NURSING VOICE IN PROVINCIAL HEALTH POLICY

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ABSTRACT

There is a prevailing narrative in the nursing literature that nurses are absent or invisible at macro-level policy discussions and that nurses lack influence in the macro-level policy sphere. To overcome these concerns, there are repeated calls for nursing leaders to enact their *nursing voice* at the macro-level. Yet, few studies have been undertaken that explore the experiences of nursing leaders in macro-level health policy, to either refute or substantiate this narrative. My purpose in this study was to begin to address this gap, especially in a Canadian context. Findings from this qualitative descriptive study revealed the elements of *nursing voice* in macro-level health policy work to be; perspective, presence and political. Further, the findings challenged the prevailing narrative of the lack of influence by nurses and highlighted some of the internal and external limitations to the profession's influence in macro-level health policy.

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LIST OF ABBREVIATIONS

ANA	American Nurses Association
CIHI	Canadian Institute for Health Information
CNA	Canadian Nurses Association
CNO	Chief Nursing Officers
ICN	International Council of Nurses
NEC	National Expert Commission
RNABC	Registered Nurses Association of British Columbia
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Health policies underpin every aspect of a health care system, and as such, directly influence nursing practice and issues. Since the late 1990's interest in and literature about how nurses can and should work to influence decision-makers and be engaged in politics and policies has grown considerably (Benton et al., 2017). Health policy has become an important and expanding domain of nursing practice (Salvage & White, 2019). The ability of nursing leaders to position themselves at policy tables and be heard in health policy discussions has been described as vital to advance the contribution and role of nurses in meeting global, national, or provincial health care transformation (Villeneuve, 2017).

1.1 PROBLEM OF INTEREST

There is a long-held belief that *nursing voice* is absent or lacking in health policy (Cohen et al., 1996; Duncan et al., 2014; Gebbie et al., 2000). Since the inception of professional nursing, nurses have been called to use their voices to improve the quality of care, advance the profession, and be leaders within health care systems (Selanders & Crane, 2012). International and national professional nursing organizations cite the need for nursing leaders to inform, influence, and have a nursing voice in health policy (American Nurses Association [ANA], 2019; Canadian Nurses Association [CNA], 2019a; International Council of Nurses [ICN], 2019). Expert nursing leaders write about the need for nursing voice in health policy (Al Rafia, 2017; Benton, 2012; Shamian, 2016) and the need for that voice to be clearly heard and used by policy decision-makers (Duncan et al., 2014; Leavitt, 2009). Moreover, the need for and yet the conspicuous lack of nursing voice in health policy, and the absence of nurses at policy decision-making tables is recognized by those outside of the nursing profession (Donelan et al., 2010; Institute of Medicine, 2011; Lewis, 2010, 2014; World Health Organization [WHO], 2020).

This perceived lack of nursing voice in health policy is my problem of interest. How does nursing move past this? I have found little empirical evidence to either refute or substantiate that there is a lack of nursing voice in health policy. Furthermore, there is a particular lack of Canadian evidence, and my study contributes to addressing this gap.

Making the Case for Nursing Voice in Health Policy

In the nursing literature there is a common narrative used to make the case for nursing voice in health policy. This narrative includes facts, arguments and reasons that are repeated over and over again, in an attempt to make the case for why nurses, individually and as a profession, must be involved and influential in health policy. Nurses are the largest group of health care providers in Canada (Canadian Institute for Health Information [CIHI], 2019) and internationally (ICN, 2019; WHO, 2020). Nurses are employed in every sector of health care, are responsible for the majority of direct patient care, and provide a continuum of care across the life span (Khoury et al., 2011). Due to the highly relational nature of their practice with individuals and communities across the health care system, nurses can offer direct and experiential insights into the effects of health care policies on individuals, communities, and populations (Benton, 2012).

In the literature, nursing scholars often attempt to justify the importance of nursing voice in policy by referring to nurses as experts in health care, who possess unique knowledge and skills that are needed in health care systems (Benton, 2012; Duncan et al, 2014; Leavitt, 2009). Scholars describe nurses as possessing an understanding of the complexity and challenges of providing health care, and of the settings where health care is delivered (Leavitt, 2009; Rasheed et al., 2020). Scholars also suggest nurses hold a deep understanding of the relationships between health, society, and environmental factors and are therefore well positioned to inform decision-makers about strategies that can enhance the health of populations (Benton, 2012; Rasheed et al.,

2020). In addition, nursing scholars produce quality health care research that is useful to policymakers. For example, nursing research has linked health care system factors to the quality of nursing care (Duncan et al., 2014), and has demonstrated how nursing care contributes to quality outcomes and the health of individual patients and whole populations (Leavitt, 2009).

Nurses are described as the first to recognize emerging health concerns, and the policy changes necessary to help address these concerns (MacDonald et al., 2012). Furthermore, meeting the future health needs of an aging population with increasingly complex medical needs, will require fundamental changes to health care policies and to health care systems (Villeneuve, 2017). As well, nurses work within the "cost-quality constraints" of health service delivery (Benton, 2012, p.3). Duncan et al. (2014) noted that it is crucial that nurses are not only heard at policy tables, but are also influential in the decision-making process that leads to needed changes. This is consistent with many other nursing scholars, who also note that nurses have the knowledge to inform and advise policy decision-makers on a broad range of issues, including the changes needed to improve access and delivery of health care, and how to improve the quality and cost effectiveness of care within health care systems (Abood, 2007; Benton, 2012; Duncan et al., 2014; Leavitt, 2009; Villeneuve, 2017).

Therefore, the argument goes, nursing professionals are among the ideal leaders to inform and advise policy decision-makers on a broad range of issues to improve global health and transform health care systems (Abood, 2007; Benton, 2012; Duncan et al., 2014; Khoury et al., 2011; Rasheed et al., 2020). Although there is a vast nursing literature related to health policy, it appears that the attempts made by the nursing profession to leverage the arguments above have not resulted in the desired level of nursing involvement and influence in policy. Indeed, nursing scholars continue to indicate that nurses are usually considered the implementers of policies, not

the decision-makers or developers of policies (Benton et al., 2017), and it is suggested that nurses lack involvement in the policy process at all levels in the health care system and that the level of involvement of nurses in policy has not improved over time (Rasheed et al., 2020).

In May 2011, the CNA provided further evidence to support the case that nursing voice is crucial to informing health policy by establishing an independent National Expert Commission [NEC] (2012) with the intention of identifying "the most efficient, effective and sustainable ways to meet the changing and pressing health needs of Canadians in the 21st century" (p.4). The NEC was a national initiative made up of leaders from multiple sectors: nursing, medicine, business, law, academia, economics, and health-care policy. The Commissioners sought to understand the concerns of Canadians about health and health care and to engage Canadians in developing solutions to transform the country's health care system. The findings of the NEC further strengthened the rationale for the importance of nursing voice in health policy, and the need to include nurses in all discussions about reforming health care. The NEC (2012) consulted with the public, nurses and other health professionals, the business sector, and policymakers across Canada, and determined that:

> nursing science and practice have to be at the core and center of a new health system because we know that nursing care is effective, it's affordable and it makes sense. Canada's nurses can and must act in collaboration with other health professionals and system leaders to ensure better health, better care and better value for all Canadians (p.1)

Furthermore, Gallup poles consistently rate the nursing profession as the highest in honesty and ethics, as compared to other professions (Brenan, 2017; Reinhart, 2020). The public trusts and expects nurses to be involved and influential in health care reform (Villeneuve & Betker, 2020). Indeed, in a survey of 1500 government, industry, and academic opinion leaders in the United States (US), Khoury et al. (2011) reported that the majority of respondents believed that nurses do have a great deal of influence in reducing medical errors and improving patient safety and the

quality of patient care. However, many respondents reported that nurses should have more influence in health policy, a greater say in improving patient safety and quality of care, and in the overall improvement of improve health care systems (Khoury et al., 2011).

