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Review Article

Existential Advocacy in Nursing Care: A Concept Analysis

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As modern nursing advances at an astounding rate, existential advocacy (EA) is vital for delivering patient care in line with wellness goals and personal values. This concept analysis aims to define EA within the context of nursing and align the concept with Jean Watson's Unitary Caring Science (UCS) and her 10 Caritas Processes. A comprehensive literature search identified 12 relevant publications from the following databases: PubMed, PsycINFO, Google Scholar, and CINAHL. Subsequently, utilizing Walker and Avant's method for concept analysis, a standardized structure to identify EA's defining attributes, antecedents, consequences, and empirical referents emerged. Antecedents for EA are patient vulnerability, nurse-patient rapport, nurse autonomy to act as an advocate, and patient request for advocacy. Defining attributes of EA include the following: supporting patient self-determination, caring-trusting nurse-patient relationship, promoting individualized meaning of health and wellness, and encouraging values-based problem-solving. The optimal consequence of EA is patients' awareness of their current health status, leading to individualized care and decision-making based on a patient's values. EA is a nurse's effort to support and promote their patients' right to self-determination by helping them discern their holistic health and wellness situation and then clarify their values within that reality. Watson's UCS and 10 Caritas Processes align with EA to facilitate nurse-patient transpersonal caring occasions. EA explicates the care and advocacy nurses provide into a defined concept while highlighting nurses' essential role in patients' physical, emotional, and spiritual well-being. With EA better defined, the concept can be assessed, measured, and implemented within the discipline of nursing.

1. Introduction

Today's constantly innovating and fast-paced healthcare environment makes patient communication surrounding healthcare goals and values more important than ever [1, 2]. While research on nurse advocacy is prolific, existential advocacy (EA) lacks a comprehensive definition relevant to modern nursing that distinguishes it from other forms of nurse advocacy [3, 4]. Jean Watson's Unitary Caring Science (UCS) falls within a unitary transformative worldview that recognizes the interconnectedness of all things, including people, their environments, and the constantly evolving universe [5–7]. Throughout every iteration of Watson's caring philosophy, she maintains nursing's need to recognize "human caring as an end in and of itself, not just a means to a medical-cure end," which provides a solid theoretical basis for EA ([5], p. 7). Therefore, this concept analysis aims to (a) clearly define the concept of EA within the context of nursing and (b) align EA within UCS and the 10 Caritas Processes.

2. Background

Existing concept analyses focus on broader conceptualizations of nurse advocacy promoting ethical actions, where nurses ensure that medical decisions are congruent with their patient's wishes [8–10]. Professional codes of ethics for most nursing organizations already integrate nurse advocacy (American Nurses Association (ANA), International Council of Nurses, Nursing and Midwifery Council, and Japanese Nursing Association) [10]. For example, the ANA specifically addresses advocacy in the context of protecting patients' rights to privacy, participation in research, ensuring high-performance standards, promoting cultural

safety, reporting questionable practices, and reporting impaired practice [11]. However, no professional nursing organization currently references EA as a valuable method of patient advocacy.

Sally Gadow introduced the concept of EA in 1980 and emphasized how nurses were uniquely suited to fill the role of an existential advocate [3]. Nursing is poised to fill this role because it is simultaneously concerned with caring, health, and wellness, provides intimate physical and emotional support to patients, and is a relative constant in the ever-changing patient environment [3, 12, 13]. Furthermore, a better understanding of the nurse's EA role supports patients' individualized healthcare needs, thereby supporting patients' self-determination. Therefore, clearly defining EA and encouraging broader dissemination of the concept can positively influence patient outcomes and satisfaction with care. Fostering open and informed patient advocacy requires nurses to assess their role as advocates to ensure that patients are not only getting the care they need but also understand the care they want [14].

Professor of Law John Bliss recently utilized the term existential advocacy within the context of "social-change lawyering" ([15], p. 1). While Bliss explores existential advocacy, his concept differs fundamentally from existential advocacy in nursing contexts. Bliss focuses on mitigating civilizational threats to humanity's collective future [15]. Nursing deals with individual patients making personal care decisions based on their values. The scope and stakes diverge dramatically—the fate of humanity versus a patient defining their own good. In addition, Bliss envisions advocates selecting goals objectively for the greatest societal benefit [15]. Nursing embraces patients' subjective definition of "good" based on personal preferences. Therefore, while "existential advocacy" appears in both contexts, Bliss's theoretical framework concentrates on broad existential risks and does not align with patient-centered nursing approaches.

UCS's emphasis on a moral-ethical worldview focusing on sustaining human dignity, wholeness, caring, and connectedness makes it an applicable theoretical basis for providing EA in nursing care [5, 13, 16, 17]. Furthermore, UCS's conceptualization of authentic presence and transpersonal caring occasions adds needed nursing perspectives to EA. Being *authentically present* refers to a nurse's complete and genuine focus on the patient's whole self, including subjective, objective, reflective, aesthetic, ethical, and spiritual ways of knowing [5, 16]. A nurse's authentic and caring presence invites an expanded understanding of the patient's well-being in their health and wellness journey. Watson's 10 Caritas Processes align with EA and share the fundamental assumption that interpersonal relationships between nurses and patients develop and are integral to holistic patient-centered healthcare decisions [12, 18].

