Chapter IV. In this chapter, I describe how this study answered the research questions, examine the most important core concepts, and review how data gleaned from this study confirms and relates to published literature. Last, I examine the implications for education, practice, and future research revealed through this study.

**Discussion**

**How do Nurses who do Political Advocacy Interpret Professional Nursing Mandates Which Address Social Justice, Health Equity, Policy Advocacy, and Ethical Care?**

The participants were asked about their understanding of *Nursing’s Social Policy Statement: The Essence of the Profession* (ANA, 2010c) and ANA’s *Code of Ethics for Nurses with Interpretive Statements* (2015; 2001). Although all of the participants expressed recognition of the importance of the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2017; 2001) none of the participants shared any specific content from it. The participants summarized the overall message contained within the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015; 2001) as (a) doing what is best for the patient, (b) doing no harm, (c) doing what is right, and (d) providing good care. Seven of the participants stated that they were familiar with *Nursing’s Social Policy Statement: The Essence of the Profession* (ANA, 2010c), but none summarized the overall message contained within. Three of the participants stated that they were wholly unfamiliar with the existence of *Nursing’s Social Policy Statement: The Essence of the Profession* (ANA, 2010c). In general, the participants were more familiar with the overall message contained within the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015; 2001) and less familiar with *Nursing’s Social Policy Statement: The Essence of the*
However, neither of the nursing mandates seemed to exert much influence in their day-to-day nursing practice. Those participants who were nurse educators seemed to have greater familiarity with both texts, because the mandates were used in their curriculums and talked about in their classrooms. However, are the students retaining the information and referring to it within their practice?

Based on the data from this study, nursing mandates have influenced nurses’ practice and ethical behaviors overall, but have had little, if any, influence on the participants’ political advocacy behaviors, beliefs, or activities. I admit to being wholly unaware of the existence of Nursing's Social Policy Statement: The Essence of the Profession (ANA, 2010c) prior to this study. No one can deny that nursing mandates have little power, influence, or ability to impact contemporary nursing, or nursing education, if nurses know little about them or they are wholly unaware of their existence. Have there been any studies relating to the nursing mandates and their influence on nurses, pedagogy, or the profession?

A search of the literature to locate a study of contemporary nurses’ knowledge and/or familiarity with nursing mandates and/or their influence on the profession or pedagogy (either as a whole or among individual nurses or student nurses) was unable to locate any studies relating to the topic. However, it is no secret that nursing pedagogy has a primary focus on NCLEX pass/fail rates due to the fact that nursing educational programs can lose their accreditation if their NCLEX pass rate falls below 80% for 3 consecutive years (Jackson & Halstead, 2016). As a result, nursing curriculums are filled with content which enables students to pass. Does the NCLEX contain any questions or content that relates to nursing mandates?

Based on a review of the most recent NCLEX-RN Examination: Test Plan for the National Council Licensure Examination for Registered Nurses (NCSBN, 2011a) there seems to
be very little relating to content contained in the nursing mandates. Nursing ethics is mentioned in their “Beliefs” section (NCSBN, 2011a, p. 2) which stated, “The registered nurse is accountable for abiding by all applicable member board jurisdiction statutes related to nursing practice.” and “Ethical Practice” is listed (NCSBN, 2011a, p. 4) under the heading “Overview of Content,” as is “Advocacy” (NCSBN, 2013, p. 4); and under the heading of “Psychosocial Integrity,” “Cultural Awareness/Cultural Influences on Health” is listed. The document has no reference to any questions relating to social justice, policy, or social determinants of health. Furthermore, there is no mention of any questions/content on the test relating to Nursing’s Social Policy Statement (ANA, 2010c) or the Code of Ethics for Nurses With Interpretive Statements (ANA, 2015; 2001) specifically in any section of the NCLEX-RN Examination: Test Plan for the National Council Licensure Examination for Registered Nurses (NCSBN, 2011a).

While the ideology contained within the mandates aligns with philosophical and foundational tenets of the profession, based on the data gleaned from this study nursing programs are not likely to devote more time studying nursing mandates if the NCLEX-RN does not contain questions relating to them. Furthermore, with so little attention devoted to them in pedagogy, and no frame of reference for nursing students, nursing mandates alone are not likely to change, influence, inspire, or promote political advocacy in nursing practice. In contrast, the participants revealed that life experiences, especially those associated with some form of injustice, seemed to have the greatest influence on the participant’s, beliefs, empathy, passion, inspiration, and motivation for political advocacy and the promotion of the social and health equity related issues that are foundational and philosophical tenets of the profession and/or those contained within nursing mandates.
What are the Implications for Advocacy Praxis for Nursing Education and for the Nursing Profession?

Several of the study participants believed that nurses needed to obtain more knowledge of the policy making process while in nursing school. Policy brief writing skills, grant writing skills, and field trips to policy makers for “lobbying” practice in which the students can interact with elected officials were some of the activities mentioned, so that students can gain a deeper understanding of how the legislative and policy making process works. One of the participants specifically suggested nurses spend time at the General Assembly, gaining an understanding of “how bills are passed” and how the policy making system works. Another participant suggested that in addition to educating policy makers about the issues, nurses needed to spend time educating policy makers about the profession of nursing itself.

Complementary to this, the participants mentioned the importance of professional nursing organizations in the political advocacy process as a means of motivating nurses to advocate for whatever their specific interests are, their specialty, and/or the issues they feel passionate about. Other benefits of professional nursing organizations noted by the participants were the leadership and professional growth opportunities, the possibility of collaborating with other nurses who have similar interests or passions, the possibility of being exposed to activities which will take you out of your comfort zone, and the increased likelihood of meeting someone that can support or mentor you throughout your career.

Helena shared her thoughts on the importance of focusing on community nursing within the nursing profession. She also offered her perspective on how nursing clinical experiences should be shifted from an acute care focus to a focus on the social determinants of health, wellness, and other aspects of life that impact health, such as the environment, economic situations, wellness, etc., which aligned with the IOM’s recommendations (2003). She also had a
strong opinion about where a newly graduated nurse’s first practice experience should be, too: in the community, not in the hospital. Helena believed a community focus would give new nurses a more thorough understanding of the impact a patient’s family, home, and community has on individual health. Community experiences with diverse, vulnerable, or impoverished populations would likely add to the depth of understanding and emotional connectedness nurses feel to the most vulnerable individuals in our society. This might improve the low Attitudes Toward Poverty scores that were identified among nursing students by Vleim (2015), Wittenauer et al., (2015) and Yun & Weaver (2010) and would help them have a better depth of understanding relating to the socioeconomic injustices which influence wellness and health. The aim of this study was to answer two questions relating to political advocacy in nursing practice. Over the course of the study, two additional questions emerged from data gathering that were more profound than the original questions:

1. How do nurses understand political advocacy?

2. What are the educational and life experiences of nurse/political advocates?

How do Nurses Understand Political Advocacy?

When the participants were asked for their understanding of political advocacy, their wording varied greatly, but there were many similarities of thought. The absence of a professional definition of this type of advocacy has created confusion within the profession and within nursing research. Due to this, the search of the literature in Chapter II was frustrating. A multitude of descriptions have been used to describe political advocacy in the past: healthcare advocacy, social justice advocacy, public health advocacy, policy advocacy, civic involvement, and so forth. It has likely been difficult for nurse educators to design pedagogy for student nurses when so many different terms are used to describe the same or similar acts and practices within
the profession, but there is no cohesiveness. What stood out among the participant’s words in this study is that in many of the situations they described, their work was not aimed at any particular policy, because in many of their examples, no actual policy currently exists. Although the goal of their work is aimed at policy creation or development, many of the acts they described were primarily aimed at influencing and educating policy makers or (others in society) about a situation, issue, or problem or set of problems which exists, with the hope of policy creation.

The Model of Political Advocacy in Nursing Praxis is versatile and depicts a process that nurses can use for public health advocacy, environmental advocacy, workplace advocacy, and all types of advocacy that fall under the umbrella of political advocacy. Matthews (2012) stated that political advocacy in nursing should be aimed at informing and persuading policy-makers regarding healthcare issues, quality healthcare, and the needs of the profession. Similarly, the goal of the Model of Political Advocacy in Nursing Praxis is to achieve social and health equity in society. This includes nurses, (the nursing profession), patients, vulnerable populations, and society at large. It is all-encompassing, because based on the evidence contained in this study, nursing’s responsibility to health and social equity in society excludes no one. The complete list of the participant’s statements of their understanding of political advocacy is shown in Table 4. The following definition condenses the participant’s words into a shorter, more concise meaning.

