




Nurses Who Assume the Role of Advocate for Older Hospitalized Patients: A Qualitative Study

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Corina Elena Luca, cand. MSN, RN¹ ,
Andrea Cavicchioli, MSN, RN², and
Monica Bianchi, PhD, EMBA, MSN, RN² 

Abstract

Introduction: Patient advocacy, acting on behalf of patients' unmet needs, is fundamental to nursing, and the perception of the need for advocacy motivated this study. Nurses experience moral discomfort, which results from a divergent view regarding medical or caregivers' decisions about patients' clinical proceedings, in which patients' involvement in making those decisions is either doubtful or absent.

Objectives: The aim of this study is to assess the need for advocacy and explore the perspectives of nurses engaged in the care of older patients.

Methods: The methodological orientation is that of a qualitative design, by using a purposive and criterion sampling. The sample was of 14 nurses of a ward of general medicine. Focus group as collecting data tool was used, followed by a thematic analysis.

Results: Nurses demonstrated a high level of moral sensitivity to ethical problems in clinical practice and on occasions, the courage to bring the problem to the physicians or patients' family's attention, or help patients develop self-determination. However, it is difficult to advocate because of insufficient communication between professionals, insufficient knowledge of ethics, and the emotional burden it places on nurses which results in emotional resignation in the face of interprofessional teams' lack of consideration of nurses' opinions.

Conclusion: This research highlighted nurses' need for advocacy to promote patients' rights, wishes, and values. It is essential for nurses to be aware of their level of moral sensitivity and develop a strategy to regain courage to engage in advocacy. Therefore, ethics education and interprofessional ethical leadership is desired, which inspires healthcare professionals' work and allows the foundations of an ethical decisionmaking process to be laid through patients and their families' active involvement.

Keywords

nursing, advocacy, moral distress, ethical decision-making, ethical dilemma

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Introduction

In clinical practice, nurses experience moral discomfort related to emotions, reflections, and dilemmas that arise with respect to older patients' care. This moral discomfort is attributable to nurses' perspectives, and leads to disagreements with medical or caregivers' choices about patients' clinical conditions, in which patients' involvement in such decisions is doubtful or absent. Nurses have reported this distress often, which suggests that

¹Ente Ospedaliero Cantonale, Ospedale Regionale di Lugano, Lugano, Switzerland

²Department of Business Economics, Health and Social Care, University of Applied Sciences and Arts of Southern Switzerland, Manno, Switzerland

Corresponding author:

Corina Elena Luca, Ente Ospedaliero Cantonale, Ospedale Regionale di Lugano, Via Tesserete 46, CH-6900, Lugano, Ticino, Switzerland.
Email: corinaelena.luca@eoc.ch



they suffer when coping with ethical dilemmas related to older patients' end-of-life care. This discomfort is known as "moral distress", to describe the psychological, emotional and physiological suffering that nurses and other health professionals experience when they act in ways that are inconsistent with deeply held ethical values, principles or commitments (Corley, 2002; Deschenes et al., 2020; McCarthy & Gastmans, 2015; Woods, 2014). The result of such repeated diversity of views about what is appropriate for patients' care can lead to psychological disequilibrium and emotional exhaustion (Corley, 2002; Malloy et al., 2009; Oh & Gastmans, 2015). Caring for frail, older persons also involves being confronted with them at the end of their lives and asking questions about the appropriateness of intensive and aggressive care (Perin et al., 2018). This can cause moral dilemmas in care practice, when, for example, aggressive, futile treatments are adopted that prolong suffering without a clear clinical rationale (Eriksson et al., 2014; Haahr et al., 2020; Perin et al., 2018). Therefore, in the care nurses provide at the end of an older persons' life, they are likely to encounter situations that cause them moral distress, with all of the consequences that entails, physically, psychologically, and professionally (Deschenes et al., 2020; Perin et al., 2018). Nurses are confronted increasingly in clinical practice with vulnerable patients who struggle to express their autonomy, which draws attention to the potential need to advocate for their expressed or unexpressed wishes. People with dementia and their carers often experience uncertainty in decision making, leading to difficulties when creating an advanced care plan. It is therefore necessary for healthcare professionals to demonstrate empathy and provide an understanding of the decisions that may need to be made along the trajectory of dementia (Sellars et al., 2019). Mahlin (2010) pointed out that, although patients are not considered vulnerable automatically, it may be difficult for them to express their views and choices fully, given the combination of illness, hospitalization, and subjection to a potentially dangerous medical establishment. The understanding of the decisions that should be made is possible through "entering the patient's world", where the nurse will develop the nurse-patient relationship as a strategy to encourage patients to participate in self-care (Strandås & Bondas, 2018). Therefore, this highlights the need to provide patients with all of the resources and information necessary to be well-informed about their health condition so they can make their own decisions (Leitungsgruppe des NFP 67 Lebensende & Schweizerischer Nationalfonds zur Förderung der Wissenschaftlichen Forschung, 2017; Ufficio federale della sanità pubblica, 2020).