3. Methods

3.1. Search Strategy and Selection Criteria. A comprehensive literature search was conducted in March of 2022 and updated in October of 2023 using PubMed, PsychINFO, Google Scholar, and CINAHL databases from the years 1975 to 2023. Employed keywords were selected based on pertinence to the research topic rather than mesh terms, and as the latter yielded excessive, irrelevant results lack the necessary specificity. Targeted keywords (*patient advocacy, nurse advocacy, existentialism, existential advocacy, nursing, and Sally Gadow*) connected by Boolean operators generated more focused results addressing EA. Inclusion criteria comprised publications addressing existential advocacy, applying existential advocacy within nursing, written in English, and full-text availability. Excluded were unpublished dissertations. This step-wise search of scientific literature identified definitions, antecedents, attributes, consequences, and empirical referents for EA (Figure 1) [19].

Database search results yielded 57 articles. After removing duplicate articles and reviewing the initial title and abstract, 26 articles remained eligible for full-text review. During the full-text review, 19 publications lacked inclusion criteria for EA, while five additional articles were identified for inclusion from reference reviews. Subsequently, 12 articles remained applicable for inclusion in this concept analysis.

3.2. Data Analysis. A concept analysis examines a specific concept of interest for clarity, depth of understanding, and applicability while providing foundational knowledge for theory development [20, 21]. Concept analyses must be rigorous and precise. However, results are inherently tentative because science, nursing, and general knowledge continuously change [21]. Walker and Avant's concept analysis methods provided a standardized structure and approach to identify EA's defining attributes, antecedents, consequences, and empirical referents [21]. The literature analysis consisted of an iterative reading and rereading of all included EA publications. Subsequently, a crosswalk analysis connected EA with UCS and the 10 Caritas Processes.

4. Results

4.1. Definitions. There is no dictionary definition for EA. However, analysis of existential and advocacy independently contributes to a fuller understanding of the concept. Merriam–Webster defines *existential* as *assertive either explicitly or by implication of existence or actuality as opposed to a mere possibility, conceivability, or ideality* [22]. *Advocacy's* definition is the *act of pleading for the cause of another and supporting or promoting the interests of another* [22]. Combining these terms into EA intersects their meanings and differentiates EA as a concept with its own unique definition.

Gadow's original definition states that EA is "the effort to help persons become clear about what they want to do by helping them discern and clarify their values in the situation" ([3], p. 44). While authors frequently quote Gadow's definitions verbatim, her work lacks modern vernacular and does not address all of the valid critiques of EA over the last 40 years. The 12 articles included in this concept analysis add additional context to EA and contain four qualitative studies

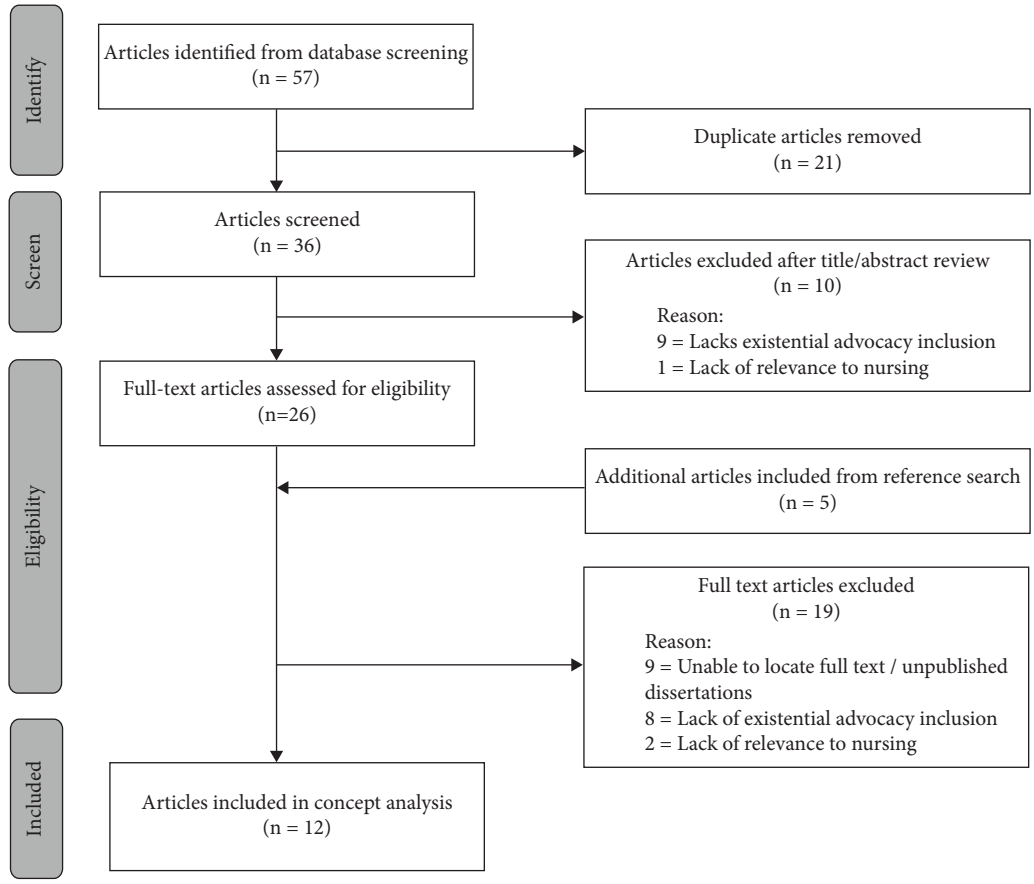

Figure 1: Data selection flowchart depicting the article selection process.

