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# Developing a Health Advocacy Campaign

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Patient advocacy has been a fundamental component of nursing practice for many years. Dating back to the Nightingale era, nursing attributes have been influential in the development of the profession. The American Nurses Association's (2001) Code of Ethics, Provision Three states, "the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient" (p. 23). Intentionally, as a core element of our nursing practice, we are advocating for the health of our patients individually and as a population. Nursing advocacy can take on various forms. Three attributes are described: (1) protecting the autonomy of the patient, (2) standing up for the patient unable to respond independently, and (3) campaigning for social justice (S. O. Paquin, 2011). As health advocates, nurses are able to influence policies that can improve the health of a population.

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## POPULATION HEALTH ISSUE: SKIN CANCER

The incidence of skin cancer has been on the rise since the 1950s (Linos, Swetter, Cockurn, Colditz, & Clarke, 2009). According to the American Academy of Dermatology (AAD, 2013), more than 3.5 million skin cancers in more than 2 million people are diagnosed each year in the United States. One in five Americans is expected to develop skin cancer at some point in their lives. Basal cell carcinoma (BCCA) and squamous cell carcinoma (SCCA) are the two most common forms of skin cancer in the United States. Melanoma is the most dangerous form of skin cancer and one of the fastest growing worldwide. Disturbingly, by the year 2015, the AAD (2013) estimates that 1 in 50 Americans will develop melanoma in his or her lifetime. It is also projected that one person will die in the United States every hour from melanoma (AAD, 2013). The critical fact is that most of these skin cancers, including melanoma, are preventable.

## POPULATION AFFECTED BY SKIN CANCER

Skin cancer can occur across the lifespan; however, targeted ages and races are identified on the basis

of the skin cancer diagnosis. Basal cell carcinoma and SCCA have been increasing in men and women younger than 40 years, with BCCA increasing faster in young women than in men. It is also important to note that, before the age of 40 years, the incidence of melanoma is higher in women; however after 40, rates are nearly twice as high as those in men (AAD, 2013).

## RISK FACTORS, PREVENTION, AND DETECTION

The primary risk factor for melanoma is ultraviolet (UV) light exposure. Sun exposure that is progressively intermittent in childhood and continues throughout the lifespan contributes to the risk of BCCA, SCCA, and melanoma. Of more recent attention is the increased risk of melanoma from exposure to tanning beds, particularly in women 45 years or younger. Individuals with a history of multiple moles (>50), atypical moles, light skin, freckles, history of sunburn, or a family history of melanoma are considered a higher risk for developing melanoma (AAD, 2013). Three straightforward approaches can impact the most preventable risk factors for *all types* of skin cancers: (1) sunscreen application, (2) protective clothing, and (3) seeking shaded areas while outdoors. Community and patient education about the warning signs of melanoma must also be a part of early detection.

## ADVOCACY PROGRAMS: SKIN CANCER PREVENTION AND EARLY DETECTION

In researching advocacy programs for skin cancer prevention and screening, I found several scholarly articles. Many of these were not based in the nursing literature. However, there were two programs I did find where nurses and nurse practitioners played a role in prevention and screening for early detection of skin cancer.

The first article described a novel prevention and detection program. The targeted groups were schools, nurses, pediatricians, and state agencies involved with those at risk for developing skin cancer, including melanoma. The author, an advanced practice nurse in dermatology, developed the program, suggesting that nurses and nurse practitioners could promote skin cancer prevention among the public through education. She also proposed that it could be accomplished with a lower budget than like programs done in the past. The first step involved a formal skin cancer education program for school health nurses, pediatricians, and other nurse providers in their practices. The next step was to educate children about sun safety through "Sunnysaurus" coloring books (developed by the Dermatology Nurses Association [DNA]). Travel agencies promoting trips to sunny climates where vacationers were at higher risk for sunburns were also targeted. Sunscreens, for those interested, were provided to the agencies to disseminate to vacationers prior to their trips. Based upon the location of this project in Maryland, where the population frequented the beach in summer, the author even proposed that melanoma-prevention literature be handed out at the bridge tollbooths (Harris, 2000).