Given the future care in which we will be confronted increasingly with complex patients in old age (Eurostat,

2020; Ufficio federale di statistica, n.d.; World Health Organization, 2018), it is important to support nurses' capacity to serve as advocates and understand their emotions and experiences while caring for patients. Indeed, as pointed out by Reed et al. (2018), advocacy action is motivated by the emotional responses of nurses to the end-of-life vulnerability people experience. Our research was designed to explore nurses' experiences as advocates and highlight which strategies may be implemented to improve the ethical reflections on clinical practice and nurses' ability to advocate.

Objectives

To assess the need for advocacy of nurses engaged in the care of older patients (65 and older) and their perspectives.

Research Design/Methods

The methodological orientation is that of qualitative research design, by using a focus group as a data collection tool, in order to obtain an understanding of nurses' advocacy roles, based on their perspectives and experiences. The data has been analysed with the method of thematic analysis. According to Braun and Clarke (2006), a thematic analysis is a flexible and useful research tool that allows a rich and complex interpretation of data. Compared to other qualitative methods, a thematic approach allows researchers to explore in depth the meaning attributed to nurses' advocacy within a specific context.

Setting

A ward of general medicine with a majority population of older adults in a regional (cantonal) hospital in southern Switzerland.

Sampling

The participants were enrolled through purposive-criterion sampling, based on "participant's experience with the phenomena under study" (Moser & Korstjens, 2018). The sample was of 14 nurses from the ward of general medicine who "vary in characteristics and in their individual experiences" (Moser & Korstjens, 2018).

The principal investigator is the clinical nurse specialist of the ward involved in the study and the working relationship with the participants represents a value, because of the common objective of understanding the phenomena, in order to improve the quality of care of patients. The principal investigator, in their dual role as researcher and team member, has from the outset reflected on their own role at every stage of the research, enabling an objective and detached view of the data.

The clinical nurse specialist was the only researcher member of the team, while the other two researchers were external to the institution.

The study was presented to the hospital's nursing director. After consent was obtained, the study was presented to the head nurse of the ward involved, who also expressed interest. Then a face-to-face approach was used to recruit participants, and no one refused to participate, highlighting the importance of the phenomena within this context. Only two participants couldn't participate, because of personal reasons.

Data Collection

Data were collected from June to August 2019 through focus groups that included structured, open-ended questions (Table 1).

"A focus group is a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research" (Powell & Single, 1996). On developing focus group questions, a funnel design was used, with a view to a discussion that moves from broader to narrower topics (Morgan & Scannell, 1998, p. 53). The groups began by reading a hypothetical clinical case study to stimulate discussion on advocacy. The fourth of the key questions asked participants to write about a situation they had experienced, which generated 14 narratives on which a thematic analysis was conducted. Before the focus groups were conducted, a qualitative methodologist trained the principal investigator specifically to moderate focus groups. Participants were

divided into three groups of four to five participants each, taking into account the personal characteristics of each one. The focus groups lasted approximately two hours and depended on how much they shared in the discussion on the topic. Field notes were made during and after the sessions, as "the collection of these first reflections can be valuable in guiding later stages of reflection and analysis" (Phillippi & Lauderdale, 2018).

Data Analysis

All focus groups were audio-recorded and transcribed verbatim. Braun and Clarke (2006) six-step procedure was followed for thematic analysis:

1. Familiarizing yourself with your data: two researchers analysed each transcript, which was read several times and analysed sentence by sentence.
2. Generating initial codes: two researchers identified first codes separately, with the support of tables.
3. Searching for themes: the two researchers brought together the initial codes and began to name themes and subthemes.
4. Reviewing themes: the list of themes was reviewed in order to ensure internal consistency.
5. Defining and naming themes: themes and subthemes were defined and described. A third researcher with expertise in qualitative research checked the analysis and helped develop the themes to ensure reliability.
6. Producing the report: the final report was reviewed by three researchers.

Table 1. Focus Group Guide.

Opening questions
Reading a hypothetical clinical case study
What does this case bring to mind for you?
Transition questions
It is clear that this clinical case describes the role of the nurse as promoter and defender of patients' will. How do you conceive of this?
Key questions
Thinking about the cases with which you have been confronted during your clinical experience, what patients needed the nurse to advocate for them? Can you describe them?
Thinking about your experiences and the characteristics of patients for whom you felt compelled to advocate, could you define the problem/reason that prompted you to act?
If you think of the word ethics, what does it evoke? What do you think about?
Please think about a situation you have experienced similar to that of the case presented, and describe briefly how you acted in that situation.
Thinking about the clinical situations you have experienced, what helped you advocate on behalf of patients' wishes? Please mention 3 factors.
If you failed to advocate for patients, describe three factors that prevented you from doing so.
When you have advocated for patients, what did you notice? What effects did it have on you and the patient?
When you failed to advocate for patients, describe the effects it had on you and the patient.
With respect to the clinical case presented, how would you act?
Final questions
What do you think are the three most important aspects that you would like to improve with respect to advocacy skills?
What lessons are you taking home from this focus group?