[23–26], five conceptual model/framework developments [3, 14, 27–29], and three literature reviews with author perspectives (Table 1) [30–32]. Considering Gadow's original EA definition along with a thorough literature review, the definition of EA for this concept analysis is *the nurses' efforts to support and promote their patients' right to self-determination by helping them discern their holistic health and wellness situation and then clarify their values within that reality.*

4.2. Defining Attributes. Defining attributes of concept analyses are the primary characteristics that encompass the concept. [21] These primary characteristics help to differentiate EA from related forms of nurse advocacy. The analysis of findings from the literature established the following defining attributes for EA: supporting patient self-determination, caring-trusting nurse-patient relationship, promoting individualized meaning of health and wellness, and encouraging values-based problem-solving.

4.2.1. Supporting Patient Self-Determination. A central element of EA is that freedom of self-determination is the most fundamental and valuable human right [3, 4, 23, 25, 29]. The right to self-determination includes the patient's right to define an individualized meaning of wellness and then have the autonomy to act on that knowledge [23, 24]. When care is provided in a patient's *best interest*, self-determination dictates that the patient, not the clinician, determines what best interests mean to the patient. Within the concept of EA, the nurse's role is to support their patient's self-determination through care, education, and reflection. Furthermore, by supporting the patient's self-determination, nurses inherently protect them from paternalistic coercion by the healthcare system. This coercion may be well-intentioned, though simultaneously contrary to the patient's wishes [3]. Therefore, nurses can only provide EA if they acknowledge their patient's right to self-determination as a fundamental right that cannot be violated even for perceived improved health outcomes [3].

4.2.2. Caring-Trusting Nurse-Patient Relationship. Existential advocacy develops within a caring-trusting nurse-patient relationship [24, 30]. This caring-trusting relationship involves developing mutual respect for a patient's values and unbiased responsiveness to another's needs as defined by the other [23, 29]. Therefore, EA requires mutuality within the caring-trusting nurse-patient relationship [26] where "the interpersonal context for care evolves as a creation of both patient and nurse in partnership with one another, whole person with whole person" ([25], p. 93). Within a caring-trusting relationship, nurses authentically listen to the patients without judgment while intending to understand their unique perspectives

Table 1: Existential advocacy literature matrix.

Title	Antecedents	Attributes	Consequences
Healing during existential moments: the "art" of nursing presence [14]	Nursing presence Nurse's self-awareness, openness, flexibility, and willingness to embrace another's situation Nurse's moral courage	Intersubjective nurse-patient relationship Therapeutic relationships	Personal and professional satisfaction Increase patient satisfaction Holistic care
A pluralist view of nursing ethics [30]	Ethical dilemma	Ethical practice grounded in relationships Determine patient's unique meaning of health, illness, suffering, or dying	Scope of EA may not be fully inclusive; therefore, patient ethical issues may not be fully addressed
Clinical epistemology: a dialectic of nursing assessment [27]	Vulnerability Disengagement from subjectivity Reduction-search for the "real" thing	Holism Engagement	Revising a situation of vulnerability into one of safety Relational narrative encompasses the particular and general nature of the patient's situation
Relational narrative: the postmodern turn in nursing ethics [28]	Subjective immersion Objective detachment	Attentive discernment and valuing of an individual as unique Care, respect, and personal responsiveness to the particular other	Lack of meaninglessness Relational narrative persons can coauthor an interpretation that may be more inhabitable than either of their individual narratives as they seek a new form of the good
Existential advocacy: philosophical foundations of nursing [3]	Sustained patient contact Participation of the advocate as a unified individual Fellow-feeling: feeling the others' feelings not just knowing it, nor judging that the other has it	Patient self-determination Holistic nurse engagement Clarification of patient values Nurse mediates lived/object body duality	Patient self-unity = lived body + object body Authentic decisions: decisions that are indeed one's own express all that one believes critically about oneself and the world, and the entire complexity of one's values Lived objectness: nurses can assist the patient in recovering the objectified body at a new level
Nurses practice beyond simple advocacy to engage in relational narratives [31]	Nurse's respect for patients' unique experiences Nurse self-awareness Respect for others requires that one tries to understand what it is for the other to live the life they live	Relational narratives allow persons to know the good they seek through their own accounts	Reaffirmation of personal values Awareness and exercise of the value of respect
Gadow's contribution to our philosophical interpretation of nursing [4]	Patient self-determination Patient request for advocacy Physical patient need or vulnerability	Intersubjective nurse relationship Mutual person-to-person relationships	Patient self-direction Determination of patients' unique meaning which the experience of health, illness, suffering, or dying is to have for that individual Nursing truth: a truth that is born anew by the patient and professional together in each situation

Table 1: Continued.