In addition, nursing scholars suggest that the nursing profession has gradually gained more status and power through professionalization, a state where professional status is obtained through "the creation of specialized knowledge, professional standards and a code of ethics, increased autonomy, the strengthening of professional organizations, and higher educational requirements" (Gunn et al., 2018, p.2798). However, bringing this status and power into the political and policy arenas has been difficult and slow (Fyffe, 2009; Waddell et al., 2017; WHO, 2020). Undeterred, many nursing professionals continue to increase their involvement in politics and policy and advance their understanding in these realms. Nurses develop strategies for political influence (Abood, 2007) and policy advocacy (Benton, 2012). They create models or frameworks to help nurses influence the policy process (Shamian, 2014), effectively participate in policy development (Waddell et al., 2017) or analyze existing policies (Turkel & Ray, 2003). Further, nurses design educational opportunities that strengthen the political and policy knowledge of future nursing leaders (DiCenso et al., 2012). All this work has been undertaken with the intent to increase the influence of nursing among policy decision-makers and ensure the voice of nursing is reflected in the development of health policies (Abood, 2007; Benton, 2012; Duncan et al., 2014). Fyffe (2009) suggested that nursing voice helps policy decision-makers understand evidence and its relevance to policy and practice. Additionally, Fyffe (2009) noted that nursing voice helps serve as a bridge linking what policymakers do, the practice of nursing, and what nurses confront every day. Further, Benton (2012) noted that the nursing profession,

individual nurses, and the patients that nurses care for all stand to benefit when nursing voice informs health policy.

The Voice of Professional Nursing Associations and Organizations

Duncan et al. (2014) asserted that harnessing the profession's collective power is critical for nurses to advocate for the profession and for system-wide change. In Canada, there are over 448 000 regulated nurses (registered nurses, registered psychiatric nurses, nurse practitioners, and licensed practical nurses) (CIHI, 2020). Many regulated nurses belong to professional associations, and expect these organizations to act as their collective voice in health policy (Matthews, 2012). In fact, in my review of the missions, mandates, and visions of some of Canada's professional nursing associations, I noted that these organizations position themselves as channels for nursing voice into federal, provincial, or territorial health policy (Association of Regulated Nurses of Manitoba, 2019; CNA, 2019a; Nurse and Nurse Practitioners of British Columbia, 2019). Scholars suggest that nursing leaders whose role it is to bring this collective voice to policy discussions should understand how to obtain and use political clout to achieve policy goals (Abood, 2007; Groenwald & Eldridge, 2019). However, the nature of experiences and degree of influence of nursing leaders in policy roles within nursing associations and organizations is only minimally documented in the literature.

The Nursing Voice Inside Government

Inside Canadian federal, provincial, and territorial governments, nurses have historically held and continue to hold formal leadership positions. Through these formal positions, nursing leaders bring a nursing voice to policy tables to advise and inform decision-makers. However, these government positions are vulnerable to constraints in the political and economic climates of the time and have come, gone, or changed over the years (Villeneuve, 2017). Nursing leaders

who have held formal health policy roles inside of government are rarely the subject of empirical research, leaving their experiences and perspectives on nursing voice in health policy largely unknown and undocumented. In fact, only one major Canadian study of macro-level nursing leaders with inside government experiences has been published, and that was in 1994 (Splane & Splane, 1994). Further, positions inside government for nursing leaders are limited and may not always be visible, as nurses may be in positions behind the scenes that provide policy information to decision-makers, perform policy analyses, or develop policy options.

Nursing scholars assert that nursing leaders, both inside and outside of government, understand the complexity of providing health care, the settings health care is delivered in, and the changes needed to improve the health care system (Fyffe, 2009). However, recent scholarship maintains the perception that nursing leaders whose role it is to work with and among government policy decision-makers, are often absent, invisible, or unheard at policy tables (Benton, 2012; Duncan et al., 2014; Villeneuve, 2017).

1.2 PURPOSE OF MY STUDY

The purpose of my study was to explore the experiences of nursing leaders from two Canadian provinces, who have engaged in provincial health policy work. I examined how nurses in formal policy positions both inside and outside of the government understood and defined nursing voice. Further, I sought to understand how they used their nursing voice to inform or advise policy decision-makers, advocate about issues that are important to health care and to the nursing profession, and influence policy decisions in political environments. The findings of this study add to the knowledge base of the nursing profession by exploring what it means to have a nursing voice.

Research Questions

My central research question for this study was: What has been nursing leaders' experience of *nursing voice* in provincial health policy in Canada? One sub-question helped frame the study: How do these experiences vary related to occupying policy roles inside or outside of government?

1.3 THESIS STRUCTURE

My thesis is divided into six chapters. In Chapter One, I have introduced my topic, my problem of interest, purpose of my study and research questions. In Chapter Two, I present my review of the literature which summarizes the existing evidence about: 1) nursing voice in macro-level health policy, including discussions about nursing leaders from professional nursing organizations and nursing leaders inside government; 2) existing research about nursing leaders experiences in macro-level health policy; and 3) identified barriers that affect the efforts of nursing leaders to engage in policy advocacy or to influence health policy decisions, including a discussion on power, oppression, patriarchy, and hierarchy. In Chapter Three, I describe the qualitative methodology and methods I employed in my research. In Chapter Four, I discuss the key findings generated from my analysis of the participant interviews. In Chapter Five, I present my discussion about my key findings, and situate these findings and their associated connections in the existing literature. In Chapter Six, I summarize my problem of interest, highlight the main findings and discussion points from my research, and present the implications for the nursing profession, limitations of my study and suggest areas for future research.

CHAPTER 2: LITERATURE REVIEW

My purpose in this literature review is to provide an overview of the literature about the experiences of nurse leaders in macro-level health policy, particularly their use of *nursing voice* to influence policy. Macro-level policies are also referred to as public policies (i.e., policies that affect populations). These policies encompass decisions, directions, strategic plans, and legislative rules. Governments use these policies to fulfill political promises, decide resource allocation, and prioritize the social, economic, and health needs of the population (Bryant, 2016). Policies developed at the government level are strategic and affect whole populations, health care systems, and health care delivery. These policies are made by authoritative decision-makers within governments and are intended to direct the actions or decisions of others. Macro-level policies may take the form of regulations, laws, or standards (Taft & Nanna, 2008). In conducting this review of nursing voice in terms of its influence on such policies, I assessed the evidence base in terms of its major foci, weaknesses, and gaps.

A search of the terms ‘nursing voice’ and ‘nursing’ and ‘voice’ returned thousands of results, covering a broad range of areas, topics, and issues. These terms were used in so many different ways that their meaning became blurred. I found no literature that defined or conceptualized the term ‘nursing voice’, nor any studies where the concept of nursing voice in health policy was explored. As Buresh and Gordon (2013) explained, the word ‘voice’ is a “non-negotiable prerequisite of advocacy” (p.16), therefore, I focused on the concepts in the literature that required nursing voice in macro-level health policy: policy advocacy and influence. The literature I found related to policy advocacy and influence was largely focused on the advocacy efforts of clinical nurses or organizational nurse managers as opposed to the influence of nurses holding formal macro-level policy roles inside or outside of government. As well, discussion

papers and empirical research made up only a small part of the literature about nursing leaders in macro-level health policy. In addition, I found that a large part of the health policy literature about the involvement of nurses in macro-level policy and politics consisted of editorial, opinion, or point-of-view writings. Although often written by well-respected and expert global nursing leaders, this literature was not included in my review. Finally, although I attempted to balance comprehensiveness with an appropriate focus on literature that pertained to my research questions, in my search of the literature it is possible that missed literature that may be relevant to my research.