Researchers discussed data saturation, and they concluded that it was reached after the third focus group, given that no further new themes emerged. A selection of the most relevant quotes for themes and subthemes was made to ensure confirmability.

Ethical Considerations

The research used audio recording, and participants were informed that all data would be anonymous and confidential. Informed consent was obtained. Moreover, the study was analysed by the National Ethics Committee, who declared that the research was conducted in accordance with national legislation (Req-2020-00093).

Results

Three focus groups were conducted with a total of 14 participants (Table 2).

At the beginning of the focus groups, the participants were presented with a hypothetical clinical case that required them to assume the role of advocate. During discussions on the hypothetical case, participants were more detached yet once they began to talk about similar cases which they have themselves experienced, more emotions were elicited. From the analysis emerged eighteen subthemes, grouped in seven major themes: i. Engaging in advocacy; ii. Living an ethical problem; iii. Living emotions; iv. Factors that facilitate advocacy; v. Factors that hinder advocacy; vi. Advocacy's effects; vii. Lack of advocacy's effects (Table 3).

Engaging in Advocacy

Engaging in advocacy represents for nurses the identification of situations of frailty/vulnerability of patients, in which the patient's self-determination could be undermined. Nurses engage in advocacy when they raise ethical issues on an interprofessional level. This major theme groups together themes concerning patient-related aspects (frailty and self-determination), ethical aspects and inter-professionalism.

Frailty/Vulnerability. Nurses indicated that they need to engage in advocacy when they perceive patients' frailty and vulnerability, which is manifested primarily in suffering, fear of hospitalization, and the consequent desire for protection and defence.

"Seeing someone in pain! This is suffering! That in the sense that one can also approach death without suffering, if it does not manifest a discomfort, but if there is a manifest suffering, someone must take charge of the situation, because one of our tasks is to alleviate suffering as much as possible." (N3)

"...then there are patients who are also scared, who are in the hospital, so they have little lucidity at that moment..." (N5)

"...the patient is in a situation of weakness, because first of all, physicians are usually in a hurry, they intimidate patients, they make them talk little and usually they don't even dare to tell the doctor..." (N6)

Participants stated that another aspect that determines a hospitalized patient's frailty is their lack of

Table 2. Description of Participants.

Nurses	Gender	Age	Working experience as nurses (years)	Degree
1	F	20–30	3	Registered nurse
2	F	30–40	16	Registered nurse
3	M	40–50	4	Registered nurse diploma of advanced studies in geriatrics
4		30–40	3	Registered nurse
5	M	40–50	21	Registered nurse
6	F	40–50	25	Registered nurse diploma of advanced studies in healthcare management
7	F	20–30	<1	Registered nurse
8	F	20–30	2	Registered nurse
9	F	20–30	7	Registered nurse
10	F	30–40	5	Registered nurse
11	F	50–60	30	Registered nurse
12	F	>60	39	Registered nurse
13	F	50–60	17	Registered nurse
14	F	30–40	10	Registered nurse

Table 3. Thematic Analysis.

Major themes	Subthemes
Engaging in advocacy	Vulnerability/frailty Patient self-determination Raising ethical issues Nursing and team collaboration
Living an ethical problem	Referring to ethical principles Cultural aspects' influence Ensuring patients' rights
Living emotions	Nurses experience different emotions
Factors that facilitate advocacy	Interprofessional collaboration Trusting nurse-patient/family relationship
Factors that hinder advocacy	Lack of interprofessional collaboration Burden of emotions Communication among different professionals Lack of time
Advocacy's effects	On nurses On patients (from a nursing perspective)
Lack of advocacy's effects	On nurses On patients (from a nursing perspective)

advance directives, as having them implies the person's reflection on his/her own state of health and future implications.

"The self-confident patient with clear ideas, who has probably already thought about his future." (N11)

"...someone who arrives with directives, who's already thought that if something happens, he has them, so he understands the situation." (N10)

"It would be an interesting cultural transition. That's what we should come to perhaps, that we all already had consciousness." (N12)

In some cases, weak social and family situations or families' failure to accept patients' clinical condition also determined patients' vulnerability.

"On the part of the family it could be a non-acceptance of the situation, and therefore it takes behind a very important work on the understanding of the situation and of what could be put in place, considering the idea of the patient himself..." (N4)

Patient Self-Determination. The nurses believed that advocacy is necessary when patients' capacity for self-determination is not respected, when the diagnosis is kept from them at family members' request, and the right to informed consent is also lost. The participants considered it important to help patients develop

self-determination, and indicated that the lack of time to reflect and make decisions for themselves is critical.

"...a patient must be the first to be informed, even if the sons say no... she still has the power to say what to do with her own life. Two different paths would have been taken if the mother would have known about the suspected neoplasm..." (N7)

"He must be asked, he must participate in his life, he must participate in his death..." (N8)

"...the patient has to decide in a short time, but he needs to think about his situation, calmly." (N5)

Raising Ethical Issues. The nurses stated that advocacy skills must be exercised when ethical issues arise in cases of potential excessive/futile therapy where patients' will is not considered, or when patients with dementia are unable to express their wishes with respect to therapeutic decisions.