*Political Advocacy in nursing practice is a process, means, or mechanism in which nurses (collectively or individually) communicate information, plans, or courses of action to policy makers aimed at influencing the prioritization of resources and promoting cognitive and emotional understanding of an issue/problem and the corresponding solution. The information, plans, or courses of action may be communicated via any or all of the following: victim statements, personal accounts, meetings, personal encounters, emails, phone calls, presentations, documentation, media platforms, policy briefs, case-based documentation, statistics, evidence-based research, and cost/benefit analyses.*
What are the Educational and Life Experiences of Nurse/Political Advocates?

The educational experiences and attainment of the participants’ nursing degrees ranged from the Associate’s level to the Doctoral level. In total, seven of the participants had graduate-level degrees. This is consistent with other studies of the general population, which have revealed that level of education and political involvement have a direct correlation. Research has shown that higher education helps individuals gain the knowledge and abilities to have a better understanding of the political process in general and a deeper grasp of the relationship between civic engagement and the conservation of democracy itself (Galston, 2001; Hillygus, 2005; Niemi and Junn, 1998; Torney-Purta, Schwille, & Amadeo, 1999).

However, though continuing education is likely conducive to political advocacy (Galston, 2001), the data gleaned from this study revealed that the participants’ life experiences with various forms of injustice (either personally or as an intimate witness), seemed to have the greatest influence on their political advocacy activities and their nursing practice in general. These experiences made the issue and problems that they represent “real” to the participants and seemed to function as a catalyst and conditioning agent which enabled them to not only have a deeper understanding of the particular injustice they had experienced and/or witnessed but seems to have helped them to have greater empathy, sensitivity, and awareness to other kinds of injustice as well.  

Implications of the Study

The most significant (and surprising) finding and similarity amongst the participants in the study related to their experiences with 8 of the 10 participants describing experiences with injustice via an intimate bearing witness experience and/or a personal experience. The participants described a variety of experiences that had influenced and/or continued to influence
their political advocacy practice and, in most cases, their nursing practice in general. Whether the participants’ experiences were personal, or those they had witnessed, seemed to make little difference. Their desire to “make things better,” “do the right thing,” “protect the vulnerable,” “protect nurses,” “promote universal health care,” “promote the profession,” “increase awareness,” etc.; and the participants’ motivation and inspiration to “change policy” and “influence policy makers” (and others), seems to be directly linked to those experiences.

Based on the data, I argue that the participants, as a result of their heightened sense of awareness brought on by their intimate experiences, developed such a deep empathic feeling or emotional connection to the plight of others that they were duly inspired and/or motivated to act on their behalf. Although there were no specific experiences that were identified as those that result in an “embodied awareness,” experiences that trigger our emotions, by default, are those that cause some sort of physiological response: epinephrine is released, the eyes become teary, heart rate rises, blood pressure rises, etc.

According to Merleau-Ponty (1996), an embodied awareness is a heightened sense of self-awareness, knowing, or “state of being” that is somewhat variable, but can loosely be described as (a) an awareness that is perceptible by the body, and/or (b) an awareness related to something that the mind has understood through a personal bodily experience, or (c) a visceral awareness that causes a cognitive shift from an abstract thought process to a concrete meaning. In other words, an “embodied awareness” is a heightened sense of awareness and/or “state of being” that occurs as a result of an intimate “in-person” experience that “makes it real” to the individual experiencing it. Merleau-Ponty (1996) believed that an embodied awareness enables someone to be better able to conceptualize what other persons are feeling in general. As a result, the experiences the participants described made them more intuitive, more sensitive, and more
capable of understanding and perceiving the experiences of others, even if the experiences had no similarities.

An embodied awareness does not imply that an individual experiencing this heightened sense of awareness would only be cognizant or “aware of” a specific experience or set of experiences. On the contrary, it implies that this heightened sense of awareness enables an individual to have a greater empathic ability to another individual’s anguish in general. Blair (2009) stated her view of empathy and its connection to caring succinctly: deep caring is intimate; intimacy creates empathy, and empathy is felt in and throughout the body. Blair (2009) believed that as a result of this heightened sense of awareness, individuals are not only more likely to “feel” the pain of another, but they are also more likely to act on another’s behalf.

This empathic awareness/ability, according to McDonald and Messinger, (2011) “is a potential psychological motivator for helping others in distress” (p. 2). The ability to empathize with others and act on someone’s behalf has long been recognized as an important part of social and emotional development (McDonald & Messinger, 2011). Similarly, the ethics of caring and advocacy both imply an embodiment of empathy for others: If one does not feel empathy for someone, you are not likely to care about them or worry about them, and as a result, are less likely to seek a remedy or advocate and/or act on their behalf (Corbin, 2008; Gadow, 1990). Caring, and/or “caring for someone” imply an action or the likelihood of some sort of action, even if it is only an emotional one. According to Murphy and Aquino-Russell (2008) trustworthiness, protectiveness, the alleviation of suffering, mutual respect, responsibility, open-mindedness, and empathy are elements of “caring relationships.” It is in this way that the concepts of caring, empathy, protectiveness, and advocacy, etc., interconnect and overlap to impact our thoughts, our beliefs, and our awareness. The participants’ experiences with injustice
functioned as a conditioning factor in the promotion of this deeper type of embodied awareness and in this way, helped them to develop empathy and a greater awareness and sensitivity to other types of injustice in general and be motivated to act on them.

The participants’ experiences, in addition to functioning as a conditioning factor, also enabled the participants to better facilitate a similar emotional connection or depth of understanding between the issue and policy makers in their nursing practice and political advocacy work. Perhaps, in some cases, even subconsciously. In other words, the participants themselves might not have been fully aware of the connection between their experiences, their empathic awareness, their emotional connection to the issue or the individuals, and the impact those experiences have made and continue to make on their nursing practice and political advocacy work. When the participants were informed of the results of this study three participants were initially surprised by the results, six participants were not surprised at all by the results, and all but one of the participants implied that the results “made sense,” even though they were initially surprised. (One of the participants did not respond.)

The relationship between experiences, emotion, and political advocacy revealed in this study also supports the results of a similar study of nurse policy advocates that this researcher became aware of only recently. Chelsea Savage’s hermeneutic phenomenological study, *The Lived Experience of Nurse Health Policy Advocates* (2015) had similar findings. Savage found that the most significant factor which connected the participants to the issues they were advocating for, what inspired them, and what ultimately motivated them to act, was the participant’s “personal meaning” or emotional attachment to the issue. Savage stated that the participant’s personal connection to the issue seemed to serve as a “catalyst for advocacy and action” (2015, p. 3).
The words of the participants in this study stand as a testimony to the connectedness of our experiences, our emotions, and the personal meanings (Savage, 2015) we attach to them and the ability of our experiences to motivate individuals to action. Although I was initially surprised by the connection between the impact of the participants’ experiences and their political advocacy work, I realize now that I should not have been. The world’s greatest political advocates are those that have either experienced injustice or been an intimate witness to it. Martin Luther King, Rosa Parks, Harvey Milk, Elizabeth Cady Stanton, and Dorothea Dix are but a few of the most famous political advocates and activists who had a passionate connection to the issue or problem their advocacy was focused on. Even though most are laypersons (and not nurses), like most people, they, too, acquired their emotional connection to the issues through both personal experiences and bearing witness experiences with injustice. Whether their emotional connection was what inspired or motivated them to action or not is beyond the scope of this study. However, this researcher thinks that their experiences, at the very least, played some part in their advocacy work.

Florence Nightingale’s emotional connection to her political advocacy work appears to have been motivated and inspired, at least in part, by her experiences. As a novice nurse, Florence Nightingale had very little interest in politics. The years she spent witnessing the injustice and suffering of the soldiers in Crimea enabled her to establish a deep emotional bond with the soldiers and the issues which impacted them. To the elected officials who had not witnessed the suffering, the casualty lists meant little more than names and numbers on paper until Nightingale graphically described the unsanitary conditions the soldiers endured and the horrific pain and suffering which resulted. Her experiences changed her, inspired her political advocacy work, and most likely helped enable her to facilitate a greater cognitive and emotional
understanding between the soldiers and the policy makers whom she sought to influence. Although no one is suggesting that nursing students be sent to combat zones, experiences with impoverished populations, vulnerable populations, and more diverse populations might help nurses have a deeper understanding of the issues and problems those individuals are faced with in their day-to-day lives.