To conduct my literature review I searched various databases including, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and ProQuest, and I also searched using the academic search engine Google Scholar. For this review, to capture recent research and scholarly writings I considered peer-reviewed articles published between the years of 2009 and 2019, and that were available in full text and English. I have included a few seminal pieces of literature written prior to 2009 as these articles were often cited in the recent literature. The initial search terms, as single words or in multiple combinations, included: 'nurse', 'nurses' or 'nursing' and 'policy', 'policies', 'politics' or 'political' and 'advocacy' or 'influence'. From the search results, I identified over 1000 potential articles and retrieved the abstracts. To select articles for full review, I further assessed the abstracts for key words or terms such as 'public policy', 'health policy', 'macro-level' or 'macro level', 'participation' or 'involvement', 'leader', 'leaders' or 'leadership', and 'professional associations' or 'professional organizations', and retrieved papers that appeared likely to address my research questions (if I was unsure, I retrieved the article for a full review). From the articles selected, I manually searched the reference lists for other relevant articles. Most of the articles retrieved and reviewed during the

selection process only briefly mentioned macro-level policy or included general statements that policy decision-makers should incorporate a nursing perspective into their decision. Many of these articles simply called for nurses to increase their involvement in politics or policy. However, to be included in my review articles needed to include substantial discussions on the inclusion of nurses in macro-level health policy. My review includes key discussion and analytical papers, empirical research, and literature reviews. Empirical research from an international context was included, as I found no empirical studies in a Canadian context. The studies included are primarily qualitative in nature except for three mixed-method studies.

Three main topical areas emerged in relation to the research questions: 1) nursing voice in macro-level health policy, including discussions about nursing leaders from professional nursing associations and nursing leaders inside government, 2) research about nursing leaders experiences in macro-level health policy, and 3) identified barriers that affect the efforts of nursing leaders to engage in policy advocacy or to influence health policy decisions, including the implications of power, patriarchy, and hierarchy in health policy.

2.1 NURSING VOICE IN MACRO-LEVEL HEALTH POLICY

Nurses have a long history of political and policy activism, advocacy, involvement, and influence. Nursing historians extol the political and policy successes of past nursing leaders such as Florence Nightingale (Selanders & Crane, 2012), Mary Agnes Snively, and Alice Girard (CNA, 2013). Canadian nursing leaders have been, and continue to be, influential in shaping both federal and provincial health policy. For example, current policy activities and influence by Canadian nursing leaders at the CNA include advocacy efforts and advisory work on the complex issue of Medical Assistance in Dying (CNA, 2016). Also, nursing leaders at the CNA (2019b) have been successful in their advocacy efforts on the issue of violence facing health care

workers in Canada. In fact, all of CNA's recommendations to the House of Commons standing committee on this important issue were included in the committee's final report. Past policy successes also include the work of nursing leaders from the Registered Nurses Association of British Columbia (RNABC) in promoting primary health care in the 1990s. The RNABC was able to "institute primary health care in nursing practice and influence provincial and local health policy" (Whyte & Stone, 2000, p.58). The RNABC concluded that through their successful policy engagement efforts, "the most significant outcome was the influence exerted on provincial health policy and many of the RNABC's recommendations were incorporated into the government's framework for reform" (Whyte & Stone, 2000, p.61). Yet, despite policy successes by nursing leaders, it is noted by nursing leaders (Benton, 2012) and those external to the nursing profession (Institute of Medicine, 2011) that nurses often lack influence in health policy. Indeed, a narrative describing nurses' lack of influence in health policy persists in the literature, and global calls for nurses to better use their nursing voice to influence health policy and increase their participation in policy advocacy continues.

Scholars in the 1990s called for nurses to move beyond individual patient advocacy towards policy advocacy, which focuses on systems-level policies. Spenceley, Reutter, and Allen's (2006) thoughtful exploration of nursing advocacy at the level of public policy provided a snapshot of nursing knowledge on the subject from the mid-1990s to the mid-2000s. During this time, nursing was broadening its views on advocacy from bedside, one patient at a time, to macro-level political and policy arenas (Spenceley et al., 2006). Spenceley et al. (2006) described the literature at the time as being "replete with normative claims that nurses should engage in policy advocacy" (p.184). The authors further noted that nursing was described as virtually invisible in policy influence in the literature, and that nursing scholars were calling for

expanded policy education. In addition, they noted a lack of empirical research on the engagement of nurses in health policy and a lack of conceptual models to guide nurses in policy advocacy (Spenceley et al., 2006). Finally, the authors identified that nursing researchers had not pursued perspectives on policy advocacy from others outside of the nursing profession, including decision-makers, and that in general, nursing had difficulty bringing its crucial knowledge to the policy table (Spenceley et al., 2006). The authors are frequently cited in the literature, and their thoughts remain consistent with current scholarly writings.

Since Spenceley et al.'s 2006 seminal paper, scholarly writings about the advocacy efforts and the influence (or lack thereof) by nurses in health policy at the macro-level have continued. For my purposes in this review, the prevalent perspective on the participation of nurses in policy advocacy in the 1990's was well-captured by this seminal article – nurses were described as largely unconcerned with system-level policy advocacy – and nursing contributions, however crucial, and described as mostly invisible. I have selected seven key discussion papers to review that were relevant to my research questions and written by nursing scholars. These discussion papers highlight the evolution of scholarly thinking since Spenceley et al.'s 2006 article about the macro-level policy advocacy and influence of nurses. These subsequent discussions mostly reaffirm and perpetuate the narrative captured in Spenceley et al. (2006), but also provide new considerations in the discourse on the topic.

In 2007, Sheila Abood, an associate director for government affairs at the ANA and who was responsible for the organization's lobbying efforts at the time, wrote a discussion paper about nursing advocacy and influence in health policy within the United States (US) legislative arena. Abood's (2007) discussion of nursing voice in macro-level health policy focused on the strategies and sources of power, nursing policy advocates could draw upon to have more

influence in policy than they currently have. She suggested the nursing profession needed to better understand the policy process and the political arena where health policy is made. Abood (2007) asserted that understanding the connection between policy and politics, who the key decision-makers are, and how to communicate with them improved the chances of influencing health policy. As well, she explained a few of the sources of power nursing leaders may use as policy advocates; expert, referent, and legitimate. Expert power, she noted, comes from the unique knowledge and skills base of the profession, attributes that enable nurses to bring expert solutions to policy decision-makers. Referent power was described as the power nursing has gained through its adherence to professional and ethical standards; thereby earning a reputation as a trusted and respected profession by the public. Legitimate power was noted as emerging from the professional authority of nursing to address social, political, and economic factors within health care systems. Abood (2007) also included the "power of numbers" (p.5) in policy advocacy and stressed the importance of professional associations as advocates that can harness the collective voice of the profession. However, nursing has accepted the myth of powerlessness, and as such, has not been able to realize its collective power. She concluded that nursing has failed to develop a unified voice or to become a powerful force that could offset the dominance of medicine in political and policy arenas.

