Wiley
European Journal of Cancer Care
Volume 2025, Article ID 9811411, 7 pages
https://doi.org/10.1155/ecc/9811411

WILEY

Research Article

Oncology Nursing Advocacy According to Burnout Subdimensions and Work Experience: An Investigational Study

Elsa Vitale,[1] **Roberto Lupo**,[2] **Giorgio De Nunzio**,[3,4] **Stefano Botti**,[5] **Serena Maci**,[6] **Ilaria Baldini**,[7] **Valentina Rizzo**,[7] **Maicol Carvello**,[8] **Raffaella Massafra**,[1] **Gianandrea Pasquinelli**,[9] **Valeria Cremonini**,[9] **Ivan Rubbi**,[10] **and Luana Conte**[4,11]

[1]*Scientific Directorate, IRCCS Istituto Tumori "Giovanni Paolo II", Bari, Italy*
[2]*"San Giuseppe da Copertino" Hospital, Local Health Authority of Lecce, Copertino, Lecce, Italy*
[3]*Laboratory of Biomedical Physics and Environment, Department of Mathematics and Physics "E. De Giorgi", University of Salento, Lecce, Italy*
[4]*Laboratory of Advanced Data Analysis for Medicine (ADAM) at the Laboratory of Interdisciplinary Research Applied to Medicine, University of Salento, Local Health Authority, Lecce, Italy*
[5]*Hematology Unit, Azienda USL-IRCCS of Reggio Emilia, Reggio Emilia, Italy*
[6]*School of Nursing, University of Bari, Lecce, Italy*
[7]*School of Nursing, University of Bologna, Campus di Ravenna, Ravenna, Italy*
[8]*Community Hospital, Local Health Authority, Ravenna, Italy*
[9]*Department of Medical and Surgical Sciences (DIMEC), Alma Mater Studiorum University of Bologna, Bologna, Italy*
[10]*Department of Medical and Surgical Sciences, School of Nursing, University of Bologna, Bologna, Italy*
[11]*Department of Physics and Chemistry, University of Palermo, Palermo 90128, Italy*

Correspondence should be addressed to Elsa Vitale; e.vitale@oncologico.bari.it

Received 22 May 2025; Revised 26 September 2025; Accepted 14 October 2025

Academic Editor: Sowjanya Thatikonda

Introduction: Nursing advocacy represents an important factor in professional nursing ethics, as a combined element of the nurse's achievements to enhance and assure both the well-being and interests of patients, ensuring their rights and accessibility to information to achieve a more informed decision. As burnout was associated to the working condition, we also hypothesized that years of work experience could worsen advocacy, too. Thus, the present study aimed to assess any differences that existed in oncology nursing advocacy according to work experience and burnout subdimensions, as emotional exhaustion, depersonalization, and personal accomplishment.
Methods: An observational, cross-sectional, national study was conducted from December 2023 to August 2024. Nursing advocacy attitudes and burnout levels were collected with also sociodemographic characteristics.
Results: A total of 183 Italian oncology nurses were enrolled. Data reported that there were no significant differences recorded among recruited nurses and their work experience associated to cognitive and behavioral attitudes in advocacy. Considering advocacy subdimensions related to burnout ones, significant differences were recorded between E.E. and behavior aspect of advocacy attitude ($p = 0.038$). Additionally, nurses, who recorded lower P.A. levels, registered higher values in behavioral attitudes in advocacy, too ($p = 0.042$).
Conclusion: Advocacy would seem to be inherent in nursing practice. However, in oncology settings, advocacy seemed to be more difficult to implement, both because the patient would seem more reluctant to communicate and because the nurse is more prone to burnout.

Keywords: advocacy; burnout; depersonalization; emotional exhaustion; oncology nursing; personal accomplishment; work experience

1. Introduction

Nursing advocacy represents an important factor in professional nursing ethics, as a combined element of the nurse's achievements to enhance and assure both the well-being and interests of patients, ensuring their rights and accessibility to information to achieve a more informed decision [1].

Advocacy also represents an essential element in the nursing professional practice to guarantee nurses' expertise in public policy, specifically in influence patient care and nursing practice in oncology care [2].