Title	Antecedents	Attributes	Consequences
Living as an oldest old in Rio de Janeiro: the lived experience told [23]	Patient as a unique human being	Patient self-determination Broad definition of autonomy: individuals may be dependent in one area while independent in others Holistic care Intersubjectivity between nurse and patient	The patient determines meaning that guides self-determination Existential care: the person providing care understands other persons' subjective worlds and experiences union with them, such that the singularity of each of them emerges
The role of advocacy in critical care nursing: a caring response to another [24]	Nurse's moral alignment with the patient rather than the physician, next of kin, or hospital Nurse's courage Nurse's cultural competence Nurse's moral autonomy Trusting environment	Caring relationship: the nurse meets the private person behind the patient's role Empowerment: educating with help and encouragement Make room for interconnection to inform, translate, communicate, and collaborate	Ethical care
Existential caring in the family's health experience: a proposed conceptualization [29]	Nurse-patient trust, fidelity, and sensitivity Patient vulnerability Sense of professional obligation Nurse confidence	Open-minded responsiveness to another's needs as defined by the other The ideal nature and purpose of the patient-nurse relationship guide caring Mutual interdependence in relationships Self-determination	Nurse's understanding of the family's perspective enhances the context for moral agency Ethical care
Actualizing Gadow's moral framework for nursing through research [25]	Patients and nurses freely decide the nature of their relationship Interpersonal care	Protect patient self-determination Enhance patient subjectivity through advocacy Regarding the patient as a subject rather than as an object	Patients feel autonomous motivation when practitioners bring more of their whole selves, interpersonal sensitivity, and respect for their patients Failure to honor patients' self-determination led patients to feel practitioners had an "agenda" about smoking
Snapshots of experience: vignettes from a nursing home [26]	Nurse-patient relationship: the nurse must know the patient as a person	Relational care Individualized care Transpersonal nurse-patient relationship Authenticity	Nurse-patient mutuality Covenantal relationship (spontaneous and developed out of the process of the relationship, each relationship being different)

[7, 14, 29]. Supportive nurse-patient relationships include empathy, caring, holistic care, and attentiveness. However, these terms alone do not fully capture the therapeutic relationship that often forms between the nurse and the patient [14]. Caring-trusting nurse-patient relationships based upon mutual respect can increase relational empathy, thereby increasing a patient's self-expression, autonomous choices, and, ultimately, self-determination [31].

4.2.3. Promoting Individualized Meaning of Health and Wellness. When engaged in EA, nurses promote an individualized meaning of health, wellness, illness, suffering, and dying for their patients [3, 30]. An individualized meaning of health considers the patient's physical, mental, and spiritual needs to provide holistic care. Contrarily, reducing a patient's body to an object diminishes the comfort and care provided for their mental and spiritual well-being [3, 33]. For example, when providing a bed bath, the nurse as an existential advocate fully engages with their patient, asking if anything hurts, is uncomfortable, or needs further attention while conscientiously providing the intimate care their patient previously did for themselves. In school, nursing students are extensively trained to complete comprehensive patient assessments, while less emphasis is placed on establishing relationships where nurses come to know a patient's value system [34, 35]. However, "practicing nurses must work at resisting the temptation to assign themes, categories, metaphors, models, or theories to unique individuals" because assigning universalities before developing a caring relationship superimposes an inaccurate mental model of the patient and their human experience [26]. Caldas and Berterö, who explored the lived experience of the "oldest old in Rio de Janeiro" using EA as a philosophical framework, eloquently stated the following.

> The elderly, in essence, already embody the human meaning of their experience, and it is nurses' privilege and challenge to assist them to regard their bodies in such a way that these meanings are not buried under clinical interpretations, but are allowed to emerge and to develop ([23], p. 376).

The patient's *best interest* is determined by the patient. However, for patients to authentically exercise self-determination, they may need support in understanding their health situation, clarifying their values within that reality, and an advocate to express the complexity of those values within the healthcare environment [25, 31]. Furthermore, promoting a patient-centric meaning of health and wellness will not always be straightforward. An individual's meaning of wellness is complex and changes as meaning emerges. However, encouraging patients to form their individualized meaning of health and wellness incorporates, not ignores, seemingly opposing elements for health, wellness, and quality of life to create a unified whole [27].

4.2.4. Encouraging Values-Based Problem-Solving. Encouraging a patient's values-based problem-solving is the final defining attribute of EA. Once patients have established their preferred involvement in the healthcare process and understand their individualized health and wellness values, they can problem-solve their health concerns with ongoing support from their nurse and healthcare team [3, 24]. EA is grounded in nurses' understanding of a patient's perspectives by *being with* their patients, not solely *doing for* them [29]. Furthermore, EA is distinct from other forms of advocacy that promote what a patient should want to do and instead help patients clarify what they want based on their values [4]. Values-based problem-solving results in patients' self-determination through authentic decision-making based on patients' values and healthcare goals [3]. Therefore, values-based problem-solving is essential to EA and individualized nursing care.

4.3. Antecedents. Antecedents precede defining attributes and must all be present for the concept to be actualized [21]. Examination of the literature identified patient vulnerability, nurse-patient rapport, nurse autonomy to act as an advocate, and request for advocacy as antecedents to EA.

4.3.1. Patient Vulnerability. While all patients should receive care and support from their nurse, not all require EA. Therefore, patient vulnerability must occur for a patient to need EA. For example, some patients come into the healthcare environment with clear and established wellness goals communicated accurately and effectively to their healthcare team [4]. Conversely, many patients and their families enter the healthcare environment for the first time, entirely mentally and physically overwhelmed, having never envisioned themselves in such a vulnerable physical and emotional state [4, 29, 30]. While a caring-trusting nurse-patient relationship hopefully develops in all scenarios, EA may only be needed in the latter scenario [4].

4.3.2. Nurse-Patient Rapport. Nurse-patient rapport is a precursor to a caring-trusting nurse-patient relationship. "Effective nurse-patient interaction is easier for some nurses than others because of different personalities, education, beliefs, self-awareness, and communication styles" ([14], p. 449). Nurses are usually assigned to their patients; therefore, personalities, communication styles, and cultural beliefs and practices may not innately align. Thus, establishing the relationship needed for EA may be challenging without nurse-patient rapport [4, 14].