There were several attributes that could make the skin cancer prevention program described by Harris (2000) effective. First, the program was innovative and developed by an advanced practice dermatology nurse knowledgeable about the skin cancer prevention needs in her community. Second, it targeted children in a geographic area where summers were spent predominantly in the sun. Third, the program built in an education focus toward nurses and other providers who could be influential in the public's attitudes and behaviors toward sun exposure and prevention. Finally, the proposed budget for this program was outlined in detail, unlike many programs implemented in the United States. This is important when analyzing the success and effectiveness of prevention and advocacy programs in today's economy.

The second article I chose had a different focus pertaining to this population health issue. This was a pilot study using nurse practitioners for skin cancer screening. The purpose was to evaluate their capability to identify suspicious lesions in clinical settings (Oliveria et al., 2001). Nurse practitioners with no previous experience with skin cancer detection were selected. They participated in a comprehensive skin cancer detection-training program that incorporated workshops, clinical apprenticeships, and didactic lectures. The preliminary results of this study suggested that nurse practitioners in the primary care setting could develop accuracy in their diagnostic abilities, triage skills, and assurance in detecting skin cancers with a comprehensive training program (Oliveria et al., 2001).

Because nurses and nurse practitioners are in an ideal position to provide prevention, detection, and screening for skin cancer, I believe that this study has significance in developing skin cancer advocacy programs. However, the literature suggests that not enough has been done in evaluating the accuracy of these practitioners as screeners (Oliveria et al., 2001). What made this program effective and replicable was the three-pronged training program developed to equip practitioners with the skills and experience needed. The nurses participated in extensive screening examinations with a board-certified

dermatologist, which included risk assessment, skin examination techniques, and patient education efforts. The importance of didactic lectures on skin cancer also impacted efficacy in detection knowledge and skills. Health advocacy campaigns will not be successful if nurses conducting them are not equipped with the expertise necessary.

## HEALTH ADVOCACY CAMPAIGN: PLAN DEVELOPMENT

The risks of indoor tanning have received recent media attention; however, the adverse effects of this behavior have been well documented in the clinical literature for some time. The U.S. Department of Health and Human Services and the World Health Organization's (WHO's) International Agency of Research on Cancer panel has confirmed that UV radiation from the sun, tanning beds, and sun lamps have identified carcinogens (AAD, 2013). Indoor tanning carries with it a similar amount of radiation as the sun. Studies reflect a 75% increase in the risk of melanoma in those who have had UV radiation exposure from indoor tanning, and increasing risk with each exposure (AAD, 2013). What is disconcerting is the 87% increased risk of melanoma to those with tanning bed exposure before the age of 35 years (AAD, 2013). Other health concerns from indoor tanning include the damages to the DNA in the skin cells, causing premature aging of the skin, immunosuppression, and injury to the eye, including cataracts and ocular melanoma (AAD, 2013). The statistics on tanning indoors are alarming. These statistics (AAD, 2013) are listed as follows.

- In the United States, more than 1 million people tan daily in tanning facilities.
- Nearly 70% of those using tanning salons are Caucasian girls and women, 16–29 years of age.
- Of the 28 million people who tan indoors in the United States, 2.3 million are teens.
- Tanning facilities generated revenue estimated to be $2.6 billion in 2010.

## LEGISLATION

Tanning facilities have proven harmful to people of all ages; however, children and adolescents should not be exposed to the unnecessary risks. A recent study revealed that children of women who used tanning facilities were more likely become users, as well. Of equal concern was the finding that young women whose first indoor tanning exposure was with their mothers were 4.6 times more likely to become tanners themselves (Skin Cancer Foundation, 2013).

The WHO has advised that indoor tanning for minors be prohibited (AAD, 2013). In 2011, California became the first state in the United States to prohibit the use of indoor tanning devices for all children and adolescents. Vermont became the second state to prohibit the use in 2011. Sadly, there are only 36 states that have restrictions on indoor tanning for minors (AAD, 2013). Continued efforts are, however, under way on a legislative level to address this health risk. In 2012, leaders of the House Committee on Energy and Commerce released a report revealing that tanning facilities are not informing consumers about skin cancer and other risks to adolescents desiring these services (skincancer.org, 2012).