As nursing considers the significance of the "whole person" within a community context, also influencing social determinants of health relying on community empowerment to improve added value also in nursing's perspective among the realities of practice impact [3, 4].

Nurses should have the essential preparation based on patient advocacy, which represents an essential element in the practice of nursing involving them in the political process through direct nurses' role as patient's advocate. Advocacy refers to the best for a patient or population, assisting nurses to bring such perspective forward to the main competencies, as essential for nurse leaders [5].

Several dimensions of nursing, such as relationship building and advocacy, shift to the political scenario, too [6, 7]. Different models have been suggested for the nurse as advocate [8, 9], with several interpretations to provide any coherent comprehension in nursing advocacy implementation to allow nurses to be in the most opportune position to advocate and to teach advocacy, too [10].

Additionally, nurses should everyday face up to heavy workload, stress, and burnout experienced during their working times [11, 12]. Maybe advocacy roles could negatively impact on the nursing burnout perceptions, as in motivating the participation in ethical decision making and encountering barriers [8, 13]. Additionally, the lack of strategy to support nursing advocacy and individual safety, impacted on obligations in direct nursing advocacy [14]. However, very few evidence suggest how nursing advocacy in oncology settings could be both perceived and influenced according to prolonged oncology experiences and pressures due to high workload which could negatively impacted on burnout and its subdimensions.

The literature suggested that nursing advocacy in oncology settings seemed to be more difficult to act, since patients did not report all their feelings, their thoughts, and their fairs [15, 16]. Additionally, oncology nurses appeared more stressed and suffered from burnout, due to their unfortunate diagnoses [17, 18].

Since burnout was associated to worst working conditions and it was more present in nurses recording higher years of work experience, we hypothesized that both burnout and working experience negatively impacted on nursing advocacy and its subdimensions.

Thus, the present study aimed to assess any differences that existed in oncology nursing advocacy according to work experience and burnout subdimensions, as emotional exhaustion, depersonalization, and personal accomplishment.

2. Materials and Methods

2.1. Study Design. An observational, cross-sectional, national study was conducted from December 2023 to August 2024.

2.2. Study Procedure. All presidents belonging to the Nursing Professional Orders distributed throughout Italy were contacted and invited to participate in the present study, specifically to spread the study-related presentation and questionnaire to all their nursing members. Only after their agreements to participate to the study, the related link to the study was sent.

In Italy, there were a total of 103 Nursing Orders. Of these, the presidents of the provincial orders of Lecce, Bergamo, Rome, Arezzo, Gorizia, La Spezia, Varese, and Asti agreed to participate in the study. Additionally, the questionnaire was also sent to the Italian association of palliative care which gave their consent to participate in the divulgation of the questionnaire on January 24, 2024.

2.3. Inclusion and Exclusion Criteria. All nurses who voluntarily agreed to participate in the study, including nursing coordinators and managers working in both the public and private sectors, were included. All nursing professionals awaiting their first employment or retired were excluded.

2.4. Sample Size. The study population included all Italian nurses employed in oncology wards and outpatients. Considering that the Italian Ministry of Health assessed the Italian nursing population about 59.2% of the total of the Italian healthcare workers, nurses were encountered as $n = 617{,}246$ [19]. The sample size was assessed among nurses within 95% confidence interval and 5% margin of error, according to the Miller and Brewer's formula [20]. Hence, a total of 400 nurses were assessed as achievable for a convenient random sampling. Additionally, the sample size referred to all the nursing specializations. Considering that there were nearly 70 clinical specialties in the Italian Healthcare System [21], we could deduct that the sample size reached could be considered as sufficient to define it as representative.

2.5. The Questionnaire. The questionnaire collected anonymous data. It contained a total of 3 subsections. The first part collected sociodemographic data, such as sex, age, educational level, work experience in oncology settings, post basic training, both in general and in oncology nursing, shift, and typology of work.