4.3.3. Nurse Autonomy to Act as Advocate. For a nurse to provide EA, they must have the autonomy to act as an advocate. Autonomy is the nurses' ability to work independently to provide the support, education, and care patients need. Nurses cannot have this autonomy if they do not have the time, resources, skills, and confidence to provide EA [3, 4, 29, 31]. Unfortunately, nurses often have multiple patients and demanding schedules that preclude them from the autonomy needed to provide EA.

4.3.4. Request for Advocacy. Lastly, Bishop and Scudder note that providing EA without patient permission intrinsically removes the patient's right to self-determination [4].

Therefore, the patient must explicitly or implicitly ask for help or support. Requesting EA can take a variety of forms. While the request can be a straightforward appeal for help, it can also be the patient expressing confusion, the nurse offering clarification, the nurse asking permission to write the patients' health goals on their whiteboard, or many other possibilities. There is no prescribed way a patient must ask for EA because no two patients are identical. However, there are many ways a nurse, seeing a patient's needs, can obtain permission to provide EA. Therefore, nurses must have an awareness of the patient's holistic needs along with the autonomy for advocacy.

4.4. Consequences. Consequences within a concept analysis are the positive or negative implications of the concept [21]. This analysis identified the following positive consequences of EA: patient awareness of their current health status [4, 23, 27–29], individualized care based on patient values [14, 23, 24, 29], and mutuality between patients and healthcare providers [4, 23, 25, 26, 31]. Possible adverse consequences include a paternalistic system of healthcare persuading patients toward divergent health goals [25], and patients regret regarding their decisions [4, 30]. Patients' health status and lives are in constant flux. Therefore, the concept of EA is not unidirectional. Furthermore, while patients' stories are valuable sources of information for individualized values-based problem-solving, new events, stories, and values will likely develop ([26], p. 122). Therefore, the conceptual model for EA is ongoing and cyclical, with the consequences often circling back to antecedents (Figure 2).

4.5. Empirical Referents. Empirical referents are observable and measurable behaviors related to a concept's defining attributes [21]. Linking EA with measurable outcomes allows for the tangible clinical application of EA in nursing practice. EA's empirical referents include self-determination, nurse-patient relationship, individualized meaning of health and wellness, and values-based problem-solving. While no independent tool measures EA, several scales measure its defining attributes. For example, *supporting patient self-determination* has several applicable self-determination scales, including Self-Determination Inventory [36], Arc's Self-Determination Scale [37], and American Institutes for Research Self-Determination Scale [38]. Empirical referents measuring *caring-trusting nurse-patient relationships* include the following: Nurse-Patient Bonding Instrument [39], Holistic Nursing Competence Scale [40], and Holistic Caring Inventory [41]. Measuring patients' *individualized meanings of health and wellness* contains scales measuring health, wellness, and meaning in illness: Steger's Meaning of Life Questionnaire [42], Perceived Wellness Survey [43], Health and Wellness Assessment [44], and Wellness Evaluation of Lifestyle [45]. Lastly, *values-based problem-solving* has no clearly defined measurement scale. However, Arc's Self-Determination Scale [37] and the Patient-Reported Outcomes Measurement Information System [46] include value assessments for health, psychological empowerment, and self-realization.

4.6. Cases. The following model case describes an ideal scenario that demonstrates all of the defining attributes of EA [21]. The subsequent alternate case exemplifies how a well-intentioned nurse may fail to provide EA. Superscripts are used to clarify the antecedents^{AN}, defining attributes^{DA}, and consequences^{CO}.

4.6.1. Model Case: Gentry. Louis is a 69-year-old warehouse manager recently admitted to the hospital for an ischemic stroke. The stroke left Louis with mild dysarthria (difficulty with speech) and flaccidity on the right side with no movement or feeling^{AN}. Louis was stable enough to be moved from the intensive care unit (ICU) to the neuroscience unit. Gentry, a registered nurse, was assigned to Louis following the transfer.

Gentry introduced herself to Louis and his family, took reports from the ICU nurse at Louis's bedside, and oriented everyone to the new unit. When the ICU nurse said goodbye to Louis, she said, "now is when you get to work on getting back to your old self!" in a genuine, kind, and optimistic tone. Later, Gentry questioned the ICU nurse regarding if the doctors thought Louis would regain full functioning^{AN}. The ICU nurse clarified that the doctors believed Louis's functioning would only improve slightly with time and rehabilitation. In addition, the ICU nurse explained that Louis had been depressed since his stroke^{AN}, so they were being overly optimistic to help him stay motivated for physical therapy.

While assessing, Gentry asked permission before touching Louis and was kind, gentle, and confident^{AN}. Gentry made a point to address any immediate physical and emotional concerns. Louis felt at ease with Gentry because she explained everything, was considerate, and always followed through with her care promises^{AN}. After providing care for Louis over several shifts, Gentry realized that his understanding of his long-term therapeutic outcomes was lacking. Gentry noted gaps in Louis's knowledge and comprehension that needed to be addressed to improve the quality of care she provided^{DA}. Louis was talking much better but had not regained any movement on his right side and admitted still feeling depressed^{DA}. Gentry always asked permission to write her patients' daily and long-term goals on their whiteboards^{DA}. When Gentry asked Louis about his long-term recovery goals, he asked her to write, "Go home and see my grandkids, get enough strength to walk again, and go back to work^{CO}." Gentry was concerned that the medical system was doing a disservice to Louis and his family by being overly enthusiastic about his recovery and addressed the situation with Louis's neurologist^{DA}.