In 2009, Judith Leavitt, a health policy consultant in the US, identified the ways nursing leaders have used their knowledge, experiences, and skills to change health policy. Leavitt (2009) departed from the dominant narrative that nurses lack influence in health policy, to write a strength-based view of the participation of nursing leaders in health policy. She described nursing as politically engaged, and as having a credible and respected voice and highlighted policies that nursing leaders had successfully influenced. She also provided several examples of

nursing leaders who held formal roles in macro-level health policy in the US. Unfortunately, she did not include the perspectives or experiences of the nursing leaders engaged in this successful policy work. Leavitt (2009) did acknowledge that nursing leaders who work on all levels of health policy within government, are often invisible, and further insisted that despite policy successes, nursing must increase its influence and visibility in the policy arena. She concluded that the profession should work to ensure a nursing voice is at the policy tables where decisions are made in the pursuit of solutions to health care issues.

In 2010 Margaret Mahlin, a nursing philosophy, and ethics professor, stressed in a discussion paper that systemic issues in US health care required nursing to move past advocacy focusing on individual patients, and towards collective advocacy on structural system issues and she posited that this should be done through professional nursing associations. She asserted that protecting individual patients will never be possible unless systemic issues are addressed. Mahlin (2010) also added new discourse about the policy advocacy of nurses, by provocatively suggesting that one of the underlying motives of the profession's adoption of the language of patient advocacy was to further the goals of increasing both professionalism and power. This perspective is not common in the policy advocacy literature; to the contrary, the literature is full of claims that health policy advocacy is a professional responsibility and moral imperative of nursing (Abood, 2007; Benton, 2012; Duncan et al., 2014; Leavitt, 2009; Spenceley et al., 2006).

David Benton, a past Chief Executive Officer of the ICN, shared many of the same views as the scholars discussed above. In his 2012 discussion paper, he further described the nursing profession as the key to improving health care access and quality of care and as well-positioned to provide advice on policies aimed at cost-effectiveness. Benton (2012) asserted that the single most important factor in influencing health policy was solidarity within the profession. He

further emphasized that collaboration among professional nursing organizations must include all nursing perspectives, including associations, unions, and regulators, when determining specific goals or purposes, and that the profession should maintain a consistent and unified position in policy discussions. As well, he noted that during policy discussions, the collective voice of professional organizations must be strong in advocating for change and influencing government decision-makers, to achieve the political and policy goals of nursing (Benton, 2012).

In 2014, Arabi et al. added to the discourse by conducting a concept analysis of policy influence by nurses. Although the authors' aim was to clarify this concept in an Iranian context, the content of the reference list is largely American, making their analysis relevant in North American context. Arabi et al. (2014) identified the attributes of policy influence by nurses as: being on a spectrum from policy literacy to policy influence, developing policy acumen and competency to reach policy influence, thinking of power as the ability to achieve goals and influence others, and considering policy influence as an important part of advocacy. The authors also noted a lack of nursing models or frameworks guiding research on the concept or the actual work of policy influence.

Also in 2014, nursing scholars Susan Duncan and her colleagues presented a Canadian perspective on the future of nursing in Canada (Duncan et al., 2014). They continued the narrative of the lack of nursing voice at policy discussions, and of the crucial need for the profession to have an active voice in health policy that is heard and used by decision-makers. Nursing leaders who work with government decision-makers, at all levels of health policy, were also described by these authors as invisible in their policy roles and work; indeed, they noted that macro-level health care policies often lack mention of nursing and “it is as if the largest group of health care providers has somehow been rendered invisible” (Duncan et al., 2014, p.627). The

authors expressed concern that this sense of exclusion is not well understood, and hinders the ability of the nursing professions to respond. They also identified a need to strengthen the engagement of the profession in health policy and to engage nurses to develop unity and collective voice in their professional work — a unity that should extend to different nursing organizations and groups. Duncan et al. (2014) suggested that the profession needed to improve its relational and strength-based leadership by recognizing that relationships and coalitions are important mechanisms in policy advocacy and influence. Indeed, they highlighted the important role of nursing leaders from professional associations in influencing health policy by developing collaborative relationships. Further, the authors posited that through professional nursing associations and the coalitions that they could form, nursing leaders could find themselves able to harness the power of the collective and achieve policy outcomes that are in the best interests of the public. Duncan et al. (2014) also pointed out that nursing leaders need to be more aware of and responsive to the power dynamics that exist at all levels of the health care system. Although the authors did not suggest practical ways to do this, they did note that leadership should move beyond positional leadership in order to achieve the various forms of power required for systems-level change. The authors concluded with a call for increased policy education and leadership capacity, improved strategies to bring nursing knowledge and voice to the macro-level policy tables, and a suggestion that the nursing profession critically reflect on how its collective power is manifested.

In keeping with the dominant narrative, Joanne Disch (2019), a long serving American nursing leader in executive positions, academia, and professional nursing associations, asserted that “when informed nurses are actively involved in shaping health care policy at any level, desired outcomes will be substantially improved” (p.4). Further, she suggested that the

congruence between the ethical mandate of the nursing profession and current US health care policy directions is not accidental or unexpected. According to Disch (2019), national policies benefit from the nursing lens as policy decisions are then "more likely to address core issues, consider system implications, employ realistic implementation strategies, and maintain a focus on patients, their families, and communities" (p.8). To make health care in the US safer, more affordable, and accessible, she asserted that nurses must play a critical role in health policy formation at all levels due to their unique strengths and sources of influence. Although many organizations have recognized and are advocating for increased and improved engagement of nurses in health policy development, Disch (2019) contended that the perception remains "that nurses bring little new insight to a decision-making group if a physician is already part of the group" (p.7). She added to the discourse by noting that this perception by decision-makers has its roots in gender bias, outdated views of nurses as physicians' helpers, and nurses being seen as biased, self-serving, and lacking in leadership capabilities. Disch (2019), also suggested that unfortunately, at times nurses forego their professional identity for the good of the health care institution. In addition, she emphasized that for nurses to influence health policy it was imperative that they understand that despite differing definitions of policy, politics, and power differ, "there are four common threads among these terms: 1) each has a goal of action or change, 2) each involves working with others, 3) they all exist at every level 4) the application of policy, politics, or power is contextual as it depends on the situation at hand" (p.8)".

The authors cited in this section of my review are all nursing leaders with expertise in health policy, and with expert knowledge and understanding of the nursing profession and complex health systems. Their scholarly writings illustrate the dominance of the narrative that there is a pressing need for, and a serious lack of nursing voice in health policy.

2.2 PROFESSIONAL ASSOCIATIONS AND NURSING VOICE

My literature search yielded little empirical evidence about the activities of professional associations in advocating for or influencing health policy. Much of the literature relating to professional associations focused on their efforts to educate and engage individual nurses in patient or health policy advocacy (Catallo et al., 2014; Jurns, 2019). However, the efforts of professional associations to educate and engage individual nurses are rarely coupled with access to opportunities for these individual nurses to learn from or collaborate and network with nursing leaders who have experience in policy work and to actively influence policy decisions (Benton et al., 2017; Catallo et al., 2014).

Globally, professional nursing associations or organizations such as the ICN, ANA, and the CNA stress the importance of the voices of nursing leaders, and nurses who work at the point-of-care, in political activism and policy development. The ICN encourages all nurses, around the world, to be actively engaged in politics and policy activism, and to increase their understanding of political and policy processes (Benton, 2012). The ANA (2019) and the CNA (2019a), both national voices of the nursing profession, call on nurses to ensure they meet their professional and ethical obligations by actively advocating for policies and ensuring their voice is heard at all levels in health systems. Nursing leaders who hold formal policy roles within professional nursing associations engage in setting priorities for macro-level policy advocacy (CNA, 2019a), educate nurses about politics and policy (Jurns, 2019), and provide testimony, information or advice to political leaders and decision-makers (ANA, 2019; CNA, 2019a; ICN, 2019).