In the second part of the questionnaire, the nurses' attitudes toward nursing advocacy were assessed thanks to the quantitative tool validated by Motamed-Jahromi et al. in Iran [22]. The Iranian questionnaire was previously developed in two studies of Barrett-Sheridan [23] and Hanks [24]. The questionnaire contained two main sections: the "cognitive (belief) aspect of attitude," including the first 9 items positively formulated. The second section of the

questionnaire assessed the "behavior (efficacy) aspect of attitude," covering the latest 10 items worded in a negative style. For each item proposed, a Likert scale varying from 1 to 5 was used. Values were assessed as "continuous" scores and assessed in mean and standard deviation ones. Higher values indicated greater attitudes for both these two dimensions. Since the questionnaire assessing nursing advocacy was not validated into Italian language, we firstly shared these items among authors (Giorgio De Nunzio, Serena Maci, Ilaria Baldini, Valeria Cremonini, Maicol Carvello, and Valentina Rizzo) to assess their comprehension after Italian translation, thanks to the "Survey Instrument Validation Rating Scale," which aimed to validate survey questionnaires [25]. A total of 13 items were proposed and each author gave a preference associated to a Likert scale, as 1 for "Strongly Disagree," 2 for "Disagree," 3 for "Undecided," 4 for "Agree," and 5 for "Strongly Agree." The items included in this validation survey are reported in Supporting File 1.

Finally, the Maslach Burnout Inventory (MBI) test was administered, containing a total of 22 items, including three subscales: emotional exhaustion, as "I feel frustrated by my job"; depersonalization, as "I have become less interested in my work since I started this job"; and decreased personal accomplishment, as "I feel exhilarated when I accomplish something at work." For each item, a Likert scale ranging from 1 to 6 grades was associated, and summing scores for each item of the three subdimensions, a different level in burnout subdimensions was assessed, as low, moderate, and high [26].

2.6. Statistical Analysis. Data were collected and elaborated in an Excel database. All demographic characteristics were considered as categorical variables and assessed according to years of work experience in oncology settings and also considered as categorical variables and divided into groups of 5 years each, as 0–5 years, 6–10 years, 11–15 years, 16–20 years, and over 21 years. Chi-square tests were performed and assessed differences in sampling characteristics. Then, ANOVA tests were assessed to highlight differences in advocacy attitudes according to work experience in oncology field and burnout subdimensions. All p values less than 0.05 were considered as statistically significant.

2.7. Ethical Considerations. An explicit explanation of the study and its purpose was presented to give all information to all the possible participants. All participants firstly read the presentation of the proposed study and then, who explicitly gave their consent for both participation and publication, could complete the questionnaire. The study was approved by the Ethical Committee of Bologna, Italy, with id no. 0388077/28.12.2023.

3. Results

A total of 183 Italian oncology nurses were enrolled in the present study. Data were presented according to nurses' work experience in oncology settings. Most of the younger nurses had a bachelor's degree ($p \leq 0.001$) and had a generic post basic training ($p = 0.046$). However, they did not have a specific post training in oncology field ($p = 0.002$). Additionally, most of the younger nurses worked also during the night shift ($p = 0.023$). As regards burnout subdimensions, nurses recorded no significant differences according to work experience (Table 1).

As regards advocacy subdimensions according to years of work experience (Table 2), no significant differences were recorded among recruited nurses and cognitive ($p = 0.485$) and behavioral ($p = 0.150$) attitudes in advocacy since nurses reported similar values in advocacy subdimensions despite their different declared years of experience.

Finally, as regards advocacy subdimensions related to burnout ones, significant differences were recorded between E.E. and behavior aspect of advocacy attitude ($p = 0.038$), since nurses recorded higher levels in behavioral attitudes in advocacy (3.5420 ± 0.54746) also reported higher levels in E.E. dimension. Finally, nurses recorded lower personal accomplishment levels registered higher values in behavioral attitudes in advocacy (3.6190 ± 0.43684; $p = 0.042$) (Table 3).

4. Discussion

The present study aimed to assess any differences that existed in oncology nursing advocacy attitudes according to work experience and burnout subdimensions.

Data reported that there were no significant differences recorded among recruited nurses and their work experience associated to cognitive and behavioral attitudes in advocacy.