Gentry coordinated a team meeting and was in the room with the neurologist, social worker, and Louis when they discussed more realistic therapeutic outcomes and resources for poststroke patients' physical, emotional, and spiritual support^{DA}. After this, "new" information was provided, and Gentry asked if Louis's long-term goals were the same^{DA}. Louis answered that his priority now was being around his grandkids because they were joyful and to be as independent as possible, even if he never got movement back in his leg.

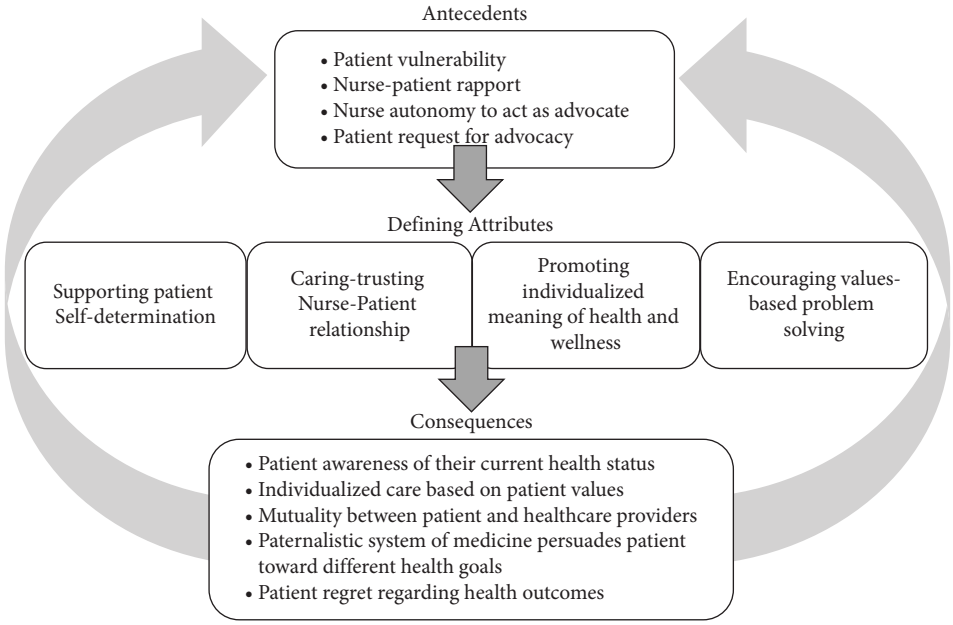

Figure 2: Conceptual model of existential advocacy.

Louis was upset and wondered why no one had explained all this sooner. Louis said he was fighting discharge because he believed he needed to be in the hospital to "get better" but was now rethinking what "getting better" meant for his unique situation[CO]. Gentry assured Louis that she would inform him of any health updates immediately[DA]. Louis laughed and said all he wanted to know was the best he could expect, and the "other medical mumbo jumbo could go through his wife[CO]."

In this case, Louis's initial ICU nurse demonstrated paternalistic care by withholding prognostic information due to the healthcare providers' assumption that they knew what was best for Louis. Paternalism is contrary to the concept of EA. However, a connection was followed by trust and caring between Louis and Gentry. The advocacy provided by Gentry was directed toward and with her patient. Gentry's advocacy supports Louis's self-insight and, thereby, his self-determination. Through Gentry's EA, Louis gained authentic awareness of his health status, allowing decision-making on his terms.

4.6.2. Alternate Case: Sandra. The following contrary case clarifies the distinction between EA and paternalism. Georgia is a 54-year-old woman with type II diabetes, renal complications, and repeated hospital stays. Now, Georgia's doctors tell her that she needs to start dialysis and has scheduled surgery for a fistula placement[AN]. Sandra has been Georgia's nurse for the last three days. Sandra does a thorough head-to-toe assessment with Georgia every morning and checks on her every couple of hours. Georgia is stable, independent with her activities of daily living, and very talkative. However, Sandra feels she does not have time to get drawn into long conversations with Georgia because she has so many other patients and tasks to complete. At lunch, Sandra walks in when Georgia is crying. Georgia states that she does not want to get a fistula and feels fine now, so she would like to go home to her family[AN]. Sandra reassures Georgia that she needs the fistula to get better. Furthermore, the vascular surgeon is an expert in the field, so she has nothing to worry about. Georgia says okay to the procedure but is still teary and visibly upset when Sandra leaves the room[CO].

In this example, the paternalistic nature of Georgia's healthcare system diminishes her freedom of self-determination. Both the nurse and surgeon assume that they know what is best for Georgia and tell her what the plan needs to be instead of taking the time to determine Georgia's health and wellness values and priorities. Had Sandra provided EA, final healthcare decisions may have turned out identically. However, the lack of EA left Georgia confused and emotionally distressed.