Currently, the Food and Drug Administration (FDA) Classification for tanning beds is as a Class 1 medical device. Under this classification, they would be interpreted as safe. There is strong support from the medical community and legislators that the FDA should reclassify tanning beds to a Class II (with restrictions), or even the consideration of a Class III medical device. An FDA panel has been debating new restrictions, but a final determination has not been made (skincancer.org, 2012).

### *Proposal for Policy Solution: Indoor Tanning*

Restrictions and bans on indoor tanning for adolescents and young adults are crucial. Understanding the population heavily at risk from the adverse effects of indoor tanning is the first step toward changing behavior. We are in a perfect position to implement change as nurses. I would propose an educational campaign to raise awareness of these health risks, targeting teens and women younger than 40 years. I believe that, without the awareness and education components, restrictions and bans will not have enough impact to drive this population toward healthy lifestyle choices.

## OBJECTIVES

In order for this health advocacy campaign to be effective, objectives of the policy would need to be identified. The objectives would include the following:

- utilizing dermatology and plastic surgery nurses to inform and educate other providers (school health nurses, community health nurses, and even aestheticians) who interface with teens and women younger than 40 years, about the risks of tanning indoors;
- educating mothers of teens, who serve as role models for their daughters, about the adverse effects of indoor tanning;

- increasing awareness of not only the health risks of indoor tanning, but also the accelerated effects on aging to women younger than 40 years, through educational programs on skin care and prevention;
- providing education and awareness of alternatives to indoor tanning to both teens and women younger than 40 years through the use of sunless tanners (spray tanning, mineral make-up bronzers, and self-tanning lotions); and
- partnering with industry (companies who promote sunless tanning products) to provide samples to the educators who can disseminate them to the population at risk.

## Conveying and Supporting the Program: Means and Methods

The first step in conveying the value and need for this proposed policy would be to provide education and awareness to stakeholders and policymakers. To make the school health and public health nurses feel vested in the program, they need to be informed. Nurses identified as skin experts from the DNA, The American Society of Plastic Surgical Nurses (ASPSN), and the Society of Plastic Surgery Skin Care Specialists (SPSSCS) could host educational programs, such as lunch and learns. These events could be funded by industry (i.e., Jane Iredale cosmetics and SkinMedica), who promote sun protection and sunless tanning products. With these local programs, the nurse would present on the topic of skin cancer awareness and prevention. Aestheticians who work alongside nurses could perform skin analyses and print visual reports, using portable systems that detect UV damage. Visia and Reveal are two proprietary systems commonly used in dermatology and plastic surgery practices.

Developing a task force focusing on the health and safety issues of indoor tanning would be another measure to convey information and establish support. This Indoor Tanning Task Force (ITTF) would comprise DNA, ASPSN, and SPSSCS nurses from every region of the country. To garner more support for the policy, these members would interact with other professional nursing organizations and present at their conferences. Having a stronger, collective voice on the heath issue of indoor tanning would make a greater impact on policymakers.

Finally, garnering the support of the skin care industry would be valuable in conveying information on a national level. Nurses in leadership positions within the DNA, ASPSN, and SPSSCS could approach these companies and volunteer to be on their advisory boards. In these positions, they would have opportunities to expose the advocacy program and influence policy.

## Application of Attributes From Effective Programs

The two health advocacy programs that I reviewed had different attributes that could be applied to this indoor tanning education and awareness program. Harris (2000), in her skin cancer prevention program, was innovative in her approach. She was also able to utilize her knowledge and experience as an advanced practice dermatology nurse. I believe that the campaign I have proposed is also innovative and would target different groups that could be reached through distinctive settings. I would also elicit nurses from dermatology and plastic surgery settings who are experienced skin specialists. These practitioners would provide the necessary education and awareness to the school health nurses, community health nurses, and aestheticians who have touch points with target populations. Harris (2000) targeted the population she sought to educate on a local level, and used resources available on a national level (the "Sunnysaurus" coloring book developed by the DNA). The indoor tanning education campaign would also work on both local and national levels. Locally, it would target schools, communities, and wellness settings where women frequent. Both awareness efforts and resources for alternative sunless tanners would be implemented. By working with professional organizations such as the ASPSN, DNA, and SPSSCS, national educational campaigns can disseminate information. Endorsements from selected celebrities and sports figures, who are genuine role models, would also have a broader impact.