"I do not judge whether the decision is right or wrong... but I must raise the issue. If I don't take this sentence back to a physician... if all this doesn't happen, I've done my job badly..." (N12)

"In my opinion with geriatric patients it is a little more difficult if they have a cognitive disorder because they cannot express themselves. It's difficult to act on their behalf, to understand what they want and what they would like to do." (N6)

“The patient is not heard at the end.” (N7)

Nursing and Team Collaboration. Finally, the participants indicated that advocacy is a skill that must be developed at the nursing and team level.

“Theoretically it should be a team effort, all together they should act for the good of the patient, so in collaboration with the physician...” (N5)

Living an Ethical Problem

When reflecting on situations that require advocacy, nurses refer to morality, injustice and ethical principles, considering the influence of culture on these aspects and the need to ensure patients’ rights. This major theme includes themes concerning ethical aspects, preserving patient safety as well as cultural implications linked to the context in which the research was carried out.

Refer to Ethical Principles. In describing the ethical problem when advocacy is needed, the nurses referred to the ethical principles of justice, autonomy, beneficence, and non-maleficence.

“I believe that it is also a question of morality, of fighting against injustice, that is what bothers me the most. (N1)

“When I think of ethics, I think of the two principles of doing good and not harming, which seem the same but are not the same at all! In the sense of asking oneself the question: what is doing good? above all it is not harming... for some people it would seem that you are doing good, while for patients’, for them it is harm. So sometimes it’s more important not to harm people than to do them good...” (N3)

Cultural Aspects’ Influence. The focus group discussions drew attention to the fact that cultural aspects and beliefs may influence ethics, medical decisions, or families’ choices and patients’ wishes. This lays the foundation for ethical conflict attributable to diverse visions influenced by one’s own value system.

“Ethics is a very delicate subject, it is as wide as a concept... influenced by religion, beliefs...” (N3)

“The cultural aspect counts, but we must also be good not to use it as a preconception...” (N12)

Ensuring Patients’ Rights. According to the participants, patients have the right to information (informed consent) and consequently, to reflect and make decisions for themselves (self-determination). Therefore, it is important that nurses support patients’ ability to self-advocate.

“With an adult who is able to discern, the physician informs her, unless she asks them to talk to her sons because she does not want to know anything.” (N10)

“I would better explain to the patient that she has the right to assert her opinion...” (N6)

Living Emotions

In this major theme the only subject is that of experiences and emotions, aspects with important content that deserved to be highlighted and, because of their specificities, could not be integrated into other major themes.

Nurses Experience Different Emotions. It emerged that the emotions the nurses feel when faced with ethical problems are ones which create their need to advocate. Among the emotions they listed were powerlessness, frustration, anger, indecision, sadness, and discomfort. These emotions erode the nurses’ state of wellbeing to such an extent that one participant defined it as nurses’ “emotional frailty.” They described the climax of this as emotional resignation, in that protracted frustration over time leads the nurse not to defend his/her patient because it will achieve nothing.

“Emotions... a very frail part of us, are our frailty.” (N13)

“The question is direct and she (patient) expresses that she doesn’t want to suffer. When she asks the question, we are doing the opposite of what she wants, and that would make me feel uncomfortable at that moment.” (N12)

“It’s like a losing battle... so you don’t even get bitter blood anymore and throw in the towel.” (N1)

Factors That Facilitate Advocacy

The nurses identified the consideration of their opinions by other healthcare professionals, as well as the development of a common team view on care situations, in which the support of superiors and the trusting nurse-patient/family relationship play an important role, as factors which facilitate advocacy.

Interprofessional Collaboration. On the one hand, interprofessional collaboration was illustrated best in the development of a team's common vision and superiors' support, and on the other in physicians' greater consideration of nurses' opinions.

"... to confront each other, to understand that it is not just you who see it that way. So yes, it gives you more strength to support your opinion." (N5)

"The support of superiors! When there's a head nurse, for example, who holds your side, who's convinced with you, it's seen as more important." (N3)

"If there is a physician who collaborates with nurses, who also listens to our opinion, then we can achieve a common goal of defending the patient's rights." (N1)

Trusting Nurse-Patient/Family Relationship. A trusting relationship established between nurses and patients was considered fundamental, and it is the nurses' role to listen to their patients' needs and wishes so they are able to act as their advocate. Nurses consider that family members' support is a great help in advocacy and when professionals alone are unable to advocate, they help family members do so.

"We are more present with a patient and often a physician does not see what we see..." (N8)

"(suffering) Whether it is physical, psychological, precisely not knowing, when you see that the patient is suffering, he expresses it to you, because in the end, if he tells someone, more often he tells us!" (N5)

Factors That Hinder Advocacy

Participants state that the divergent view and the lack of involvement in the patient's decision-making process by the physician makes them feel that they are losing their professional autonomy, over time feeling resigned when faced with these situations. The strategy they identify is clear and transparent communication and the opportunity to confront their opinions. Nurses also consider workload as an obstacle to advocacy.