There is evidence that service-learning and clinical experiences with vulnerable, impoverished, and diverse populations might enable nurses to develop a deeper understanding, awareness, and sensitivity to injustice-related issues and problems, and, as a result, might positively influence nurses’ political advocacy actions. A study by Murphy, Canales, Norton, and DePhilippis (2005) offered service-learning as a potential strategy to connect nurses with the profession’s foundational values and also to enhance their cultural competence and “political advocacy” practices. Similarly, the results of two additional studies, Prentice and Robinson (2010) and DeBonis (2016), suggest that service-learning can increase cultural awareness and civic involvement. If nurses have more opportunities to communicate with patients who have experienced poverty or injustice, they might gain a greater depth of understanding.

One of the participants highlighted the importance of improving nurse-patient communication and interpersonal relationships, so that nurses can learn more about the financial, economic, and health-related difficulties individuals are dealing with on a day-to-day basis. Her reasoning was simple: how can nurses help others and/or advocate on their behalf, if they are not aware that any problem/issue exists? She pointed out that prioritizing “nursing skills” over “patient communication” might skew nurses into thinking that communicating with the patient is not important, thus shifting nurses’ time and focus away from issues that really matter, such as spending time communicating with the patient, in order to gain more information relating to their
needs, their home conditions, their ability to buy medicine or food, and other issues more commonly known now as the “social determinants of health.” Shifting the focus back to prevention, wellness, and the social determinants of health might enable nurses to have a more realistic and thorough understanding of the impact that family, home, the environment, community, etc. have on individuals and their health.

Helena’s concerns have merit when you consider the results of a study by Wittenauer et al. (2015) who surveyed the attitudes of hospital nurses toward poverty and found that most nurses were more likely to agree with stigmatizing statements about poor individuals than statements which placed blame on structural factors or personal deficiencies rather than the poor individuals themselves. There was a slight difference relating to the education level of the nurses surveyed. When compared, nurses who had a baccalaureate degree or higher were more likely to attribute poverty to structural explanations than their lesser educated peers. Experiences with the poor will contribute to nurses’ political awareness and will help nurses gain an in-depth understanding of the resulting effect that societal problems (Sword et al., 2004) and structural factors have on the poor.

**Nursing Education**

Although there is not much nurse educators can do to change an individual’s childhood experiences or personality traits, nurse educators can address the prejudicial thinking and stigmatization of people and populations that individuals may have been exposed to throughout their lives. Stigmatized ways of thinking and labeling are strongly discouraged in nursing and run counter-intuitive to many numerous nursing mandates and human rights mandates: *Nursing's Social Policy Statement* (ANA, 2010c); the *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015; 2001); and the *Universal Declaration of Human Rights* (Dura, 2015),
endorsed by the International Council of Nursing (2001), as well as the nine core human rights
documents of the United Nations (Buergenthal, Shelton, & Stewart, 2009). Nursing education
must do more to address a nurse’s personal beliefs that may be tainted by racism or other
prejudices and therefore may not align with nursing mandates. Cultural competence classes have
been shown to help reduce this type of thinking.

Most nurse educators will agree that there is currently little wiggle room for additional
content. Several studies have already documented the high stress levels of nursing students
reportedly due to the excessive workload requirements which currently exist in nursing education
(Brown, Anderson-Johnson, & McPherson, 2016; Maville, Tucker, & Kranz, 2004; Taylor,
2013). However, if basic nursing skills were required prerequisites to nursing school, perhaps
some of the time gained within the curriculum might be better spent teaching nurses how to
better communicate with the patients they are working with.

Similarly, one of the participants shared her views on the need for a shift from acute care
to community care within nursing education. Acute care venues may skew a nurse’s view due to
the fact that patients whom nurses see in the hospital (by default) are individuals who are
receiving care. But, what about the individuals who are receiving no care because they do not
have health insurance, may not have a means of getting to the hospital, and/or the individuals
who refuse to go seek treatment because they have no means to pay for their care? Individuals
who do not seek treatment at a hospital, emergency room or urgent care, because they have no
means to pay for their care, are (by default) individuals that acute care nurses have never seen.
How can nurses help fashion the best policies for social and health equity of all individuals, if
nurses are not aware of the varying needs of all individuals? In addition, hospital nurses may be
unaware of individuals’ needs due to the de-personalization of hospital patients who, once
admitted, are told to take off their own clothing, shoes, and anything of value and are systematically assigned the exact same gown as everyone else. In a sense they are “homogenized” and made to look the same for many reasons that are justified; however, this practice may put hospital nurses at a disadvantage in other ways. How can a hospital nurse know which patients have the greatest needs, if everyone is made to look the same? How can hospital nurses know which patients do not even own a single pair of shoes, if no one is wearing any?

If the goal of the nursing profession is health and social equity of all individuals in society, (based on nursing mandates), we must do more to expand our viewpoint in nursing education to examine the structures which inhibit this process. Several study participants expressed the lack of exposure nursing students have to vulnerable groups of individuals: those diagnosed with developmental disabilities, intellectual disabilities, the elderly, those with mental illness, and many others.

**Policy-related Skills**

Several of the participants believe that policy-related skills contribute positively to political advocacy work and they offered advice to nurses and nursing education in this area: (a) more knowledge of the policy making process, in general; (b) spending time at the General Assembly in order to gain a better understanding of “how bills are passed” and how the policy making system works; (c) policy brief writing knowledge; and (d) experience examining and analyzing policies. The participants’ suggestions are consistent with Reutter and Duncan’s (2002) recommendations for nurses interested in the policy making process. They focused on seven content areas for nurse education which they considered “fundamental” knowledge for the policy making process: (a) policy analysis, (b) policy theory, (c) policy making processes, (d) societal influence on policy, (e) legislative processes, (f) how to influence policy, and (g) case-
based policy advocacy examples. Similarly, Nannini and Houde (2010) posited that nurses need to have a working knowledge of how to take evidence from a systematic review and be able to easily convert it into a policy brief and/or other formats that can be easily understood and communicated to policy makers.

**Professional Nursing Organizations**

Several of the participants believed that professional nursing organizations can contribute positively to political advocacy. Their reasoning was that professional organizations can offer an online platform for collaboration, opportunities to interact with peers who may share similar interests, can offer an online and/or in-person platform for sharing ideas, and they can help nurses find mentors and role models that have expertise in the area of nursing they are most interested in. Nurse educators have a unique opportunity to share their experiences within professional nursing organizations with nursing students and can simultaneously encourage nursing graduates to become members. Matthews (2012) agreed and stated that these organizations are critical in order to define the ethical obligations of the profession, promote advocacy for the profession, promote advocacy for healthcare, disseminate new research information, and to serve as an intermediary for collaboration of nurses. Frank (2005) believed that professional nursing organizations can help nurses see the “bigger picture” (p. 13) and can also provide nurses with the opportunity to network with other nurses and interact with peers and potential mentors.

**Professional Nursing Mandates**

If the nursing profession wants to continue to proclaim *Nursing’s Social Policy Statement: The Essence of the Profession* (ANA, 2010c) as the “essence of the profession” and *The Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015, 2001) as the “ethical
standard of the profession” (p. vii) more must be done to promote them within the profession and ensure that all nurses have a deeper understanding of their contents, their implications for universal healthcare, their implications relating to socioeconomic influences on health, and the seeking of social justice as part of “ethical care.” Furthermore, a practical framework for how the provisions set forth within the mandates can be readily accomplished within nurse’s scope of practice and within the profession would be extremely helpful. Currently, the vagueness of the mandates and their lack of step-by-step instructions or guidelines on what nurses are to do to promote what is contained in them, are detrimental to their practical application and effectiveness. Nursing’s Social Policy Statement: The Essence of the Profession (ANA, 2010c, p. 4) stated,

Nursing has an active and enduring leadership role in public and political determinations about the following six key areas of health care: Organization, delivery, and financing of quality health care; Provision for the public’s health; Expansion of nursing and healthcare knowledge and appropriate application of technology; Expansion of healthcare resources and health policy; Definitive planning for health policy and regulation; Duties under extreme conditions.