Attributes from the Oliveria et al (2001) program, where nurse practitioners were used for skin cancer screenings, could also be applied to the indoor tanning education program.

It was effective and replicable because of the three-pronged approach used to equip practitioners. I would also develop a comprehensive curriculum on skin cancer, in general, and the adverse health effects of indoor tanning. All nurses responsible for educating other providers would be required to learn this curriculum through didactic or video presentation. It would also enhance the campaign if school nurses, community nurses, and aestheticians could shadow dermatology and plastic surgery nurses to see firsthand the sequelae of skin cancer diagnosis and treatment.

## Proposed Policy Enactment

The proposed health policy and advocacy campaign that I have described could be endorsed through

modifications to existing regulations. Legislation is already in place where states, and now, cities restrict indoor tanning use by minors. Policy statements have been established by organizations such as the American Medical Association, the WHO, the Academy of Dermatology, the Skin Cancer Foundation (2013), and The American Academy of Pediatrics, calling for a ban on youth tanning (skincancer.org, 2012). Other efforts are also under way by Representatives Waxman and DeGette to reveal false information being circulated by the tanning industry (skincancer.org, 2012).

State legislation to restrict indoor tanning use by minors is not enough. Because this legislation has been enacted in some states, I would advocate for requiring a nationwide ban. Policymakers have demonstrated efforts toward exposing misleading messaging about indoor tanning. I believe that additional measures to educate the public through new advocacy campaigns would be well received. In addition to the policy statements already in place, calling for a ban on youth tanning, greater influence could be achieved through position statements from key nursing organizations such as the DNA, ASPSN, SPSSCS, and the ANA.

### Analysis of Methods Used for Policy Support

Effective implementation of the advocacy program will require involvement on local and national legislative levels. Milstead (2013) describes the success in this arena being likened to a three-legged stool; all legs are necessary for stability. Leg 1 would involve contacting lobbyists from both the nursing and physician professional organizations in plastic surgery and dermatology. I would work along with task force members from the DNA, ASPSN, and the SPSSCS to inform these lobbyists about the proposed educational efforts to address indoor tanning risks.

Leg 2 would focus on the grassroots level. Milstead (2013) reports that some of the most effective lobbying can occur at this level. Through the ITTF established by the ASPSN, DNA, and SPSSCS, key contacts would be made through various routes. In-person visits to local and national legislators, personally written letters by the membership from all three organizations, and e-mails, faxes, and phone calls are measures that would all be implemented. It would also be valuable to establish connections with the staff members and legislative aides (particularly women) of the lawmakers to target them with these efforts.

The third leg of the stool involves money and endorsements. The task force would elicit funding from industry and their collaborating physician specialty organizations (American Society of Plastic Surgeons, AAD, and American Society of Aesthetic Plastic Surgeons), where pockets are deep and educational grants are available. The ITTF would also contact the ANA on state and national levels to determine if their political action committees would provide either monetary support or a publicized communication of support. Establishing three high-profile celebrities, models, or sports figures who publically endorse this educational campaign would make a strong impact. I would select these figures from three age groups: (1) teens, (2) young adults, and (3) women 30–40 years of age.

### Obstacles to the Legislative Process

The beauty industry in the United States today is big business. The Indoor Tanning Association (2013) reports that this industry employs more than 140,000 people. The industry's revenue was estimated at $2.6 billion in 2010 (AAD, 2013). Just like there are lobbyists in support of indoor tanning restrictions, there are also lobbyists fighting against these efforts. This obstacle could be overcome by having a collective voice among nursing organizations in Washington. Through the efforts of a joint task force and position statements from all of these organizations, a strong legislative impact could be made. Eliciting the financial support through unrestricted educational grants from the skin care industry would allow more funding for these efforts. Milstead (2013) states that our nation is in support of the increased role for nurses in health care debates; therefore, we need to seize our opportunities. Soliciting assistance from policy nurses and organizations such as the Nightingale Policy Institute and the National Institute of Nursing Research may also help in overcoming hurdles (Milstead, 2013).