Lack of Interprofessional Collaboration. The participants identified ineffective interprofessional collaboration as a cause of divergent views between nurses and physicians in which a nurse perceives the loss of professional

autonomy and lack of involvement in patients' decision-making.

"In my opinion we are (nurses and physicians) often on different tracks, physicians have one goal and we have another one and we cannot meet each other." (N6)

"... our role has become more marginal in the interaction with the physician... so when there is something important to say, maybe you are blocked by this hierarchy and they (physicians) don't listen to you..." (N3)

"I think we're back to just following orders." (N5)

The Weight of Emotions. The feeling that the participants indicated was the most common obstacle in engaging in advocacy was emotional resignation, in that protracted frustration over time develops in countless situations in which nurses' opinions are not acknowledged and/or considered.

"But in my opinion, it is also about the frustration that you may have, that you carry with you from previous situations... you find yourself in front of a wall, you try once, you try twice, try three times, at the fourth you say enough, you don't even try because you know it is useless." (N2)

Communication Among Different Professionals. The participants' reflections revealed that they often do not know the way to raise an ethical problem and communicate it so that it will be heard. Some believed that healthcare professionals should communicate more and transparently, and compare their different opinions so they can make clinical decisions that respect patients' wishes.

"... it also depends so much on knowing how to argue" (N2)

"Communicating is the best thing... being transparent at the moment, even if not nice and pleasant, but feeling better." (N8)

"...we should be able to communicate more with each other, maybe within debriefings." (N9)

Lack of Time. The nurses believed that their increased workload and duties leave them with insufficient time to dedicate to speaking with patients; therefore, with only a superficial knowledge of them, they cannot identify their wishes.

“If we want to advocate, however, we must also have the time to do it. How can you advocate for a person if you can’t study the case, evaluate the pros and cons, talk to the patient to discuss at least with him what he wants. . . daily, we are in a hurry to finish our shift, to finish our interventions, so we have almost no more time to build relations with the patient.” (N1)

Advocacy’s Effects

From data analysis, it emerged that advocacy’s effects are related to being able to engage in advocacy and defend patients’ rights and wishes, contributing to the well-being of nurses, patients and their families.

On Nurses. The participants stated that serving as an advocate makes them feel proud and satisfied to have been able to meet their patients’ needs, giving them a feeling of serenity, wellbeing, peacefulness, and a reduced sense of frustration and helplessness. Furthermore, the focus group discussions indicated that even when they engage in advocacy without achieving their goal, they feel gratified for having advocated for patients’ rights or wishes.

“It is a matter of pride that brings value to our actions.” (N1)

“Come home in peace! I come home thinking that I did something good for that person. I’m happy.” (N7)

“Frustration no, in hindsight I did what I could, I insisted, if it didn’t work out I have a clear conscience.” (N7)

On Patients (From a Nurse’s Perspective). The participants said that advocacy leaves patients and families satisfied, as patients feel appreciated, respected, and welcome to express their needs. Further, patients feel supported in developing their self-determination, all of which help strengthen the nurse-patient relationship.

“... the situation is less tense... the situation of the patient and family is calm, more relaxed, they finally got what they wanted, and that is the greatest satisfaction...” (N3)

Effects of Lack of Advocacy

The results underline that a lack of advocacy has as much an effect on nurses and patients as its presence. In fact, participants point out that failure to engage in

advocacy causes several negative emotions among nurses, with consequences in nurse-patient relationships.

On Nurses. Failure to assume the role of advocate triggered multiple emotions in nurses that may cause emotional resignation and loss of pleasure in their work. These included discouragement, anger, remorse, frustration, a sense of helplessness, lack of motivation, dissatisfaction, a sense of futility, guilt, disappointment, resentment, and annoyance.

“Disappointment, anger, resentment, sometimes you wish, maybe when you think back to the situation, you wish you’d said something in that situation . . . and you feel resentful.” (N10)

On Patients (From Nurses’ Perspective). The nurses indicated that patients who are undefended feel frustrated, insecure, and sad because they feel misunderstood and disregarded, which makes them even more vulnerable. This leads patients to withdraw with a consequent and inevitable break in the nurse-patient relationship.

“They feel disregarded, what has been said has gone unheard.” (N7)

“It can make them sad inside, because they are poorly understood.” (N8)

Narratives’ Data Analysis

The narratives’ data analysis revealed a single theme, “Applying advocacy” with 5 subthemes. Nurses’ *moral sensitivity* emerged in all narratives, in which they identified situations that required advocacy, and in some cases, the *moral courage* that led them to defend their patients. The narratives also showed the way *superiors’ support* through listening to nurses’ opinions was crucial, while in some cases the development of a *common team view* of the problem was effective. When nurses failed to advocate because physicians did not listen to them, they felt angry, helpless, frustrated, sad, and distressed.