While commendable, what does this mean in practical terms to professional nurses in their day-to-day work? There is no doubt that nurses are capable of carrying out tasks if they know what the specific problem is, what actions they are to take, and what the outcome or goal should be, but all are lacking in the ANA’s (2010c) statement. Furthermore, and most importantly, based on the evidence obtained in this study, the mandates will likely have little or no meaning to nurses who have no experiences, emotional connection, or frame of reference to relate to them. What meaning can a novice nurse assign to “the promotion of universal healthcare” if she has never experienced a lack of access to healthcare herself, nor has never had an experience with any impoverished individuals who did not have access to quality healthcare? How can a novice nurse understand how the mentally ill are stigmatized, if she has no intimate personal experience with
mental illness herself, nor has never had any intimate bearing witness experience with anyone, personally or professionally, who is mentally ill and has been treated unfairly?

I argue that based on the evidence, if political advocates have recognized that the only way to make things “real” to policymakers is to establish an emotional connection between them and the issue, would not the same hold true for nurses, nursing students, nursing mandates, etc.? In other words, it is only when nurses have been exposed to intimate personal experiences or intimate bearing witness experiences to injustice, that the words contained in the mandates will have any true emotional meaning to them. As Rachel said, “…Unless it touches you directly, not only nurses--but it's just human nature--you don't find yourself getting involved until you have an experience yourself.”

**Peer Support and Mentorship**

The participants’ views on mentorship and their experiences with mentors were consistent with two additional nursing research studies which sought to identify what had motivated nurses to become politically involved. Winters and Lockhart (1997) interviewed 11 nurse/policy advocates who attributed their motivation for the work to the mentoring they had received to a range of individuals in their lives, including former teachers and family members. Another study, Gebbie et al. (2000), interviewed nurses who had political careers as part of their practice. The participants in the study identified three main factors which contributed positively to their entry into politics: (a) personal experiences with role models who were politically active, (b) exposure to politics in education, and (c) an employment experience that stimulated their interest. The potential of mentorship to inspire and motivate nurses to become not only more involved, but more knowledgeable, is promising. Exposure to politics in education, the second
factor identified by Gebbie et al. (2000) is also consistent with the participants’ views in this study.

**Limitations**

Limitations relate to the inability to make generalizations that relate to all nurses who participate in political advocacy based on such a small sample size of nurses in the Virginia; Washington, DC; and Maryland, Mid-Atlantic region. This study also lacked gender and racial diversity among the participants. In addition, the absence of a professional definition of “advocacy,” “political advocacy,” or “social justice advocacy” within the profession causes a lack of conformity of thought among nurses who may assign dissimilar meanings to the terms. And lastly, political, religious, cultural, and socioeconomic beliefs of nurses in DC, Virginia, and Maryland, may differ from nurses in other locales, and as a result, the concepts of social justice and political advocacy may be duly impacted.

The impact of the geographical location may lessen the significance of the results due to the close proximity to the nation’s capital and its influence. Local news coverage in the Virginia, Maryland, and DC areas tends to be filled with more politics, (in general), than news coverage in other areas. As Jane, said,

> Sometimes, I think I'm a little bit of aberrancy because I live and work, uh, in university systems so close to Washington, DC and once you leave the Washington, DC area, even the news changes. Sometimes it's hard when you're on vacation to even know what's going on.

The increased daily exposure to politics, policy, and the politicians themselves (who reside in the area) could possibly enable nurses in this area to be more politically savvy than nurses who reside in more distant locales throughout the country. It is also possible that regional, cultural, ethnic, gender, and socioeconomic differences among practicing nurses might influence their
beliefs or behaviors and their nursing and/or political advocacy beliefs and practices may be duly impacted.

**Future Research**

This study revealed that nurses’ personal and intimate witness experiences with injustice have a significant impact on not only their political advocacy work, but their motivation and inspiration to become involved in the political and/or policy-making process in the first place. However, because so little is known relating to the actual political advocates themselves, there is a multitude of research opportunities. Repetition of this study in other locales may prove beneficial in a variety of ways. It is possible that nurse/political advocates in other locales might encounter different barriers. Likewise, they may have differing professional facilitators as well.

In addition, more research on empathy and the emotional connection between political advocates and the issues and problems they advocate for might help the profession have a deeper understanding of the power of this connection and might help provide greater insight into how this emotional connection is formed and/or best replicated. At present, service learning seems a plausible start, but more research is needed. A pre/posttest study which measures nursing student’s awareness to injustice before a service-learning intervention, followed by a post-intervention test, (which could then be used to compare the two scores), might provide some insight into the effectiveness of the service learning experience. However, it is important that the service learning experience be carefully planned, so that it contains certain elements. Gillis and MacLellan (2010) in their literature review on service learning, concluded that service learning, (as a pedagogical approach), must contain the following qualities:

a) an activity or service that responds to a need identified by the community members; b) a balancing of the service activity provided by students with the achievement of the student’s academic objectives; c) authentic community partnerships and reciprocal relationships between the school of nursing and the community; and d) structured time to
reflect on the complexity inherent in the service issue, the context in which care is
provided, the social meaning of the client or population served, and the link to academic
objectives. (p. 1)

Cohen and Milone-Nuzzo (2012) described a pre/post service learning intervention at the Yale
University School of Nursing, in their study, *Advancing Health Policy in Nursing Education
Through Service Learning*. The service learning activity covers 2 semesters and features clear
objectives focused on the development of policy and critical reflection achieved through group
discussion, journaling and other assignments. This same pre/post study aimed at measuring
student’s awareness to injustice could also be undertaken in other disciplines, such as social
work, psychology, medicine, dentistry, physiology, etc. It could also be used to assess high
school students who plan on entering health-related fields of study in college. The service
learning pre/post intervention test, could be used in conjunction with the *Attitudes Towards
Poverty Short Form* (ATP) (Yun & Weaver, 2010) or the *Class and Poverty Awareness Quiz*
(Gorski, 2013), which are both fairly similar. More long-range studies that would evaluate the
student’s political advocacy behaviors 3-5 years post-intervention might also provide more
information relating to the possible long-term benefits of the service learning intervention as
well.

Another research area worthy of exploration is the examination of how societal beliefs
and/or the media influence healthcare policy making, nurse’s beliefs and/or nurse’s political
advocacy activities. Stigmatized views of universal healthcare policy as those which promote
“socialism” and/or “Communism” should also be examined and fully addressed in nursing
research in order to expose their inaccuracies. If the profession of nursing does not address these
inaccuracies, proposed universal healthcare policy, (as well as the politicians who support it),
will continue to be politically attacked as history repeats itself.
In recent years, President Obama has been falsely accused of being a socialist (Adair, 2012), in much the same way as other U.S. Presidents have been. President Truman called for the creation of a national health insurance fund to be run by the Federal government in 1945 (Holtzman, 2013), but was publicly attacked by the American Medical Association (AMA) who characterized his policy proposals as the promotion of "socialized medicine." The AMA even went so far as to accuse Truman’s administration of being “followers of the Moscow party line” (Poen, 1989) and claimed that the healthcare plan was part of a “Communist plot” (Bizzle, Fraga, Seremetis, & Lambrew, 2008, p. 251). The AMA continued their smear campaign of Truman and his administration for several years distributing printed pamphlets which were handed out to the public with messages meant to further incite fear of Communism. The pamphlets contained statements such as, “Would socialized medicine lead to socialization of other phases of life? Lenin thought so. He declared socialized medicine is the keystone to the arch of the socialist state” (Starr 1982, p. 285). From that point forward Reid (2009) told us, the term “socialized medicine” was used as a weapon in the American political arena to oppose any policy or politicians who supported universal healthcare programs. Whether or not this opposition has influenced nurses’ behaviors or political activity/advocacy is unknown. No research could be found which examined whether or not “anti-Communist campaigns” have impacted nurses’ beliefs or behaviors relating to the promotion of universal healthcare or social justice in society.

In addition, the recognition of the connection between conservative political ideology itself and stigmatized views of the poor (Noone et al., 2012; Vielm, 2015; Wittenauer et al., 2015) needs to be examined in nursing research more thoroughly, as it may be a potential problem for nurses charged with promoting social justice and health equity in society. Examining how stigmatized views of the poor impact political advocacy, nursing education, patient
interaction, healthcare, and the profession itself might be helpful. In Caring Beyond Nursing: Politics from the South, Gastaldo (2000, p. 1) pointed out, “In acknowledging the political nature of nursing thought and practice we have an opportunity to challenge the orthodoxy of neutral caring . . .”. Acknowledgment of the dichotomy which exists between extreme political conservatism and professional nursing mandates may be one of the first steps the profession of nursing must take in order to promote political advocacy within the nursing profession.