4.7. Clarifying Patient Autonomy. Protecting a patient's autonomy and EA are two separate concepts. Many definitions of nurse advocacy promote patient autonomy [10]; however, without EA, the nurse might be promoting, even advocating for, something the patient does not want. Therefore, EA promotes congruence of patients' values, wishes, and goals. Complete autonomy requires patients to make decisions entirely by themselves, while complete paternalism entails decisions made solely by an outside person [3, 47]. Simplified interpretations often label patient autonomy as "good" and paternalism as "bad;" however, EA recognizes that patients' values are individualized and do not fit neatly into any category, theme, or theory. Unintentional paternalism may occur because the healthcare providers feel that they know what is in the patient's best interest [3]. Furthermore, the patient may appreciate the healthcare provider's perspective and want their directive. On the other hand, paternalism infringes on patients' self-determination

when used as "coercion to provide a good that is not desired by the one whom it is intended to benefit" ([3], p. 42). Therefore, nurses' EA supports patient autonomy while helping patients determine where they fall on the spectrum of decision-making from total autonomy to entirely relying on the guidance of their healthcare team. In this way, the nurse-patient relationship supports the patients' right to self-determination through EA.

4.8. Alignment with Unitary Caring Science. Within the broader discipline of nursing, EA aligns well with UCS and Watson's 10 Caritas Processes [7]. UCS embodies a *wisdom of knowing*: a nurse's increased ability to provide compassionate care through a sense of shared humanity. This wisdom of knowing coincides with EA's individualized meaning of health and wellness through patient and nurse mutual self-discovery [3]. Furthermore, UCS describes *caring occasions* as existential moments between nurses and patients grounded in transpersonal caring-trusting relationships. These caring occasions inform the nurses' and patients' actions and are guided by intentionality and conscientiousness [7, 14]. Caring occasions and EA occur in tandem. They simultaneously provide nurse-patient enlightenment while allowing patients to make self-determined health and wellness decisions. In addition, most of EA's antecedents, defining attributes, and consequences can be incorporated into the Caritas Processes, exemplifying how nurse utilization of EA can facilitate interpersonal and transpersonal caring occasions that support patient care concordant with their values and beliefs. Table 2 summarizes the alignment between the Caritas Processes and EA with corroborating excerpts from Gentry's model case.

Watson describes the Caritas Processes as "the core activities and orientations a professional nurse uses in the delivery of care" and illustrates them as "the common and necessary professional practices that sustain and reveal nursing as a distinct (caring) profession" ([7], p. 32). Nursing skills associated with EA merit the same recognition as traditional nursing tasks [14]. However, because the nurse's application of EA and the Caritas Processes are often viewed as unconscious nursing instincts, nurses miss the opportunity to take credit for these unique and valuable services. Watson clarifies that "nurses generally are not conscious of their own phenomena; they do not have the language to identify, chart, and communicate systematically" for services that are not tangibly apparent ([7], p. 32). Furthermore, Bishop and Scudder highlight how nursing often seeks meaning solely through excellent practice while neglecting the philosophical and practical meaning behind the nurse-patient relationship [4, 28]. Devaluation of the profession and discipline of nursing occurs when nurses do not have a language to place a voice to their accomplishments, "nursing and nurses engage in this human caring process every day, but often in the back recesses of patient's rooms where it is not seen, nor valued, nor counted as 'evidence' or knowledge" ([48], p. 914). However, EA and the Caritas Processes provide caring literacy and a common language to articulate nursing's unique attributes.

5. Implications

EA aims to help patients reach wellness decisions congruent with their authentic health reality instead of an idealized, paternalized, or strictly medical interpretation. Providing EA is dynamic and changes with every nurse, patient, and situation [3, 4, 22, 27]. For example, patients with identical diseases and prognoses may have contradicting feelings on what constitutes quality of life. By having more time with patients than other healthcare professionals, nurses can engage and learn about their patients' values and quality-of-life goals, which may result in vastly different healthcare decisions and outcomes. In this way, EA can result in concordant care aligned with patients' values.

EA impacts nursing by condensing the unconscious and instinctual advocacy many nurses provide into a defined nursing concept. Without nurse's awareness of their unique skill sets, "additional education, and advancement of professional caring in nursing. . .are likely to occur in an ad hoc, rather than a systematic fashion" ([7], p. 32). However, with concepts such as EA and the Caritas Processes better understood, they can be assessed, measured, and implemented. Measuring concepts such as EA highlights nurses' essential role in patients' physical and emotional care. Furthermore, a better understanding of EA in the nursing community allows nurses to give voice to their specific contributions and use a language that describes their unique and valuable work.

Pairing EA with UCS and the Caritas Processes provides a framework to guide nurses within their patient relationships. Research utilizing an EA framework highlights its effectiveness in improving patient outcomes. In addition, the distinct alignment between EA's defining attribute of a *caring-trusting nurse-patient relationship* and UCS' *caring occasion* emphasizes the value of the nurse-patient connection and the potential for healing, growth, and understanding within that relationship. For example, a study conducted by Minicucci et al. demonstrates that participants who felt their autonomy and self-determination were supported by their nurses also reported higher autonomous motivation to stop smoking [25]. However, despite existing research showing EA's efficacy, overall research utilizing EA is limited. More rigorous studies are needed to establish EA's positive impact on the nursing profession and patient wellness. Furthermore, future research must assess how nurses consciously or unconsciously use EA to provide holistic care. Potential areas for future nursing research include qualitative interviews with nurses and patients and measuring patient satisfaction after EA.

6. Limitations

Several limitations presented themselves throughout this concept analysis. Primarily, few studies directly utilized EA within their research. In addition, the term EA is not well known and rarely explicitly studied, even while many nurses naturally provide care aligned with the concept. The Walker and Avant concept analysis method is limited by what has been published surrounding a concept, and no articles meeting the inclusion criteria for this analysis have been

Table 2: Aligning Watson's 10 Caritas Processes with existential advocacy.