Matthews (2012) described the advocacy activities of American professional nursing associations. Advocacy was portrayed as the cornerstone of nursing, the primary role of

professional associations, and as being motivated by the moral and ethical principles of nursing (Matthews, 2012). Further, Matthews (2012) asserted that policy advocacy by professional associations contributes to the profession's accountability to society. Matthews (2012) also described the ways in which professional associations advocate for their policy goals by issuing position statements on health policy concerns, offering processes to engage nurses in health policy advocacy, and by educating, informing, and influencing policymakers through lobbying or political advocacy. Although non-empirical, this paper was informative in its description of the collective advocacy activities of professional associations in the US. From the perspective of my research, it would have been helpful for Matthews to have also explored the experiences of nursing leaders exercising nursing voice in their roles inside professional associations.

In MacDonald et al.'s (2012) interpretative scoping review, the authors examined priority setting and policy advocacy and explored the factors that influence the policy choices and actions of professional associations. For my purposes, a limitation of their scoping review was the small amount of evidence from a Canadian context (10.5%). The authors described multiple internal factors, such as intraprofessional nursing relationships, as well as external factors, such as political or socio-economic system disruptions, that create complex policy advocacy environments. These internal and external factors influenced the choices, actions, failures, or successes in policy work by professional associations (MacDonald et al., 2012). However, the ways in which nursing leaders experienced these internal and external factors was not described in this literature.

MacDonald et al. (2012) also posited that policy advocacy and influence by professional associations is dependent on their organizations' nursing leaders possessing: multiple types of knowledge and evidence; an understanding of the policy process; and opportunities to attend

meetings with government officials. As well, the authors noted a lack of empirical evidence on the policy advocacy of professional associations, and a lack of larger health systems perspective by professional associations in their priority setting and policy advocacy activities (MacDonald et al., 2012). MacDonald et al. (2012) concluded that policy work is relational in nature and that professional associations forge relationships with multiple stakeholders. These relationships ultimately involve conflict, collaboration, and the creation and participation in networks (MacDonald et al., 2012).

MacDonald et al.'s (2012) conclusions are consistent with the findings of a mixed-methods study by Contandriopoulos et al. (2018) on health care reforms and the dynamics of stakeholder views and group influence. Conflict between stakeholders and government decision-makers was described as common. Networks between stakeholders were noted to be complex, and sometimes conflicting. However, the researchers found that these networks had the potential to be collaborative and to facilitate the development of strong policy options (Contandriopoulos et al., 2018). Contandriopoulos et al.'s findings were not specific to professional associations but were based more generally on stakeholders or interest groups. This suggests to me that more research is needed about the relational nature of government decision-making and the involvement of professional nursing associations.

Jiwani (2011), a Canadian nursing and political scholar, conducted a qualitative study of key factors influencing government policy decision-makers and explored how these decision-makers make decisions. In this study, Jiwani (2011) highlighted the importance of understanding the decision-making styles of decision-makers. Jiwani found that decision-makers often relied on their personal thinking and ethical processes over the use of credible advice and scientific research by stakeholders when engaged in political and policy decision-making. Therefore,

developing trusting relationships with decision-makers can be an important strategy of the stakeholders who seek to influence them. Jiwani's insight as a previous nursing leader in health policy, and a health policy strategist and researcher, provides compelling evidence to support leaders in professional associations in enacting their policy advocacy role and influencing policy decision-makers.

In a qualitative descriptive study, Donovan et al. (2012) explored the perceptions of 25 nurse leaders and Fellows of the College of Nurses Aotearoa, on the state of policy and political leadership in New Zealand. The participants agreed that involvement by nursing organizations in policy work was still developing and ranged from "self-interest to political sophistication to leading the way" (Donovan et al., 2012, p.17). The authors identified five themes that emerged as personal or professional factors that affected policy and political leadership in New Zealand: understanding political and policy language; leadership succession planning; anti-feminist tendencies and historical hierarchical ideas of leadership; the advantage of being a small country; and the importance of speaking with one voice (Donovan et al., 2012). These authors confirmed that formal policy roles in professional nursing associations are important in inserting the perspectives of nursing into the decision-making arena. However, they also noted that among these nursing leaders there was a frequent absence of a sense of personal determination and a perception of a lack of power to enact change.

Although it is important to understand how professional nursing associations set their policy priorities and what policy advocacy activities they engage in, what was lacking in the existing literature was an exploration of how their nursing leaders enact their policy advocacy roles at the macro-level. Understanding what nursing leaders from professional associations experience during their policy work and while engaging with decision-makers and others, may

help provide empirical evidence for (or against) the common narrative that nurses lack involvement and influence, or are invisible, in health policy.

2.3 NURSING VOICE INSIDE GOVERNMENT

I found scant empirical research in the literature related to the experiences of nursing leaders within government, despite the reality that many nursing leaders work inside federal and provincial governments. It is possible that these individuals may not have been included in research due to the difficulty in accessing these individuals, or as government employees they may not have been able to speak to issues. Alternatively, they may have been included in the research, but their perspectives may not have been identified as coming from inside government. In fact, only one major Canadian study of macro-level nursing leaders with inside government experiences has been published, and that was in 1994. The researchers were Dr. Verna Splane, and her spouse Dr. Richard Splane. Dr. Verna Splane had a long and distinguished history of nursing leadership in the Canadian federal government. Dr. Richard Splane was a social work, social policy, and political science expert, and was influential in the development of Canadian federal social programs (Waltham, 2016). I expected that the findings from their descriptive research would have provided seminal knowledge for nursing scholars on leadership and health policy, but I found very few citations of their work, which was only available in book form. However, two similar studies are more widely available in the form of articles (Ramsammy, 1999; Salmon & Rambo, 2002). Similar to Splane and Splane's research, these two articles are seldomly cited in the literature.

Concerned with the perceived lack of nursing leadership in the UK, Ramsammy (1999) interviewed 51 high-level nursing leaders — "a sample which could truly be described as representing nurse leaders who could be considered as having been influential" (p.4). However,

it is difficult to comment on the quality of the research as Ramsammy did not describe the design or methods of the study, but the findings did provide a historical perspective (1948-1998) of the evolution and decline of nursing leadership in the UK. As Ramsammy's research occurred around the same time as Splane and Splane's research, it is possible that concerns with socio-political factors, reorganization, and the reform of health care and its corresponding effects on nursing leadership may have been similar in the UK and Canada at the time. These authors saw the need for and the value in research that explored the perspectives of nursing leaders inside government.

Salmon and Rambo (2002) also conducted a qualitative study in which they surveyed international government chief nursing officers (CNOs). In the background for their study, the authors referred to Splane and Splane's research as a "landmark descriptive study of CNOs" (Salmon & Rambo, 2002, p.137). Salmon and Rambo (2002) reported their study as the first-ever research of international CNOs, with a stated aim of developing an understanding of the current state of international CNOs. The authors (2002) anticipated this research would help nursing leaders both inside and outside of government understand and advance these CNO roles. The authors stated their belief that advancing CNO roles would enhance the health of society, and that more research from an inside-government perspective was needed (Salmon & Rambo, 2002). A campaign, *Nursing Now* (Nursing Now, 2019), a collaboration between the ICN and the WHO, further recognized the importance of CNOs in health systems. One of the campaign's ambitious objectives was that by the end of 2020 at least 75% of countries would have a CNO as part of their most senior management team in health systems. Salmon and Rambo expressed the value in better understanding an inside-government perspective, as well as the need for more research informed by an insider perspective. I found no other empirical studies about nursing

leaders who provided a macro-level insider perspective in the nursing literature. By way of contrast, political science scholars consider the study of government insider perspectives to be crucial for their discipline's knowledge base (Craft & Howlett, 2012; Evans & Sapeha, 2015; Maley, 2015; Tenbensel, 2008).