In addition, even though the ANA and the NLN both claim to be bi-partisan or politically neutral, professional nursing’s mandates, Nursing’s Social Policy Statement: The Essence of the Profession (ANA, 2010c) and the Code of Ethics for Nurses With Interpretive Statements (ANA, 2015; 2001) are supportive of universal healthcare, health equity, social justice, and the liberal political ideology of Nightingale. Their claim of political neutrality may be confusing to nurses and might undermine the power of the message contained within the mandates. More research in these areas might be beneficial to both nursing education and the profession.

**Conclusion**

This study examining the experiences and perspectives of political advocates can help us to understand more about policy making in general, and the connection between experiences, empathy, emotion, and the part they play in the political advocacy process. The participants’ descriptions of how their beliefs and experiences have motivated them to “do what is right” and in so doing, have inspired their advocacy work are surprisingly similar to those Nightingale shared in her Notes on Nursing: What it is and What it is Not (1859), in which she told nurses, “. . . Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?” (p. 58).
Nightingale demonstrated how political advocacy can be used as a mechanism to guide the policy making process in order to promote social equity, health equity, and the dignity and wellness of all individuals. She used every means available to her to influence policy makers in order to remedy the injustice she had intimately witnessed and promote nursing to the status of a profession. While contemporary nursing mandates support Nightingale’s foundational, philosophical, and ethical standards for the profession, nursing education must do more to ensure nurses have a thorough understanding of their content and create opportunities for nurses to obtain the varied and diverse clinical experiences needed to inspire political advocacy.

The need for nurses to become more involved in political advocacy to guide healthcare continues to grow and the fate of healthcare in the United States is currently in a precarious state. The Congressional Budget Office’s (CBO) recent assessment of the GOP’s latest budget proposal estimates that by the year 2027, 13 million people will lose their healthcare coverage as a direct result of the proposed budget cuts (CBO, 2017). Although the World Health Organization’s (2010) ranking of health system performance placing the United States 37th among 191 countries is somewhat dated, a 2017 Commonwealth Fund study of health system performance among 11 high-income countries, The United Kingdom, the Netherlands, Australia, New Zealand, Norway, Switzerland, Sweden, Germany, Canada and France, (none of which are Communist), ranks the United States in last place when comparing access, equity, and healthcare outcomes (Schneider, Sarnak, & Squires, Shah & Doty, 2017). While all of the recent political happenings are a move in the wrong direction, they offer nurses additional opportunities to influence policy makers in order to defend, support, and promote universal healthcare in this country. Support and promotion of policies establishing a universal health care program in the
United States should be part of every nurse’s ongoing practice, but are nurses prepared to take up the mantle?

Hopefully, this study will shed new light on the critical importance of political advocacy in nursing as a mechanism to promote health and social equity, as well as the nursing profession. Political advocacy itself is not the goal, but merely a mechanism nurses can use to uphold professional nursing mandates and the philosophical, foundational and ethical responsibilities of the profession. Political advocacy’s importance to nurse’s practice, nursing education, healthcare and social equity has been overlooked for far too long. Perhaps, political advocacy has now come full circle and will henceforth be synonymous with the profession of nursing, much like the profession’s first political advocate, Florence Nightingale herself.
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APPENDIX A

SOCIOPOLITICAL OBLIGATIONS IN THE 1985 CODE FOR NURSES
<table>
<thead>
<tr>
<th>“Section”</th>
<th>Page</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>2</td>
<td>Each nurse has the moral obligation to be knowledgeable about the moral and legal rights of all clients and to protect and support those rights.</td>
</tr>
<tr>
<td>1.2</td>
<td>3</td>
<td>The need for health care is universal.</td>
</tr>
<tr>
<td>3.1</td>
<td>6</td>
<td>The nurse’s primary commitment is to the health, welfare, and safety of the client. As an advocate for the client, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practice by any member of the health care team or the health care system.</td>
</tr>
<tr>
<td>4.1</td>
<td>7</td>
<td>The recipients of professional nursing services are entitled to high quality nursing care . . . . Professional nursing must bear primary responsibility for the nursing care clients receive.</td>
</tr>
<tr>
<td>4.3</td>
<td>9</td>
<td>Neither physicians’ orders nor the employing agency’s policies relieve the nurse of accountability for actions taken and judgments made.</td>
</tr>
<tr>
<td>8.2</td>
<td>14</td>
<td>The nurse has the responsibility to monitor these standards in daily practice and to participate actively in the profession’s ongoing efforts to foster optimal standards of nursing practice.</td>
</tr>
<tr>
<td>9.1</td>
<td>14</td>
<td>The nurse must be concerned with conditions of employment that (a) enable the nurse to practice in accordance with the standards of nursing practice and (b) provide a care environment that meets the standards of nursing service.</td>
</tr>
<tr>
<td>9.2</td>
<td>14</td>
<td>Articulation and control of nursing practice can be accomplished through individual agreement and collective action.</td>
</tr>
<tr>
<td>11.1</td>
<td>16</td>
<td>Nurses have an obligation to promote equitable access to nursing and health care for all people.</td>
</tr>
<tr>
<td>11.2</td>
<td>16</td>
<td>Nurses should ensure representation by active participation in decision making in institutional and political arenas to assure a just distribution of health care and nursing resources.” (Ballou, 2000, p. 178).</td>
</tr>
</tbody>
</table>
APPENDIX B

RECRUITMENT LETTER
Dear [insert name],

I would like to extend an invitation to you to participate in a research study examining the “politics” of nursing advocacy and policy development. The aim of my study is to gain understanding into the concept and practice of “political advocacy” in nursing from the educational and professional experiences of nurse advocates. Public policies control all facets of our social system, our healthcare system, nurses and the nursing profession. Research has shown that nurses and the nursing profession need to have a deeper conceptual understanding of political advocacy (in general) if nurses ever hope to participate effectively in this type of advocacy as part of their nursing practice (Ballou, 2000). You are eligible to be in this study because you [insert description]. I obtained your contact information from [describe source]. The only other eligibility requirements are that you have been a licensed registered nurse for at least five years and presently participate in any type of advocacy or policy development: a professional nursing organization; a disability advocacy organization; any kind of public policy advocacy; healthcare policy development; any type of health related advocacy; any kind of policy development; advocacy for a minority group; advocacy for women, veterans or children; hold a leadership role in a professional nursing organization; are an elected official in local, state or federal government or are presently actively participating in any political campaign. All of the aforementioned can be through volunteer work or employment.

If you decide to participate in this study, we will schedule a face-to-face, audio-recorded interview session in which you will be asked questions about your advocacy and/or policy work, your perspectives and experiences, and your nursing practice. After the session, the information will be transcribed verbatim and will be used in the study to describe the work of nursing advocates, their perspectives, and the concept of “political advocacy” within the nursing profession. The particulars relating to the interview: the time, the date, and the site, will be arranged to accommodate your schedule, your prior commitments, and will take place at a location most convenient to you and mutually agreed upon. Participation in this is study is completely voluntary. You can choose to be in this study or not.

I am a graduate student in the dual MSN/EdD Instructional Leadership Program at the University of Alabama in Tuscaloosa. My residence is in Virginia, and I am able to accomplish the requirements of the program through both weekend sessions in Tuscaloosa and online as a distance student. If you’d like to participate or have any questions about the study, please contact me at (540) 846-8516 or email: tammietallent@comcast.net. I look forward to hearing from you soon.