Historically, we have seen most of the legislative support and activity from the health care side coming from professional medical organizations. Some of the leadership and membership of these organizations may not initially be as receptive to collaborative efforts until we prove our knowledge and competence. By serving together on joint panels, advisory boards, and task forces, we can gain their confidence and respect. Collectively, as professional nurses and nursing organizations, banning together with our physician colleagues and their societies, we will have a stronger voice on health issues such as the risks of indoor tanning.

## Ethics

### Dilemmas

Milstead (2013) states that an effective program will anticipate potential ethical conflicts and identify approaches to avoid them or address them as they

develop. Ethical dilemmas may arise in three ways: (1) conflict between the administrator, researcher, and advocate; (2) conflict between the right to privacy and the right to know; and (3) conflict between the requirements of the researcher, administrator, and advocate (Milstead, 2013). In the ANA Code of Ethics, Provisions 7, 8, and 9 relate to (a) nursing's contributions to society through active involvement with its progress and development, (b) nursing's intracollaboration with other health care professions and the community in meeting health needs, and (c) the responsibilities of nursing associations in shaping policy and protecting the integrity of the profession (ANA, 2001). Each of these codes relates to the advocacy program I have described.

The advocacy campaign focusing on the health risks of indoor tanning does not pose significant ethical dilemmas; however, I will identify three potential issues that could develop.

The first conflict could be an outside nurse who is involved in this program. She may be interacting with women in wellness settings that may not want to be seen or recognized. A scenario such as this could be addressed by having the providers who work in those settings first inform the women about the educational program offering, and second, obtain informed consent to participate. Informed consent is a standard component of all care provided by the advanced practice nurse and is a process used to safeguard people from harm (Milstead, 2013). Another ethical dilemma that could arise involves partnership with the skin care industry and funding or products they may provide for these programs. This could be considered a conflict of interest with the health care providers and the programming, altogether. A measure should be put in place that protects from commercial bias. By submitting for funding and any in-kind product through an unrestricted educational grant from the manufacturers, compliance with the ANCC and ACCME standards and guidelines would be maintained (Accreditation Counsel for Continuing Medical Education [ACCME], 2011; American Nurses Credentialing Center, 2013). The final potential ethical dilemma revolves around the right of choice. Some may argue that by prohibiting the rights of minors to access indoor tanning facilities, it is restricting their right to choose. This is one potential issue I would not attempt to resolve.

### *Laws*

I believe that there should be restrictions on a minor's right of choice when the consequence has the potential for physical harm. According to Mayer et al. (2011), existing laws have proven ineffective in decreasing indoor tanning use among adolescents. The authors propose that a ban is needed to effect change, and that parental involvement is necessary to implement these preventive measures (Mayer et al., 2011). Dellavalle et al. (2003) proposed that statutes be put in place, specifying age restrictions for the use of indoor tanning. Their rationale was that laws governing youth access to tobacco are comparable and do reflect protecting the health and safety of minors.

I believe that a multidimensional advocacy program, focusing on awareness and education about the risks of UV exposure on all types of skin cancer, would have the most impact on legislation. Reporting requirements have been established when eliciting support for funding or other types of involvement of industry. These guidelines are clearly outlined in ANCC and ACCME policies and maintain that all stakeholders are held accountable through detailed program evaluations.

### *Challenges*

Ethical challenges will arise when working with women, younger adults, and adolescents in attempts to increase awareness of safety and restrict the use of indoor tanning. One of the fundamental issues when dealing with minors would be taking away their right to choose. Some critics would debate that when considering youth access laws, change in behavior cannot be legislated. In contrast, endorsing laws or bans restricting access to indoor tanning for minors could impact societal changes that, consequently, promote behavioral change. The expectation would be that healthy behaviors in youth would transcend into adulthood. In turn, this legislation would impact cultural beliefs toward healthy behavior and, subsequently, influence population health.

## SUMMARY

According to the ANA Social Policy Statement, social policies and the impact they have on individual, family, and community health are a part of nursing care and nursing research (Milstead, 2013). Ultimately, the essence of our commitment is to the patient, whether that be an individual, family, group, or community. As health advocates, advanced practice nurses must be prepared to fulfill that role and influence policies that enhance both quality and access to health care.

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