Influential Canadian nursing leaders with policy experience from professional nursing organizations and/or inside governments are often the authors of publications describing their own perspectives. For example, these perspectives are seen in published articles in professional journal (MacDonald-Rencz, 2009), academic textbooks (Bryant, 2016; Villeneuve, 2017), or narrative pieces on the nursing profession (Rafferty, 2018). Further, their experiential knowledge helps inform their research (Stevenson et al., 2012), or is used to develop new theories and models (Shamian, 2014). Although some studies do include nursing leaders from professional nursing organizations or inside government as participants (Juma et al., 2014; Shariff, 2014, 2015; Waddell et al., 2017), these studies are limited in their specific relevance to my study, as they have been conducted in international contexts and do not include specific exploration of the experiences and perspectives of these nursing leaders.

2.4 EXPERIENCES OF NURSING LEADERS IN HEALTH POLICY

In the nursing literature, I found seven studies that documented the perspectives or experiences of executive or high-level nursing leaders engaged in macro-level health policy. Although I found no studies in a Canadian context, findings from international studies help provide an evidence base to inform my research. Four of the studies included are from countries with different socio-political environments and where the degree of professionalization of nursing may differ from Canada. Therefore, the experiences explored in these studies may not be

consistent with the experiences of nursing leaders in policy work in Canada, and this is potentially a limitation of these studies in informing my research.

Shariff (2014, 2015) used a Delphi survey to explore the knowledge and experiences of expert nursing leaders in macro-level health policy development within three East African countries. From this empirical research Shariff produced two peer-reviewed articles. One paper was focused on the barriers and facilitators to participation by nursing leaders in health policy, and is discussed later in this review (Shariff, 2014). In a second paper, Shariff (2015) categorized the leadership attributes necessary for participation by nursing leaders in health policy development: the ability to influence, communicate effectively, build relationships, feel empowered, and have professional credibility. Even though the socio-political context of this study is different from Canada, these attributes of nursing policy leaders are deemed important in other scholarly writings and international studies (Abood, 2007; Donovan et al., 2012; Duncan et al., 2014; Leavitt, 2009; MacDonald et al., 2017)

In a mixed-methods study, Juma et al. (2014) examined how nurses were involved in Kenya's national health policy process. Study participants included national-level nurse leaders, front-line nurses, managers, and non-nursing decision-makers. The authors research helped substantiate the need for a collective voice in health policy discussions. They posited that the inability of nursing leaders to take unified action divided the nursing profession, and weakened nursing voice and its influence in health policy. I noted one of the strengths of this study was the inclusion of the perspectives of non-nursing decision-makers. Juma et al. (2014) found that even when nursing leaders were included in policy discussions, decision-makers believed that nursing leaders lacked policy knowledge and the skills to engage in the policy process, or saw nursing knowledge and research as not credible. The notion that nursing scholars often do not seek the

perspective of others outside of the nursing profession, including those of decision-makers, was identified as a concern by Spenceley et al. (2006), and this gap remains in the nursing literature related to policy advocacy and influence.

In their mixed-methods study, Waddell et al. (2017) used a conceptual framework, which merged a nursing and a health policy model to explore the policy participation of nursing leaders in the US. Influential factors important to the policy work of nursing leaders were identified as: knowledge, authority, status, communication, and timing (Waddell et al., 2017). These findings are consistent with other literature in my review (Abood, 2007; Donovan et al., 2012; Shariff, 2014). The need to develop and use conceptual models to explore the policy advocacy of nurses was identified by Spenceley et al. in 2006. This assertion remains valid, as I found few models or frameworks that have been applied in health policy research.

Ditlopo et al. (2014) conducted a series of descriptive case studies that explored the dynamics, strengths, and weaknesses surrounding the participation of nurses in the making of four national policies in South Africa. Initial interviews were conducted with 28 key nurse informants who had knowledge, involvement, or influence in the policy-making processes in the policies of interest. These initial interviews were followed by interviews with 73 frontline nurses to garner their outside government perspective. Key nurse informants included a small sample from national and provincial governments and professional nursing associations. Ditlopo et al. (2014) noted that in general, there was a perception among participants of insufficient, or ineffective, involvement by nurses in policy development. Findings from their study revealed that several key nurse informants viewed the policy process as top-down. As such, these informants viewed nursing leaders as reactive instead of proactive in the policy process, often participating in policymaking only after policy decisions had already been made. Further,

although some nurses held senior positions in provincial government and had the potential to influence policy, these nurses were viewed by key nurse informants as "not assertive enough to ensure that changes that could affect the nursing profession are achieved" (p.7). As well, even when government policymakers did consult with nurses, the authors observed that the views of nurses were often not incorporated into policy decisions, which lead to unintended negative consequences during policy implementation (Ditlopo et al., 2014).

By way of contrast, in one national policy case, Ditlopo et al. (2014) revealed that the perceptions of policy involvement varied depending on the vantage point. Key nurse informants from inside government felt the policy process had been nurse-led and that nursing leaders and representatives from all sectors of the nursing profession had been involved. Yet, key nurse informants from outside of government believed that the policy process and development was led by non-nursing government staff. In addition, several key nurse informants from both inside and outside of government expressed concern that other national policies had been developed by individuals who had a limited understanding of the complexity of the nursing profession. Ditlopo et al. (2014) also noted that the majority of key nurse informants were concerned with the lack of unity and collective action amongst the different nursing groups. Internal conflicts and divisions amongst the nursing groups made it difficult for nurses to have a unified voice and this negatively impacted how nurses were viewed by policymakers. Further, the researchers reported that existing power relationships and hierarchies between government officials or other stakeholders and nurses made it difficult for nurses to influence policy. Additionally, power relationships and hierarchies between nursing groups led to tension over the perceived legitimacy of different nursing stakeholder groups as representative of the nursing voice in policy discussions. The authors suggested that power relationships and hierarchies reflected the reality

that the nursing profession consists of different voices and perspectives, and that policymaking is a negotiation between many groups with competing interests. Ditlopo et al. (2014) concluded that the extent and nature of the experiences of nurses in policymaking was both complex and contested. The authors recommended that the National CNO should provide leadership and facilitate a process where different nursing stakeholders are brought together throughout the policy process. In addition, they concluded that the national nursing association should develop its leadership in policy and build the capacity and skills to analyze, provide feedback on, or lead the development of health policies. This empirical work provided an important perspective in the published evidence, in that it was one of the only studies to explore the views of nurses on policymaking from both inside and outside of government vantage points.

I have included an older, seminal, and often-cited qualitative study by Gebbie et al. (2000) as the authors are nursing researchers with extensive experience in health policymaking at all levels of government. Their research provided insights on the effectiveness (or lack thereof) of nursing leaders in health policy, which likely remain relevant today. Gebbie et al. (2000) interviewed 27 nurses who were actively involved in health policy work. Their research sought the perspectives of nurses in policy work, but the participants experience of the process was not a focus of their work. The authors concluded that nurses require education, experience, opportunity, and policy and political knowledge to effectively engage in health policy (Gebbie et al., 2000). Relationship-building and effective communication with policy decision-makers, as well as the generation of policy-relevant research were indicated to be crucial in influencing health policy (Gebbie et al., 2000). Gebbie et al.'s findings on the barriers to and facilitators of the engagement and influence of nursing leaders in health policy are also consistent with other

scholarly discussions (Abood, 2007; Benton et al., 2017; Leavitt, 2009; Spenceley et al., 2006) and research findings (Juma et al., 2014; Shariff, 2015; Waddell et al., 2017).