Sincerely,

Tammie Tallent Williams, MSN, EdD-ABD
(recruitment email #1)

Dear [insert name],

I would like to extend an invitation to you to participate in a research study examining the “politics” of nursing advocacy and policy development. The aim of my study is to gain understanding into the concept and practice of “political advocacy” in nursing from the educational and professional experiences of nurse advocates. Public policies control all facets of our social system, our healthcare system, nurses and the nursing profession. Research has shown that nurses and the nursing profession need to have a deeper conceptual understanding of political advocacy (in general) if nurses ever hope to participate effectively in this type of advocacy as part of their nursing practice (Ballou, 2000). You are eligible to be in this study because you [insert description]. I obtained your contact information from [describe source]. The only other eligibility requirements are that you have been a licensed registered nurse for at least five years and presently participate in any type of advocacy or policy development: a professional nursing organization; a disability advocacy organization; any kind of public policy advocacy; healthcare policy development; any type of health related advocacy; any kind of policy development; advocacy for a minority group; advocacy for women, veterans or children; hold a leadership role in a professional nursing organization; are an elected official in local, state or federal government or are presently actively participating in any political campaign. All of the aforementioned can be through volunteer work or employment.

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Sincerely,

Tammie Tallent Williams, MSN, EdD-ABD
Dear [insert name],

You should have recently received a request to participate in a research study that I am conducting. I would like to again extend an invitation to you to participate in a research study examining the “politics” of nursing advocacy and policy development. The aim of my study is to gain understanding into the concept and practice of “political advocacy” in nursing from the educational and professional experiences of nurse advocates. Public policies control all facets of our social system, our healthcare system, nurses and the nursing profession. Research has shown that nurses and the nursing profession need to have a deeper conceptual understanding of political advocacy (in general) if nurses ever hope to participate effectively in this type of advocacy as part of their nursing practice (Ballou, 2000). You are eligible to be in this study because you [insert description]. I obtained your contact information from [describe source]. The only other eligibility requirements are that you have been a licensed registered nurse for at least five years and presently participate in any type of advocacy or policy development: a professional nursing organization; a disability advocacy organization; any kind of public policy advocacy; healthcare policy development; any type of health related advocacy; any kind of policy development; advocacy for a minority group; advocacy for women, veterans or children; hold a leadership role in a professional nursing organization; are an elected official in local, state or federal government or are presently actively participating in any political campaign. All of the aforementioned can be through volunteer work or employment.

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Sincerely,

Tammie Tallent Williams, MSN, EdD-ABD
APPENDIX C

NEGATIVE HEALTH CONDITIONS WITH A CORRELATION TO POVERTY
<table>
<thead>
<tr>
<th>Negative Health Condition</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor Oral Health</td>
<td>(Dye &amp; Thornton-Evans, 2010; Nikulina &amp; Widom, 2014)</td>
</tr>
<tr>
<td>Obesity</td>
<td>(Drewnowski and Specter 2004; Darmon and Drewnowski 2008; Richmond, Field, and Rich 2007; Larson, Story, and Nelson 2009)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>(Nikulina &amp; Widom, 2014)</td>
</tr>
<tr>
<td>Poor Mental Health</td>
<td>(Poole, Higgo &amp; Robinson, 2013).</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>(Donini et al., 2013).</td>
</tr>
<tr>
<td>Increased Infant Mortality Rates</td>
<td>(Collins, Soskolne, Rankin, &amp; Bennett, 2013; Sims, Sims &amp; Bruce, 2007; Yao, Matthews, &amp; Hillemeier, 2012)</td>
</tr>
<tr>
<td>Developmental Delays</td>
<td>(Engle &amp; Black, 2008)</td>
</tr>
<tr>
<td>Intentional Injuries</td>
<td>(Faelker, Pickett, &amp; Brison, 2000; Bernard, Paulozzi, &amp; Wallace, 2007)</td>
</tr>
<tr>
<td>Disabilities</td>
<td>(O’Connor &amp; Fernandez, 2007)</td>
</tr>
<tr>
<td>Asthma</td>
<td>(Akinbami, LaFleur, &amp; Schoendorf, 2002; Canino et al. 2006)</td>
</tr>
<tr>
<td>Violence in Adolescence</td>
<td>(Spano, &amp; Bolland, 2013).</td>
</tr>
<tr>
<td>Higher Rates of STD’s</td>
<td>(Chu &amp; Selwyn, 2008; Weinstock, Berman, &amp; Cates, 2004)</td>
</tr>
<tr>
<td>Poor Pre-Natal Care</td>
<td>(Mazul, Ward, &amp; Ngui, 2016)</td>
</tr>
<tr>
<td>Increased Incidence of Chronic Disease</td>
<td>(WHO &amp; Public Health Agency of Canada, 2005)</td>
</tr>
<tr>
<td>Detection of Disease Processes at a Later Stage</td>
<td>(Barry, Breen, &amp; Barrett, 2012; MacKinnon et al., 2007)</td>
</tr>
<tr>
<td>Stress</td>
<td>(Rosenbaum &amp; Blum, 2015)</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>(Dominelli, 2016).</td>
</tr>
<tr>
<td>Diabetes</td>
<td>(Estes &amp; Wallace, 2006)</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>(Estes &amp; Wallace 2006)</td>
</tr>
<tr>
<td>Lack of Educational/Intellectual Attainment</td>
<td>(Olshansky et al., 2005; Zimmerman, Woolf &amp; Haley, 2015)</td>
</tr>
</tbody>
</table>

(lower high school graduation rates & less likely to attend and/or graduate from college)
APPENDIX D

AMERICAN NURSING ASSOCIATION ISSUE BRIEFS
(ANA, 2016b)
<table>
<thead>
<tr>
<th>Name of ANA Issue Brief</th>
</tr>
</thead>
<tbody>
<tr>
<td>The North Carolina State Board of Dental Examiners v. FTC</td>
</tr>
<tr>
<td>Nursing Licensure Portability</td>
</tr>
<tr>
<td>State Health Insurance Changes: The Critical Role of Nurses and Nursing</td>
</tr>
<tr>
<td>Ignorance is Not a Defense: Implications of heightened scrutiny of fraud and abuse.</td>
</tr>
<tr>
<td>Nursing Beyond Borders: Access to Care for Documented and Undocumented Immigrants.</td>
</tr>
<tr>
<td>Health System Reform: Nursing’s Goal of Quality, Affordable Care for All.</td>
</tr>
<tr>
<td>Care Delivery Models in Health Care Reform: Opportunities for Nurses</td>
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<tr>
<td>Solving the Crisis in Primary Care.</td>
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<tr>
<td>A Nurse’s Duty to Respond in a Disaster.</td>
</tr>
<tr>
<td>APRN’s with a National Provider Identifier.</td>
</tr>
<tr>
<td>Fighting Childhood Obesity.</td>
</tr>
<tr>
<td>2009 Registered Nurse Employment and Earnings.</td>
</tr>
</tbody>
</table>
APPENDIX E

HEALTH DISPARITY STATISTICS
(National Center for Health Statistics, 2013)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Statistical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality</td>
<td>Infant mortality increases as mother’s level of education decreases. In 2004, the mortality rate for infants of mothers with less than 12 years of education was 1.5 times higher than for infants of mothers with 13 or more years of education (Shapiro-Mendoza, Tomashek, Anderson &amp; Wingo, 2006).</td>
</tr>
<tr>
<td>Cancer deaths</td>
<td>In 2004, the overall cancer death rate was 1.2 times higher among African Americans than among Whites (He, Akil, Aker, Hwang, Ahmad, 2015).</td>
</tr>
<tr>
<td>Diabetes</td>
<td>As of 2005, Native Hawaiians or other Pacific Islanders (15.4%), American Indians/Alaska Natives (13.6%), African Americans (11.3%), Hispanics/Latinos (9.8%) were all significantly more likely to have been diagnosed with diabetes compared to their White counterparts (7%) (Brennan-Ramirez, Baker and Metzler, 2008).</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>African Americans, who comprise approximately 12% of the US population, accounted for half of the HIV/AIDS cases diagnosed between 2001 and 2004. In addition, African Americans were almost 9 times more likely to die of AIDS compared to Whites in 2004 (Shapiro-Mendoza, Tomashek, Anderson &amp; Wingo, 2006).</td>
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<tr>
<td>Tooth decay</td>
<td>Between 2001 and 2004, more than twice as many children (2–5 years) from poor families experienced a greater number of untreated dental caries than children from non-poor families. Of those children living below 100% of poverty level, Mexican American children (35%) and African American children (26%) were more likely to experience untreated dental caries than White children (20%) (Shapiro-Mendoza, Tomashek, Anderson &amp; Wingo, 2006).</td>
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<tr>
<td>Injury</td>
<td>In 2004, American Indian or Alaska Native males between 15–24 years of age were 1.2 times more likely to die from a motor vehicle-related injury and 1.6 times more likely to die from suicide compared to White males of the same age (Shapiro-Mendoza, Tomashek, Anderson &amp; Wingo, 2006).</td>
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APPENDIX F