Discussion

Participants in this study repeatedly emphasised the importance of advocacy in professional activity and the definitions that emerged were similar to those of the International Council of Nurses, where advocacy is considered to be an integral nursing professional competence. As the nursing code of ethics states: “The nurse promotes an environment in which the human rights, values, customs, and spiritual beliefs of the individual,

family and community are respected . . . and ensures that the individual receives accurate, sufficient, and timely information in a culturally appropriate manner on which to base consent for care and related treatment” (International Council of Nurses, 2012). An aspect considered important is the respect of the patient’s perspective related to self-determination helps in laying the foundations for developing a relationship with the person. Arcadi and Ventimiglia (2017) stated that in the nurse/patient relationship, it is impossible to guarantee a positive outcome in the absence of a relationship based on trust. The participants believe that the relationship of trust is fostered by the time spent in contact with the patient. Indeed, proximity promotes professional intimacy, as a component of the therapeutic nurse-patient relationship which encourages closeness, self-disclosure, reciprocity and trust through emotional and/or physical forms (Antonytheva et al., 2021). Both MacDonald (2007), who examined the nature of the relationships between nurses and patients and their significant role in influencing the engagement in advocacy, and Foley et al. (2000), who considered the relationship of proximity, considered the time the nurse spends in contact with patients. The participants believed that the time spent interacting with patients is essential to become familiar with their needs and wishes, as well as their role as a reference during the hospital stay, as highlighted also by Koloroutis and Willems Cavalli (2008, p. 125). The nurses considered building relationships with both patients and their families a factor favourable to advocacy as it is the family who supports the nurse in advocating when their joint visions of the clinical proceedings overlap. The participants’ experiences showed that in cases in which they failed to advocate, they helped and encouraged patients and families to develop this ability nonetheless, while respecting the principle of patients’ autonomy. Indeed, the nurse-patient relationship is a “story of health enhancement” that requires active participation and commitment from both nurses and patients, that strengthens not only health but also the patient’s own resources for health and well-being (Strandås & Bondas, 2018). The effects on nurses and patients of assuming the role of advocate, and respectively, not doing so, were analysed thoroughly from a nursing perspective. Being able to engage in advocacy generated a sense of pride, serenity, wellbeing, tranquillity, and satisfaction in the participants because they had been able to satisfy patients’ needs. It was also found that engaging in advocacy even without achieving the goal leads to gratification for having defended the patients’ rights or wishes. On the other hand, not engaging in advocacy causes them to experience depression, anger, remorse, frustration, a sense of helplessness, lack of motivation, dissatisfaction, sense of futility, guilt, disappointment, resentment, and annoyance that could

lead to emotional resignation and the loss of pleasure in their work. Such emotions eroded the nurses’ well-being, which one participant described as “emotional frailty”. This emotional state could lead to psychological disequilibrium and emotional exhaustion, as pointed out by Corley (2002) and Oh and Gastmans (2015). With respect to patients, the participants stated that engaging in advocacy leads to patient and family satisfaction, as patients feel justified, respected, appreciated, and supported in developing self-determination, as pointed out also by Baldwin (2003), all of which strengthen the nurse-patient relationship. Another important aspect is related to not being able to advocate, and patients who are undefended feel frustrated, insecure, and sad because they feel misunderstood and disregarded, which makes them even more vulnerable. This leads patients to shut down, with a consequent and inevitable breakdown in the nurse-patient relationship.

The participants identified the characteristics of patients who need to be defended and the situations in which advocacy is required. These characteristics included their state of frailty/vulnerability, defined as manifest suffering attributable to hospitalization (Arcadi & Ventimiglia, 2017; Baldwin, 2003). This concept of vulnerability is broadened in the mind of the nurse as both the patients’ and families’ caregiver, as they may also present with socially frail conditions. The increased life expectancy and aging population confront us with situations in which caregivers themselves are older, or in which patients are even another older person’s primary caregiver. These family social dynamics, characterized by significant frailty, prompt families to adopt a protective perspective toward their loved ones, such that they request that patients not be informed of their diagnosis to prevent additional emotional distress. In these situations, nurses feel they need to advocate for patients’ rights to informed consent and help them develop the capacity for self-determination, while respecting their right to freedom of choice, as legislation dictates (Ufficio federale della sanità pubblica, 2020). In this study participants also believed that having advance directives could decrease such situations, as decisions would be based on the wishes patients expressed when they were able to discern and during which they had the opportunity to reflect on their own state of health and future developments in their life. Current legislation, Article 377 of the Swiss Civil Code, confirms this aspect with respect to patients who are incapable of discernment (Il Consiglio federale, 2020). This assumption stems from the urgency the nurses highlighted, who argued that patients may not have time to reflect on the decision they need to make when diagnosed. In this respect, the nurses believed that if the population were aware of their serious implications and developed advance directives, it would represent an important