Considering advocacy subdimensions related to burnout ones, significant differences were recorded between E.E. and behavior aspect of advocacy attitude ($p = 0.038$). Additionally, nurses, who recorded lower P.A. levels, registered higher values in behavioral attitudes in advocacy, too ($p = 0.042$). Maybe burnout levels, also considering high depersonalization levels, could be also dependent on the oncology nature and the difficulty to care for these patients in all their wholeness. However, no significant difference was reported between advocacy attitudes and years of work experience. The role of an advocate nurse has just been highlighted in previous studies [8, 27], as several moral exhortations suggested nurses as advocates for susceptible patients [28]. Previous traditional power structures within the institution, the absence of any pathways of support for nurse advocates, time forces, and personal security issues, provided to the obligations on nursing advocacy.

The literature highlighted the importance of oncology nurses in their roles in supporting patients' self-advocacy and the ability to ensure values and priorities in cancer patients during their disease journey [29, 30]. Cancer patients often avoid speaking up for their feelings, their concerns, and priorities which negatively influenced the received care and their relations with the caring staff [31].

However, literature reported low attitude in nursing advocacy [32] and by Thacker who had stated that most participants agreed with perceptual behavior of nursing advocacy [33]. Conversely, our data reported advocacy levels above mean values.

Table 1: Participants' characteristics according to years of work experience in oncology settings ($n = 183$).

Sampling characteristics/work experience in oncology settings n(%)	0–5 years 76 (41.5%)	6–10 years 37 (20.2%)	11–15 years 23 (12.6%)	16–20 years 19 (10.4%)	> 21 years 28 (15.3%)	p value
Sex						
Female 143 (78.1)	58 (31.7)	27 (14.8)	17 (9.3)	16 (8.7)	25 (13.7)	0.491
Male 40 (21.9)	18 (9.8)	10 (5.5)	6 (3.3)	3 (1.6)	3 (1.6)	
Education level						
Diploma 57 (31.1)	16 (8.7)	6 (3.3)	4 (2.2)	13 (7.1)	18 (9.8)	≤ 0.001*
Bachelor 110 (60.1)	50 (27.3)	29 (15.8)	18 (9.8)	4 (2.2)	9 (4.9)	
Master and above 16 (8.7)	10 (5.5)	2 (1.1)	1 (0.5)	2 (1.1)	1 (0.5)	
Post basic training						
Yes 101 (55.2)	34 (18.6)	24 (13.1)	14 (7.7)	15 (8.2)	14 (7.7)	0.046*
No 82 (44.8)	42 (23)	13 (7.1)	9 (4.9)	4 (2.2)	14 (7.7)	
Post basic training in oncology						
Yes 46 (25.1)	8 (4.4)	11 (6)	8 (4.4)	9 (4.9)	10 (5.5)	0.002*
No 137 (74.9)	68 (37.2)	26 (14.2)	15 (8.2)	10 (5.5)	18 (9.8)	
Shift work						
Only morning 55 (30.1)	20 (10.9)	8 (4.4)	4 (2.2)	7 (3.8)	16 (8.7)	
Morning and afternoon 56 (30.6)	26 (14.2)	10 (5.5)	7 (3.8)	8 (4.4)	5 (2.7)	0.023*
Morning, afternoon, and night 72 (39.3)	30 (16.4)	19 (10.4)	12 (6.6)	4 (2.2)	7 (3.7)	
Work typology						
Full-time 176 (96.2)	74 (40.4)	37 (20.2)	23 (12.6)	17 (9.3)	25 (13.7)	0.072
Part-time 7 (3.8)	2 (1.1)	0 (0)	0 (0)	2 (1.1)	3 (1.6)	
Burnout subdimension:						
Emotional exhaustion						
Low risk	29 (15.8)	11 (6)	8 (4.4)	4 (2.2)	10 (5.5)	0.121
Intermediate risk	36 (19.7)	11 (6)	7 (3.8)	9 (4.9)	9 (4.9)	
High risk	11 (6)	15 (8.2)	8 (4.4)	6 (3.3)	9 (4.9)	
Burnout subdimension:						
Depersonalization						
Low risk	21 (11.5)	14 (7.7)	4 (2.2)	7 (3.8)	1186)	0.126
Intermediate risk	29 (15.8)	5 (2.7)	6 (3.3)	5 (2.7)	5 (2.7)	
High risk	26 (14.2)	18 (9.8)	13 (7.1)	7 (3.8)	12 (6.6)	
Burnout subdimension:						
Personal accomplishment						
Low risk	8 (4.4)	3 (1.6)	2 (1.1)	3 (1.6)	5 (2.7)	0.715
Intermediate risk	25 (13.7)	10 (5.5)	6 (3.3)	6 (3.3)	4 (2.2)	
High risk	43 (23.5)	24 (13.1)	15 (8.2)	10 (5.5)	19 (10.4)	

*$p < 0.05$ is statistically significant.