POLITICAL COMPETENCY STUDIES
<table>
<thead>
<tr>
<th>Study Name &amp; Year</th>
<th>Study Design</th>
<th># of Participants</th>
<th>Educationa l Level</th>
<th>Intervention</th>
<th>Setting</th>
<th>Results</th>
<th>Evaluation method</th>
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<tbody>
<tr>
<td>Byrd et. al., 2012</td>
<td>Quantitative</td>
<td>40</td>
<td>RN to BSN, Regular BSN</td>
<td>Public/ community health nursing course</td>
<td>Rhode Island College</td>
<td>Significant Improvement</td>
<td>PAI</td>
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<tr>
<td>Cohen and Milone-Nuzzo, 2001</td>
<td>Qualitative</td>
<td>Not given</td>
<td>MSN, APN</td>
<td>Service learning practicum</td>
<td>Yale University</td>
<td>Self-evaluation and Faculty evaluation</td>
<td>Self-evaluation</td>
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<td>Conger and Johnson, 2000</td>
<td>Qualitative</td>
<td>Not given</td>
<td>Graduate level (MSN, ANP)</td>
<td>Public policy course w/legislative mentors</td>
<td>Brigham Young University</td>
<td>Significant Improvement</td>
<td>Self-evaluation</td>
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<td>DiCenso et al., 2012</td>
<td>Qualitative</td>
<td>13</td>
<td>11-PhD &amp; DNP 2-Post Doctoral fellows</td>
<td>Health Policy Practicum</td>
<td>Canadian University</td>
<td>Significant Improvement</td>
<td>Self-evaluation</td>
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<td>Faulk and Ternus, 2004</td>
<td>Qualitative</td>
<td>Not given</td>
<td>Not given</td>
<td>Health Policy Course</td>
<td>Auburn University</td>
<td>Positive/ Greater Understanding of Policy</td>
<td>Self-Evaluative</td>
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<td>Magnussen, Itano and McGuckin, 2005</td>
<td>Qualitative</td>
<td>Not given</td>
<td>Not given</td>
<td>Public Policy Course and Legislative Internship</td>
<td>University of Hawaii</td>
<td>Significant Improvement</td>
<td>Self-Evaluation</td>
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<td>Qualitative</td>
<td>Not given</td>
<td>BSN</td>
<td>Community Development Course and Service Learning Practicum</td>
<td>Canadian University</td>
<td>Extremely beneficial</td>
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<td>Primomo, 2007</td>
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<td>Health systems and policy</td>
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<td>Primomo and Bjorling, 2013 Study I</td>
<td>Quantitative Retrospective</td>
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<td>ADN-MSN</td>
<td>Washington State Nurses Association (WSNA) Legislative Day</td>
<td>Web-based</td>
<td>Significant</td>
<td>PAI</td>
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<td>Washington State Nurses Association (WSNA) Legislative Day</td>
<td>Web-based</td>
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<td>Rains and Barton-Kriese, 2001</td>
<td>Qualitative, cross-sectional comparative study</td>
<td>17</td>
<td>Senior-level BSN students and Political Science Majors</td>
<td>None</td>
<td>Midwest University</td>
<td>Positive/ Greater Understanding</td>
<td>Faculty Conducted Interviews</td>
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<td>Health Policy Course</td>
<td>Indiana University</td>
<td>Significant</td>
<td>The Assessment of Political Competence for Nursing Scale</td>
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<td>Health Policy Course</td>
<td>United Kingdom</td>
<td>Significant</td>
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</tbody>
</table>
APPENDIX G

INSTITUTIONAL REVIEW BOARD APPLICATION
August 18, 2016

Tammie Williams
ELPTS
College of Education
Box 870302

Re: IRB # 16-OR-282, “Political Advocacy in Nursing: Perspectives from the Field”

Dear Ms. Williams:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(*) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on August 17, 2017. If your research will continue beyond this date, please complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, please complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent forms to obtain consent from your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

Carpanito T. Myles, MSM, CRM, CIP
Director & Research Compliance Officer
Office for Research Compliance
October 11, 2016

Tammie Williams
ELPTS
College of Education
The University of Alabama
Box 870302

Re: IRB # 16-OR-282 “Political Advocacy in Nursing: Perspectives from the Field”

Dear Ms. Williams:

The University of Alabama Institutional Review Board has reviewed the revision to your previously approved expedited protocol. The board has approved the change in your protocol.

Please remember that your approval period expires one year from the date of your original approval, August 18, 2016, not the date of this revision approval.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants.

Good luck with your research.

Sincerely,

Carpentaro T. Myles, MSM, CIH, CIIP
Director & Research Compliance Officer
Office for Research Compliance
June 20, 2017

Tammie Williams  
ELPTS  
College of Education  
The University of Alabama  
Box 870302

Re: IRB # 16-OR-282-R1 “Political Advocacy in Nursing: Perspectives from the Field”

Dear Ms. Williams:

The University of Alabama Institutional Review Board has granted approval for your renewal application. Your renewal application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on June 19, 2018. If your research will continue beyond this date, complete the relevant portions of Continuing Review and Closure Form. If you wish to modify the application, complete the Modification of an Approved Protocol Form. When the study closes, complete the appropriate portions of FORM: Continuing Review and Closure.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

Carpentier T. Myles, MSM; CIN, CIP  
Director of Research Compliance  
Office for Research Compliance

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APPENDIX H

INTERVIEW PROTOCOL
Introduction

To facilitate my note-taking, I will be audio taping our conversations today with a digital voice recorder. You have been selected to participate in this study because you have been identified as someone who has a great deal to share about political advocacy in nursing. This research project as a whole focuses on understanding more about the concept of political advocacy in nursing and nurses who function in political advocacy roles. Examining the life experiences, professional experiences, educational experience and personal perspectives of nurses currently serving as political advocates will hopefully provide valuable insights into not only what the practice of political advocacy “looks like”, but to also gain understanding of its conceptual meaning and its relevance within the profession. In addition, obtain the perspectives and insight of current, practicing nurse/political advocates will help reveal what educational experiences, work experiences, personal experiences and/or pedagogical interventions are necessary to enable nurses to become successful political advocates in their area of nursing practice.

Here is the Informed Consent to participate form. Please read it and let me know if you have any questions. Essentially, this document states that: (1) all information will be held confidential; (2) your participation is voluntary, (3) you may stop at any time if you feel uncomfortable, and (4) this study does not intend to inflict any personal, professional or psychological harm.

Post Consent

Thank you for your agreeing to participate in this study. You will now be given a Demographic Sheet to fill out. This information will be used to determine if there are any similarities among participants. This information will be kept separate from any other data obtained during the study. For your information, only the primary investigator and co-investigator/dissertation chair, Dr. Nirmala Erevelles, will be privy to any of your personal information. All information obtained during this study will be kept in a locked file box for a period of five years and then destroyed. This interview is planned to last no longer than two hours. If you need to stop at any point, please let me know. During this time, there are several questions that need to be covered. If time begins to run short, it may be necessary to interrupt you in order to push ahead and complete the questioning.

Question: What are your educational experiences?
Probes:
1. How long have you been a licensed Registered Nurse?
2. Through which state Board of Nursing did you obtain your license?
3. Where did you go to school?
4. When did you graduate?
5. What is your highest nursing degree?
6. Do you have any degrees in any other areas?

Question: What are your professional experiences?
Probes:
1. What is your current position?
2. How long have you been in your present position?
3. Briefly describe your role or position.
4. What are your daily activities?
5. What are the goals of your work?
6. What is the purpose of your work?
7. What are the greatest challenges of your work?
8. What are the greatest barriers to your work?

Question: What is your understanding of political advocacy in nursing?
Probes:
1. What does political advocacy mean to you and to your nursing practice?
2. What does social justice mean to you and to your nursing practice?
3. What is your understanding of social justice advocacy in nursing?

Question: How do you interpret professional responsibility and/or professional nursing mandates which address social justice, health equity, policy advocacy, ethical care and/or population health?
Probes:
1. Are you familiar with either the ANA’s “Nursing’s social policy statement: The essence of the profession” (ANA, 2010c) or the ANA’s “Code of Ethics for Nurses with Interpretive Statements” (ANA, 2015; 2001)?
2. What is your understanding of either document?
3. What is the relevance of these documents to your current work, your professional/ethical responsibilities and/or to the nursing profession (in general)?
4. What has changed and/or stayed the same, relating to political advocacy within your nursing practice?
5. What does your work accomplish (if anything)?