cultural change. In this study nurses consider that cultural aspects, such as religion and beliefs, influence patients', families and healthcare professionals' views on a clinical situation. This makes sense in a national context that has four national languages, sees increased plurilingualism due to immigration from European and non-European countries and also reflects increased religious diversity (Ufficio federale di statistica, 2016). The participants consider cultural aspects important and believe decisions should be made according to patients' own value systems. Indeed, de Vries et al. (2019) support this assumption, arguing that cultural aspects such as ethnicity, religiosity, and spirituality, as well as the level of health literacy, influence people's choices greatly when they draw up plans, which consist not only of advance directives on resuscitation, but also of wishes during the end-of-life phase. In this respect, according to Killackey et al. (2020), an Advanced Care Plan (ACP) should be implemented as a continuous process of exploring values and goals and should involve the input of patients, family members, and a variety of healthcare providers. However, in this study the origin of an ethical problem was linked to the divergent views among nurses, other healthcare professionals and patients' families, which lays the foundation for a reflection on the problem's multidisciplinary nature, which will require an interprofessional approach to be resolved successfully, as highlighted by Woods (2014) and Tracy and O'Grady (2019, p. 313). Nurses supported this approach strongly, and identified advocacy as the responsibility of the nursing and multidisciplinary team through active involvement of patients and families. Therefore, it is necessary for nurses, physicians, and families to share their perspectives by involving patients actively in decision-making, as indicated in PNR research's recommendation no. 3 on shared decision making (Leitungsgruppe des NFP 67 Lebensende & Schweizerischer Nationalfonds zur Förderung der Wissenschaftlichen Forschung, 2017, p. 51).

Participants believed that advocacy skills are required when ethical issues are raised, i.e., in cases of patients' unmet or disregarded needs, as pointed out also by Josse-Eklund et al. (2014), of possible excessive/futile therapy with respect to patients expressed will, or in the case of patients with dementia who are unable to express their own will regarding therapeutic decisions. By raising ethical issues and bringing the wishes patients expressed to the caregivers and families' attention, nurses play the role of mediator, as they serve as those who defend the rights and wishes patients expressed and thus, play an active role in their decision-making (Baldwin, 2003; Tiscar-Gonzalez et al., 2020).

This research studied the origin of the ethical problem the participants described as the diverging views between nurses and physicians, as highlighted also by Tracy and

O'Grady (2019, p. 313), or between nurses and patients' families on the basis of decisions for clinical proceedings. These divergent perspectives and decisions cause nurses to experience varied emotions that determine their perception of the need to advocate for their patients. The participants identified the problem causing these emotions, which they described in terms of justice, disrespect for patients' autonomy in making decisions, and whether the care undertaken was necessary and good for the person assisted, or posed a risk of engaging in excessive/futile therapy; thus, the nurses tended to describe the problem from Beauchamp and Childress' theoretical perspective on ethical principles (Johnstone, 2016, p. 36). It has also emerged that it is important for nurses to be able to ensure patients' rights and respect their wishes, even if those may conflict with the nurses' value system.

Participants identified the nursing team's development of a common vision of the problem and superiors' active support in engaging in advocacy as factors favourable to advocacy, as suggested also by Abbasinia et al. (2020), superiors and colleagues' support makes nurses feel more confident in defending patients' wishes before other healthcare professionals or families. As a result, nurses' need for interprofessional collaboration emerged, where a nurse's opinion is considered to a greater extent so they can play an active role in patients' decision-making process. Indeed, health professionals' collaboration is essential, because no single health professional can meet all patients' needs (Matziou et al., 2014). The failure to consider nurses' perspectives not only fails to promote interprofessional collaboration, but also causes nurses to perceive the loss of professional autonomy, to feel belittled continuously as a professional, and frustrated. The findings revealed that protracted frustration leads to emotional resignation, which causes nurses to lose their motivation to engage in advocacy. The participants had the opportunity to reflect on this obstacle, and identified their difficulty in communicating ethical issues that physicians or patients' families need to consider. Indeed, Eriksson et al. (2014) pointed out that the decision-making problem is based on communication barriers.

In this study, nurses perceive that the increased workload in the hospital prevents them from spending enough time with patients, which is perceived as an obstacle to advocacy, as found also by Dadzie et al. (2017). Recently it was highlighted that communication and information sharing, care planning, discharge planning and decision, emotional and psychological care including spiritual support are all among the categories of care which nurses missed; factors associated with missed care were related to staffing levels and/or labor resources skill mix, material resources not being available, patient acuity and teamwork/communication (Chaboyer et al., 2021). The perception of workload as an obstacle to advocacy

is the basis for a reflection and further research on why this happens, on the challenges faced in managing hospital activities and on the nursing skills that need to be developed, considering that according to Eriksson et al. (2014) the time limitation is also a reason for the lack of discussion of deeper ethical dilemmas, daily experienced thoughts, and evaluations.