Table 2: Cognitive and behavioral attitudes of advocacy according to work experience in oncology settings.

Advocacy subdimensions/work experience in oncology settings	Mean	Standard deviation	Error std.	C.I. 95% Min	C.I. 95% Max	F	p value
Cognitive aspect of advocacy attitude							
0–5 years	2.8842	0.50413	0.05783	2.7690	2.9994		
6–10 years	2.9108	0.56015	0.09209	2.7240	3.0976		
11–15 years	2.9522	0.62440	0.13020	2.6822	3.2222	0.868	0.485
16–20 years	2.6842	0.52521	0.12049	2.4311	2.9374		
More than 21 years	2.8000	0.55777	0.10541	2.5837	3.0163		
Total	2.8645	0.54126	0.04001	2.7855	2.9434		
Behavior aspect of advocacy attitude							
0–5 years	3.4006	0.48042	0.05511	3.2908	3.5104		
6–10 years	3.4204	0.48583	0.07987	3.2584	3.5824		
11–15 years	3.1884	0.63337	0.13207	2.9145	3.4623	1.709	0.150
16–20 years	3.3801	0.64184	0.14725	3.0708	3.6895		
More than 21 years	3.5714	0.50031	0.09455	3.3774	3.7654		
Total	3.4019	0.52770	0.03901	3.3250	3.4789		

Note: $p < 0.05$ is statistical significant.

Table 3: Cognitive and behavioral attitudes of advocacy according to burnout subdimension levels.

	Mean	Standard deviation	Error std.	C.I. 95%		*F*	*p* value
				Min	Max		
Advocacy subdimensions/emotional exhaustion							
Cognitive aspect of advocacy attitude							
Low risk	2.7726	0.50055	0.06357	2.6455	2.8997		
Intermediate risk	2.8417	0.50928	0.06002	2.7220	2.9613	2.893	0.058
High risk	3.0143	0.61169	0.08738	2.8386	3.1900		
Total	2.8645	0.54126	0.04001	2.7855	2.9434		
Behavior aspect of advocacy attitude							
Low risk	3.2849	0.43739	0.05555	3.1739	3.3960		
Intermediate risk	3.4074	0.56686	0.06681	3.2742	3.5406	3.336	0.038*
High risk	3.5420	0.54746	0.07821	3.3847	3.6992		
Total	3.4019	0.52770	0.03901	3.3250	3.4789		
Advocacy subdimensions/depersonalization							
Cognitive aspect of advocacy attitude							
Low risk	2.8211	0.47236	0.06257	2.6957	2.9464		
Intermediate risk	2.7900	0.50719	0.07173	2.6459	2.9341	1.529	0.220
High risk	2.9461	0.60364	0.06924	2.8081	3.0840		
Total	2.8645	0.54126	0.04001	2.7855	2.9434		
Behavior aspect of advocacy attitude							
Low risk	3.4016	0.45024	0.05964	3.2821	3.5210		
Intermediate risk	3.4156	0.49883	0.07055	3.2738	3.5573	0.027	0.974
High risk	3.3933	0.60135	0.06898	3.2559	3.5307		
Total	3.4019	0.52770	0.03901	3.3250	3.4789		
Advocacy subdimensions/personal accomplishment							
Cognitive aspect of advocacy attitude							
Low risk	2.9667	0.57562	0.12561	2.7046	3.2287		
Intermediate risk	2.7765	0.52291	0.07322	2.6294	2.9235	1.135	0.324
High risk	2.8856	0.54236	0.05148	2.7836	2.9876		
Total	2.8645	0.54126	0.04001	2.7855	2.9434		
Behavior aspect of advocacy attitude							
Low risk	3.6190	0.43684	0.09533	3.4202	3.8179		
Intermediate risk	3.4662	0.48637	0.06811	3.3294	3.6030	3.226	0.042*
High risk	3.3313	0.55007	0.05221	3.2279	3.4348		
Total	3.4019	0.52770	0.03901	3.3250	3.4789		

* $p < 0.05$ is statistically significant.