Question: What recommendations do you have for the nursing profession (in general), individual nurses and/or for nursing education, to better prepare future nurses for your role?
Probes:
1. What educational experiences have had the greatest influence on your work?
2. What life experiences have had the greatest influence on your work?
3. What professional/work experiences have had the greatest influence on your work?
4. To what extent is political advocacy valued within your profession?
5. Do you have any particular skills that contribute positively to your work? If so, what are they, how did you obtain them and how have they helped you?
6. Do you see any additional political advocacy related employment opportunities emerging within your work and/or the profession? If so, what are they?
7. Based on your experience, is there any particular skill, education, training and/or personal characteristic that you associate with nurses who are employed in political advocacy work? If so, please explain
APPENDIX I

INFORMED CONSENT FOR A NON-MEDICAL RESEARCH STUDY
You are being asked to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not. I am now going to explain the study to you. Please feel free to ask any questions that you may have about the research; I will be happy to explain anything in greater detail.

Public policies control all facets of our social system, our healthcare system, nurses and the nursing profession. Research has shown that nurses and the nursing profession need to have a deeper conceptual understanding of political advocacy (in general) if nurses ever hope to participate effectively in this type of advocacy as part of their nursing practice (Ballou, 2000). The purpose of this study is to examine political advocacy within the nursing profession through the narratives, perspectives and understanding of nurses who participate in advocacy within the profession. Gaining practical knowledge and a deeper understanding of the practice and concept of nursing advocacy which is “political” from practicing nurses are goals of this study.

You will be asked a series of questions in a face-to-face, audio-recorded, semi-structured interview session in which you will be asked questions about your life experiences and views on the subject. After the session, the information will be transcribed verbatim and will be used in the study to describe your perspectives, your educational background, your work and your life experiences. The interview will take approximately 1-2 hours of your time, but there may be additional contact with you by phone to clarify any of your statements that may be unclear. Any personal information that relates to you will be kept confidential. I will assign a pseudonym in place of your real name and only I will have the key to indicate which pseudonym belongs to which participant. The digital recorder will be erased after the audio file is downloaded. In any articles I write or any presentations that I make, I will use your pseudonym and I will not reveal details or I will change details about where you work, where you live, any personal information about you, and so forth. During the interview process, the participant may voluntarily choose to share documents and other written data with the researcher. This written data may include policies, curriculums, regulations, reports, projects, archival materials, minutes of meetings, letters, press releases, research journals, or nursing mandates that relate to advocacy and/or social justice, etc.; any other documents produced in the course of the participant’s daily work; or documents which relate to policy development, social justice, political advocacy, healthcare or nursing advocacy. Any information obtained from this written data will be documented on the Field Notes template. Any written data the participant chooses to share with the researcher will be kept in a locked, secure file box with the rest of the materials from the study. After the typed transcripts of your interview are completed, you may be briefly contacted by phone or in person for (10-15 minutes) to clarify your words. If further clarification is needed, you may be requested to participate in a face-to-face meeting for 10-15 minutes. All information obtained during this study will be kept in a locked file box for a period of five years and then destroyed.

The benefit of this research is that you will be helping the profession gain a deeper understanding of the concept and practice of “political advocacy” in nursing that is based on your perspectives and your experiences. The risks to you for participating in this study are minimal. Participation is voluntary. If you do not wish to continue, you have the right to withdraw from the study, without penalty, at any time. If you would like to withdraw at any time in the future or have further questions, you may contact the researcher, Tammie Williams at (540) 846-8516 or by email at: tammietallent@comcast.net or my faculty advisor, Dr. Nirmala Erevelles at (205) 348-1179 or nerevell@bamaed.ua.edu. If you have any questions, concerns, or complaints about your rights as a person in a research study, call Ms. Tanta Myles, the Research Compliance Officer of the University, at (205) 348-8461 or toll free at 1-877-820-
3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email the Research Compliance office at: participantoutreach@bama.ua.edu. If you choose to participate, you will receive a signed copy of the consent form by mail for your records.

All of my questions and concerns about this study have been addressed. I choose, voluntarily, to participate in this research project. I certify that I am at least 18 years of age and I am a licensed Registered Nurse that has been practicing for at least 5 years and I am participating as an advocate as a part of my nursing practice.

Printed name of participant  Signature of participant  Date

I agree to have the interview audio-recorded. Yes ☐  No ☐

Printed name of investigator  Signature of investigator  Date
APPENDIX J

DEMOGRAPHIC INFORMATION FORM
This information will be stored separately from any other information that you complete during this study and will not be linked with your responses in any way. The information will allow us to provide an accurate description of the sample. Please provide a response for each of the following questions:

1. Name: ______________________________________________________

2. What is your age? __________

3. What is your sex? Female ○ Male ○ Transgendered ○

4. What is your marital status? Single ○ Married ○ Separated ○ Divorced ○ Widowed ○

5. With which racial or ethnic category do you identify? African American ○ Asian/Pacific Islander ○ Caucasian ○ Latino ○ Other ○ ______________

6. With what denomination or faith tradition do you most closely identify? Episcopal ○ Baptist ○ Methodist ○ Catholic ○ Jewish ○ Lutheran ○ Hinduism ○ Buddhism ○ Atheism ○ Other ○

7. How many years have you been a licensed Registered Nurse? __________

8. If you are a nurse educator, what is your current academic rank? Assistant Professor ○ Associate Professor ○ Full Professor ○ Distinguished Professor ○

9. a. What is your highest degree obtained? __________________________________________

   b. What school did you graduate from? __________________________________________

10. a. What is your highest nursing degree obtained? ________________________________

    b. What school did you graduate from? ________________________________

11. Do you hold degrees in other fields? Yes ○ No ○ If so, please list your other degrees:
12. Do you have any advanced practice credentials? Yes ☑ No ☑ If so, please list them:

13. Which of the following best describes the area you live in? Urban ☑ Suburban ☑ Rural ☑

14. Which political party do you most strongly identify with?
   Republican Party ☑ Democratic Party ☑ Independent ☑ Other ☑

15. Did you vote in the last Presidential election? Yes ☑ No ☑
APPENDIX K

FIELD NOTE
Date: ____________________________________________

Time: ____________________________________________

Interviewee Pseudonym /Street Address:

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________


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<th>Notes to Self (Reflection)</th>
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APPENDIX L

MEMOING TEMPLATE
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APPENDIX M

MEMBER CHECK QUESTIONNAIRE
APPENDIX N

LIST OF CONCEPTS AND THEMES
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February 2017

Darlene’s words were difficult to hear. Her daughter had received very negligible care. I considered the possibilities surrounding the nurse’s actions. Were they treated so poorly because Darlene “threw something on” and was not well-dressed? Not likely. Who would be dressed well in the middle of the night? And, even if this was the case, it is still negligent, unacceptable and unethical. Nurses are trained to treat everyone with the same respect and dignity; even criminals. Were they treated so poorly because it was a particularly busy night in the ER? It is possible the nurse was feeling overwhelmed? Yes, maybe that is what happened, but that factor alone is not a valid excuse for negligent care. Nurses have an ethical responsibility to seek help from another nurse, if they cannot fulfill their duties. They cannot simply “not do them”. Nurses can not only lose their license, but be charged criminally. It is also possible that the nurse was overly tired, was going through some sort of emotional difficulties herself, etc. Although it does not “excuse” her behavior, it could be a factor. Even so, I cannot help but wonder: if this is how the daughter of a well-educated woman of color is treated, how much worse are the poor, uneducated people of color treated when they seek out care in the ER, in the middle of the night? The event Darlene and her daughter had experienced had likely impacted her life in some way, but how and to what degree? Anger? Sadness? Helplessness? What? Did this event impact Darlene’s nursing practice, and if so, how? What about her political advocacy work? However, the bottom line is this: it doesn’t matter what I think, what matters is what Darlene thinks. What is Darlene’s perspective on the events? What else does she say relating to the event? What is her understanding? Note to self: use Darlene’s words. Make sure to include her statements & my thoughts on them in her member check, so that her perspective is not misinterpreted by me.