Although non-empirical, one other relevant piece of literature is Najar and Hubbard's (2008) compilation of the personal perspectives of national nursing leaders who are or were members of a US national advisory committee. Najar and Hubbard (2008) found that nursing leaders believed that formal advisory roles gave them a place at the policy table, where their nursing knowledge was used, and nursing voice was incorporated into health policy. These nursing leaders reported that participation in policy discussions required nurses to: avoid using nursing-centric language, resist focusing solely on nursing views and, ensure they bridged the gap between nursing and policy language in policy discussions (Najar & Hubbard, 2008). This paper offered a strength-based perspective of nursing leaders engaged in health policy, and was a rare look into the ways these nursing leaders were effective in policy advocacy and influence.

Due to the scant amount of literature about the experiences of nursing leaders in macro-level health policy it appeared to me that there was more to be learned in this area. I believe that an empirical exploration on the topic could make a useful contribution to the knowledge base of the discipline.

2.5 BARRIERS TO NURSING VOICE IN HEALTH POLICY

Several barriers affecting the advocacy and influence efforts of nursing leaders in the political and policy arena are noted in the scholarly literature. This is not surprising given that the prevailing narrative is that nurses are absent, invisible and lack influence in health policy, or do not participate in policy advocacy. In 2017, Benton et al. undertook a fulsome integrative review of articles published until 2015 about the evidence supporting the work by the nursing profession in pursuing policy and political competence. The authors included 45 sources, including

empirical research, and peer-reviewed manuscripts, articles, and reports. Most sources were written within the US context. Although the findings are important, the authors noted that the vast majority of the published work they reviewed on policy and political competencies or attaining such competencies have a number of significant weaknesses, such as small opportunistic samples, a lack of evaluation for long-term impact, little detail on how samples compared to a wider population, data collection occurring immediately upon nurses finishing an educational opportunity, and a lack of transparency in data collection methods and assessments of the validity and reliability of instruments used.

In their review, Benton et al. (2017) identified five specific themes. Four themes related to theoretical models for measuring or evaluating the policy activity of nurses, and the opportunities and competencies needed by nurses to engage in policy activity. The fifth theme, barriers to the policy and political competence of nurses, included such factors as: a dearth of access to relevant education about health policy and politics, a lack of nursing leaders with practical policy experience, limited opportunities for nurses to engage in policy experiences, and the potential negative effects of individual nurse characteristics such as age, gender, and clinical experience on the participation of nurses in politics and policy.

North American and international scholars have also noted that these same barriers play a significant role in limiting the influence of nursing in politics and health policy. For example, Ellenbecker et al. (2017) suggested that attempts to educate nurses in health policy can be overly broad and ambitious, and that a more in-depth and focused approach would be more effective. In a literature review of health policy training by Heiman et al. (2016) the authors asserted a new approach was required to develop engaged health policy leadership and a health professional workforce that is prepared to fulfil leadership roles. Heiman et al. (2016) emphasized that this

new approach would require educators to build health policy capacity in the leaders of all health care professions, including nursing, by: adopting broader policy approaches and an interdisciplinary lens, acknowledging the importance of non-health sectors, and by moving education outside the walls of academia. A strength of this review was their inclusion of literature from nursing and other health care professions (Heiman et al., 2016). Salvage and White (2019) pointed out formal nursing leadership programs are limited and focus mainly on organizational management. They asserted that this approach ignores strategic, political and policy leadership skills and limits the ability of nursing to influence decision-makers (Salvage & White, 2019).

Consistent with the prevalent narrative, scholars have observed that even though nurses around the world have become more knowledgeable, educated and skilled in policy, nursing has not had a significant increase in their influence on health policies (Salvage & White, 2019). A lack of strong political leadership, unwillingness to take on leadership roles, and a failure of the profession to succession-plan for new nursing leaders (Donovan et al., 2012) have been noted as barriers to policy influence by nursing. Ditloto et al. (2014) reported that nursing leaders lacked assertiveness throughout the policy process, which often led nursing leaders to be reactive to policy decisions, instead of proactive in policy development. Salvage and White (2019) expressed concern that a crisis of weak and reduced leadership in nursing is occurring, and that nurses simply may not know how to influence and shape health policy. Duncan et al. (2014) also asserted that nursing is experiencing a crisis of leadership and drew attention to Canada's ongoing erosion of nursing leadership positions, and the loss of senior nurse executives at policy decision-making tables. Duncan et al. (2014) suggest that nursing knowledge and expertise is not easily available to, valued, or utilized by policy decision-makers.

Several scholars have noted that nursing leaders must not only understand the policy process better, but also the complex connection between policy and politics, as decision-makers rely heavily on the political process in policy making (Abood, 2007; Jiwani, 2011; Leavitt, 2009; Shariff, 2014; Villeneuve, 2017). Other barriers identified in the literature that may limit the ability of nursing leaders to be effective influencers in health policy include a lack of political awareness (Groenwald & Eldridge, 2019) and a lack political skill (Abood, 2007). In an integrative review, Montalvo (2015) described political skill as an important competency in navigating and influencing politics and policy. Additionally, it has been noted that the unfamiliar world of politics and policy requires nursing leaders to step out of their comfort zone into a world they may not be prepared for, or be effective in (Abood, 2007). In their review of the sources of health policy, Taft and Nanna (2008) identified nurse's general lack of understanding of the sources of health policy and the complexity of the multiple factors that drive them such as economics, public policy, technology, politics or social needs.

When engaged in health policy work, nurses have often been identified as ineffective communicators in their written or verbal messages, in public speaking and debating, and in their ability to articulate issues using political and policy language (Benton et al., 2017). In fact, ineffective communication as a barrier to effective policy influence was cited in most of the existing empirical evidence in my review (Donovan et al., 2012; Gebbie et al., 2000; Juma et al., 2014; Shariff, 2014, 2015; Waddell et al., 2017). To successfully convey messages in a credible, convincing, and understandable way, nursing leaders must use the language of policy and politics (Donovan et al., 2012). It has been noted that communication must also be free of nursing-centric jargon (Najar & Hubbard, 2008; Shariff, 2014; Waddell et al., 2017) to enable nursing leaders to effectively explain or promote nursing to non-nursing audiences (Shariff,

2015). The ability to articulate the positions, issues or ideas of nursing clearly, concisely, and effectively are noted as crucial to nurses influencing policy (Waddell et al., 2017). Additionally, developing carefully constructed arguments and preparing concise, audience-relevant messages were noted to enhance the effectiveness of nursing leaders in health policy discussions (Donovan et al., 2012).

Also present in the scholarly literature are discussions about the barriers internal to the nursing profession that may inhibit the ability of nurses to influence health policy. Benton et al. (2017) suggested that fragmentation of the nursing profession leads to an inability to speak with a unified voice. The reluctance of nursing organizations to collaborate has been noted as detrimental to the ability of nursing to present a unified voice in health policy (Benton, 2012; Ditlopo et al., 2014; Duncan et al., 2014). Gebbie et al. (2000) posited that the inability of nursing to see the profession as part of a larger system may lead nursing to overvalue the importance of the goals and values of the profession in health policy. Ditlopo et al. (2014) expressed concern that nursing leaders exhibited a victim mentality, even when they held government positions, and that this mentality undermined their effectiveness in influencing decision-makers. In addition, it has been observed that when nursing leaders exhibited a singular focus on nursing issues it decreased their policy influence and hindered their ability to be convincing in policy discussions (Juma et al., 2014; Shariff, 2015). Whereas, according to Najar & Hubbard (2008) avoiding these inward-looking views during health policy discussions has increased the credibility of nursing leaders and reflected the value of collaboration by the nursing profession (Najar & Hubbard, 2008).