Within healthcare systems, also nurses had an accountability to advocate the reasonable health resources sharing, that could reduce achievements and pathways put in place to delete healthcare system related obstacles [31, 34]. Ethical nursing practice encouraged mindfulness among nurses for the extensive social equity which positively impacted on the social determinants of health and on the people well-being [35, 36], leading structural and social challenges and improvements in clinical practice, training and policy within cancer care [37].

4.1. Strengths and Limitations. The present study investigated "forgotten" concepts of advocacy and burnout in oncology nurses highlighting emotional and socioeconomic challenges in nurses. Further, the study adopted MBI and previously validated questionnaire among comprehensive national Italian population (183 nurses) which showed heterogeneity and adequate representation of the population. These factors allowed us to support the study reliability and validation.

However, findings could be treated considering some limitations of the study. First of all, we only assessed any differences that existed between advocacy subdimensions and years of work experience and burnout, since the literature has deeply investigated that these two variables were positively associated despite years of work experience in nursing seemed positively associated with burnout [26]. Secondly, the lack of a complete validation with construct validity and reliability of the instrument assessing advocacy should be considered in the management of these data.

Thus, future studies will consider further aspects in nursing advocacy trying to analyze and conceptualize which factors deeply influenced nursing advocacy.

5. Conclusion

Advocacy would seem to be inherent in nursing practice. However, in oncology settings, advocacy seemed to be more difficult to implement, since the patient seemed to be more reluctant to communicate and the nurse was more prone to burnout.

By recording high levels of burnout, it was also hypothesized that a higher number of stays in oncology wards had negatively affected nurses' advocacy propensity. Conversely, the results disproved this research hypothesis: years of working experience in oncology did not seem to influence levels of advocacy. On the other hand, burnout levels showed in the behavioral component of advocacy a worse attitude in nurses with higher levels of E.E. and P.A.

Therefore, burnout negatively affected the behavioral part of advocacy. In this regard, healthcare institutions should pay more attention to the well-being of their nurses, who have been one of the most important actors in patient care and advocacy [38].

Data Availability Statement

Data are available upon reasonable request.

Ethics Statement

This study was approved by the Ethical Committee of Bologna, Italy, with id no. 0388077/28.12.2023.

Consent

The authors have nothing to report.

Disclosure

The authors affiliated to the IRCCS Istituto Tumori "Giovanni Paolo II," Bari, are responsible for the views expressed in this article, which do not necessarily represent those of the institute. All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Conceptualization: Elsa Vitale.

Methodology: Elsa Vitale, Luana Conte, Stefano Botti, and Raffaella Massafra.

Investigation: Roberto Lupo, Ivan Rubbi, Maicol Carvello, Ilaria Baldini, Valentina Rizzo, Maicol Carvello. Resources: Elsa Vitale, and Giorgio De Nunzio.

Data curation: Elsa Vitale, Luana Conte, Roberto Lupo, and Giorgio De Nunzio.

Writing–original draft preparation: Elsa Vitale.

Writing–review and editing: Elsa Vitale and Luana Conte.

Visualization and supervision: Elsa Vitale, Roberto Lupo, Valeria Cremonini, Ivan Rubbi, and Gianandrea Pasquinelli.

Funding

The authors received financial support for publication of this article from the Bibliosan funding, Italy.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. *(Supporting Information)*

Supporting File 1. Validation Rating Scale by Authors.

The "Survey Instrument Validation Rating Scale," which aimed to validate survey questionnaires. A total of 13 items were proposed and each author gave a preference associated to a Likert scale, as 1 for "Strongly Disagree," 2 for "Disagree," 3 for "Undecided," 4 for "Agree," and 5 for "Strongly Agree."

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