10 Caritas Processes	Existential advocacy	Excerpt from model case
Embrace (loving-kindness): sustaining humanistic-altruistic values by the practice of loving-kindness, compassion, and equanimity with self/others	(i) Patient vulnerability (ii) Nurse-patient rapport (iii) Patient request for advocacy (iv) Caring-trusting nurse-patient relationship	"Gentry always asked permission before touching Louis and was kind, gentle, and confident. Louis felt at ease with Gentry because she explained everything, was considerate, and always followed through with her care promises"
Inspire (faith-hope): being authentically present, enabling faith/hope/belief system; honoring subjective inner, life-world of self/others	(i) Patient request for advocacy (ii) Supporting patient self-determination (iii) Caring-trusting nurse-patient relationship	"Gentry was concerned that the medical system was doing a disservice to Louis by being overoptimistic about his recovery. After this new information, Gentry asked if Louis's long-term goals were the same. Louis answered that his priority now was being around his grandkids because they were joyful"
Trust (transpersonal): being sensitive to self and others by cultivating own spiritual practices; beyond ego-self to transpersonal presence	(i) Nurse autonomy to act as an advocate (ii) Nurse-patient rapport (iii) Caring-trusting nurse-patient relationship	"Gentry assured Louis that she would inform him of any health updates immediately. Louis laughed and said all he wanted to know was the best he could expect, and the other medical mumbo jumbo that could go through his wife"
Nurture (relationship): developing and sustaining loving and trusting-caring relationships	(i) Nurse-patient rapport (ii) Caring-trusting nurse-patient relationship	"Gentry always asked permission to write her patients' daily and long-term goals on their whiteboards"
Forgive (all): allowing for expression of positive and negative feelings and authentically listening to another person's story	(i) Caring-trusting nurse-patient relationship (ii) Promoting individualized meaning of health (iii) Supporting patient self-determination	"Louis was upset and wondered why no one had explained all this sooner"
Deepen (creative self): creatively problem-solving-"solution-seeking" through the caring process; full use of self and artistry of caring-healing practices via the use of all ways of knowing/being/doing/becoming	(i) Caring-trusting nurse-patient relationship (ii) Encouraging values-based problem-solving (iii) Promoting individualized meaning of health (iv) Supporting patient self-determination	"Louis said he was fighting discharge because he believed he needed to be in the hospital to "get better" but was now rethinking what "getting better" meant for his unique situation"
Balance (learning): engaging in transpersonal teaching and learning within the context of a caring relationship; staying within other's frame of reference; shifting toward a coaching model for expanded health/wellness	(i) Caring-trusting nurse-patient relationship (ii) Promoting individualized meaning of health (iii) Encouraging values-based problem-solving (iv) Patient awareness of their current health status (v) Individualized care based on patient values	"Gentry was in the room with the neurologist, social worker, and Louis when they discussed more realistic therapeutic outcomes and resources for poststroke patients' physical, emotional, and spiritual support"
Cocreate (Caritas field): creating a healing environment at all levels; a subtle environment for an energetic authentic caring presence	(i) Nurse autonomy to act as an advocate (ii) Caring-trusting nurse-patient relationship (iii) Mutuality between patient and healthcare providers	"Gentry introduced herself to Louis and his family, took a report from the ICU nurse at Louis's bedside, and oriented everyone to the new unit. Gentry made a point to address any immediate physical and emotional concerns"
Minister (humanity): reverentially assisting with basic needs as sacred acts, touching the mind, body, and spirit of others; sustaining human dignity	(i) Patient vulnerability (ii) Nurse-patient rapport (iii) Supporting patient self-determination (iv) Caring-trusting nurse-patient relationship	"Gentry always asked permission before touching Louis and was kind, gentle, and confident. Gentry made a point to address any immediate physical and emotional concerns"
Open (infinity): opening to spiritual, mystery, and unknowns and allowing for miracles	(i) Supporting patient self-determination (ii) Caring-trusting nurse-patient relationship (iii) Encouraging values-based problem-solving	"After this new information, Gentry asked if Louis's long-term goals were the same"

published within the last ten years. Therefore, essential considerations for EA, such as social determinants of health and cultural humility in nursing, may have been omitted. The scarcity of literature on EA suggests that further research and knowledge development of EA are needed to apply it effectively in modern nursing care and education.

7. Conclusion

EA is a unique form of advocacy that needs explication beyond nurse advocacy alone. EA is the effort to support and promote a patient's right to self-determination by helping them discern their authentic health and wellness situations and then clarify their values within that reality. Subsequently, EA aims to help patients reach holistic wellness decisions congruent with their authentic health situation. EA condenses the care and advocacy many nurses already provide into a defined nursing concept while highlighting nurses' essential role in patients' physical, emotional, and spiritual care. While UCS never explicitly uses the term EA, its recognition of "human caring as an end in and of itself, not just a means to a medical-cure end" and its focus on how nurse-patient relationships facilitate transpersonal caring occasions exemplifies nurses unique position to provide EA ([5], p. 7). With EA better defined, the concept can be assessed, measured, and implemented within the discipline of nursing. Therefore, this concept analysis is crucial to expanding EA beyond its original work in 1980 to become a recognizable and respected aspect of modern nursing care.

Data Availability

No data were used to support this study.

Disclosure

The results of this concept analysis were presented as a poster presentation at the 2023 Western Institute of Nursing Research Conference under the title Existential Advocacy in Nursing: A Concept Analysis [49].

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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