The data collected in our research confirmed the presence of situations in which nurses are confronted with ethical problems related to patients' end-of-life decision making. This is supported by the findings of a national research programme that investigated end-of-life, and found that in one in four cases in Switzerland, the physician did not talk to patients about the end-of-life decision, although they were still able to discern it. In half of these cases, physicians consulted the family or were aware of the person's wishes regarding the end of life (Leitungsgruppe des NFP 67 Lebensende & Schweizerischer Nationalfonds zur Förderung der Wissenschaftlichen Forschung, 2017, p. 21). Respecting a dying person's dignity means respecting his/her freedom and self-determination and protecting the lives of particularly vulnerable people (Leitungsgruppe des NFP 67 Lebensende & Schweizerischer Nationalfonds zur Förderung der Wissenschaftlichen Forschung, 2017, p. 11). Therefore, it is an element of dignity to allow patients capable of discernment to choose freely to determine their circumstances in the final phase of their lives. With regard to this aspect, the participants believe that it is necessary to act to defend patients' rights and wills through advocacy, even if they encounter difficulties in assuming this role.

In light of the connotation that the concept of advocacy takes on in the studied context, it is essential to develop a plan of interventions on the basis of the needs that emerged, which will allow the development of awareness, knowledge and advocacy skills. To reduce the emotional distress associated with living and coping with an ethical conflict, strategies like daily debriefings and consultations with a psychologist about the complexity of relationships with older patients and their families could be implemented (Choe et al., 2018; Dufrene & Young, 2014; Pileggi et al., 2014). According to Helmers et al. (2020) and Stolt et al. (2018), educational interventions are those used most in the development of ethical reflections in clinical practice, and these could address the needs that emerged from the participants of this study, regarding their knowledge about ethics and current legislation related to the care of older hospitalized patients. Furthermore, the nurses' narratives of their experiences allowed for a focussed reflection and analysis, and lead the basis for increasing awareness and knowledge on the topic, as supported by Foley et al. (2002) and Woods (2012).

Nurses consider family conferences to be privileged moments in which they can bring the wishes their patients have expressed to the physicians and the family's attention and, as outlined by Tiscar-Gonzalez et al. (2020), by means of a dialogue that highlights the responsibilities of each. Bianchi et al. (2019) pointed out that the achievement of interprofessional collaboration is highly desirable, as it is a resource not only for patients, but also for professionals, which can increase their professional satisfaction and skills attributable to exchanging views with other professionals. Further, the participants considered the hospital ethics committee's support crucial in the face of ethical dilemmas.

Strengths and Limitations

This research facilitated an awareness and deeper knowledge of the issue and highlighted nurses' need to engage in advocacy in a hospital context, in order to promote patients' satisfaction and safety with full respect of their values, wills, and rights. The study was conducted in a single ward of a regional hospital. Hence, future research that investigates the perspectives of nurses in more departments and hospitals in this context, and includes those of physicians, patients, and their families, would be interesting and useful. Further, as this was a qualitative study, the results can be generalised only to similar experiences in similar contexts. In order to ensure the validity and significance of the findings, the researcher adopted strategies of data triangulation. Furthermore, considering the saturation of data achieved and that the results of this research are consistent with previous literature in nursing (Abbasinia et al., 2020; Arcadi & Ventimiglia, 2017), the findings may be considered relevant also in other contexts.

Conclusions

A strong level of moral sensitivity on the part of nurses faced with ethical problems in the care of older patients approaching the end-of-life emerged from this study, as their narratives told of situations in which it was necessary and appropriate for them to intervene as patients' advocates. Sometimes moral courage was used, to raise the ethical problem and bring it to other professionals' attention or make families aware of the wishes patients expressed. Therefore, it is essential for nurses to be aware of their personal level of moral sensitivity to allow them to develop a plan of measures to regain their moral courage to engage in advocacy. Thus, interprofessional ethical leadership that inspires and supports healthcare professionals' daily work and lays the foundations for ethical decision making through patients and families' active involvement is necessary. This consideration underlines the need for the development of educational

and managerial strategies, by introducing the nurses to different moral theories and ethical decision-making procedures in a context supported by values where nurses' leaders can increase the involvement of nurses through a transformational leadership style, in order to support patient advocacy and improve the quality of care (Goethals et al., 2010; Johnstone, 2016, p. 121). After an in-depth reflection on these aspects, a replication of this study is recommended, including multiple acute care settings admitting older adults in several study centres, in order to obtain a deeper understanding of the concept and to identify the most effective strategies in promoting ethical decision making in healthcare.

Implications for Nursing/Clinical Practice

Understanding the importance of advocacy and being aware that it is a responsibility of the nursing profession is extremely helpful for nurses and nursing leaders. Some of the concrete ways of ensuring that nurses' advocacy for older adult patients is always supported and encouraged in the health organizations are to sustain an ethical leadership among nursing leaders and cultivate moral sensitivity. Educational strategies on ethics, assertive communication and promotion of ethical decision-making models are essential in the healthcare setting. Starting from this, nursing leaders should be careful to ensure that the conditions are in place to express advocacy in clinical care settings.

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ORCID iDs

Corina Elena Luca  <https://orcid.org/0000-0002-8004-4550>
Monica Bianchi  <https://orcid.org/0000-0001-6927-4622>

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