Another significant barrier to nursing participation in policy advocacy noted in the literature is systems-level constraints, where neoliberalism, managerialism, and economics have

been noted as factors that negatively affect the ability of nurses to influence health policy (Villeneuve, 2017). As well, the policy agendas or political ideologies of governments and the professional values of nursing may conflict (Abood, 2007; Annesley, 2019; Villeneuve, 2017). Additionally, government decision-makers may view the agenda of nursing as purely self-interested (Cull, 2016) or as having a conflict of interest (Groenwald & Eldridge, 2019). Further, a general unwillingness by decision-makers to listen to nursing voices in policy discussions, or even the poor timing of nurses' attempts to be heard in the policy process, have been described as negatively affecting the policy influence of nursing (Annesley, 2019). It is important to note that researchers have also observed that even when decision-makers do consult with nurses on policy issues, nurses' insights and perspectives have been ignored by these decision-makers when making policy decisions (Ditlopo et al., 2014). As well, some scholars have suggested that decision-makers may view nursing research as uncredible, nursing-focused, and possibly lacking a broader systems perspective (Gebbie et al., 2000; Juma et al., 2019).

Finally, it has been noted that conflicts with other interest groups, and within nursing itself, may leave decision-makers confused and unclear about what the profession wants and can result in decision-makers being unwilling to be seen to be favoring one group over another. This can lead decision-makers to look to other individuals or groups at the policy table to make decisions that will affect the nursing profession (Groenwald & Eldridge, 2019). As well, Donovan et al. (2012) suggested that it is in the best interests of government or medicine to portray nursing as divided or hostile, as this strategy diminishes nursing credibility and keeps nursing from effectively influencing health policy (Donovan et al., 2012).

2.6 POWER IN HEALTH POLICY

Power is often identified as a key concept in the general (non-nursing) discourse around policy advocacy and influence. Sriram et al. (2018) suggested that power manifests, implicitly or explicitly, in the interactions of the diverse group of health policy actors. The interactions between these actors are dynamic and require negotiations on resource distribution and health policy priorities to shape health policy actions, processes, and outcomes. According to Sriram et al. (2018) "analyzing and engaging with power has important potential for improving our understanding of the underlying causes of inequity, and our ability to promote transparency, accountability and fairness" (p. 611). So, it is puzzling that power is rarely explicitly discussed or analyzed in the nursing literature about health policy influence. Neither are the adverse effects of power, whether exerted by organized medicine or the governing political group of the time, on the nursing profession in health policy work. For example, within the nursing scholarly literature, power has been identified as an attribute needed by nurses to influence policy and a necessity to achieve the goals of nursing (Arabi et al., 2014; Groenwald & Eldridge, 2019). Yet, is it suggested that nurses may feel powerless as individuals, and lack an awareness of the potential capacity that power in numbers holds for the nursing profession (Abood, 2007) and this perceived powerlessness is described as one force that casts nurses as less effective in influencing health policy (Ditlopo et al., 2014; Groenwald & Eldridge, 2019).

Although power (or powerlessness) may be discussed in general in the nursing literature, there is little analysis of the role power dynamics play in the perceived powerlessness of nurses in health policy. In contrast, scholarly writings about the power of physicians, and the perceived powerlessness and oppression of nursing are abundant in the general nursing literature (Bradbury-Jones et al., 2008; Dubrosky, 2013; Fletcher, 2006). For example, Manojlovich

(2007) examined the concepts of power and empowerment in the nursing literature and observed that power was viewed as an outcome of masculinity and in direct opposition to caring as the essence of nursing and femininity. A masculine view of power implies having control, influence, and domination. Manojlovich (2007) suggested that this masculine image of power may contribute to the perceived lack of power by the nursing profession. According to Manojlovich (2007) empowerment is one variable that may offset a perceived lack of power. The author noted that empowerment must be cultivated in nursing to shape and control the content and context of nursing practice and to optimize the contributions of nursing to health care. Similarly, Shariff (2015) suggested that "true empowerment can only be achieved when there is a balance of power between the oppressors and oppressed" (p.2), and that "nursing voice is muted in the presence of more powerful others, fashioned and reinforced through self-perceived patterns of hierarchical communication and internalized threat of sanction" (p.2).

The concept of empowerment was first described in the nursing literature in the 1980s and is now seen extensively in the literature. Scholarly writings about the empowerment of nurses are often directed at how nurses can and should empower patients, or how through the process of empowerment nurses achieve professional growth and development. For example, according to Bradbury-Jones et al. (2008), one outcome of empowerment is improved self-esteem, or a process "whereby self-efficacy is associated with adequately coping with situations" (p.261). Manojlovich (2017) suggested that based on her review of empowerment research, empowered nurses motivate themself and others, and experience less burnout and job strain. In contrast, feelings of disempowerment in nurses create feelings of frustration and failure in their nursing practice. This line of thinking focuses on the individual characteristics or qualities of nurses as the means to empowerment, and ignores the complex and longstanding structural

factors within social, political, and organizational contexts (Bradbury-Jones et al., 2008). Bradbury-Jones et al. (2008) suggested that for nurses to be able to empower others they must first understand the ways hierarchical and patriarchal hegemony affects nursing practice. For example, nurses need to recognize that long standing gender inequalities and biases are embedded in health systems, but so are the ways policy decision-makers respond to these inequalities and biases. Decision-makers function within health system hierarchies (social, political and gender) and through their policy decisions maintain the existing power structures that advantage some professions over others, which reinforces the social and gender inequalities within health systems (Hays et al., 2019). Again, this line of thinking is rarely discussed in the nursing literature about health policy. This reaffirmed the need for empirical evidence in order to further evolve the knowledge and discourse of the nursing profession about the influence (or lack thereof) of nurses in health policy.

Oppressed Group Behaviors

Understanding the role that power plays in the prevalent view of nurses as invisible or non-participatory in policy advocacy or influence led me to the evidence relating to oppressed group behavior. Closely linked to power and empowerment, is the scholarly recognition of nursing as an oppressed group. This notion first emerged in the nursing literature in the 1980s and is attributed to the work done by the educationalist and philosopher Paulo Freire (Roberts, 1983). Freire theorized that oppressed group behaviours developed in groups when "dominated people feel devalued in a culture where the powerful promote their own attributes as the valued ones. The oppressed, therefore, develop disdain for themselves and a belief in their own inferiority that leads to a lack of pride and feelings of low self-esteem" (Roberts et al., 2009, p. 289). Roberts (1983) theorized that nurses exhibited oppressed group behaviours due to the

oppression they experienced from hospital administrators and physicians. Roberts (1983) then proposed that by understanding oppressed group behaviours, nursing scholars could explain and predict the behaviours of nurses in the workplace from a systems perspective. Further, Roberts (1983) suggested that this understanding of oppressed group behaviours could help empower individual nurses to break the cycle that keeps them powerless in the health care system. According to Roberts (1983) there are two dimensions that interact to create and maintain a state of oppression in nurses: 1) the external situation created and maintained by the oppressor (i.e., patriarchal and medical hegemony) and 2) the internalization of the dominance (hegemony) of the oppressor.

Patriarchal and Medical Hegemony in Health Policy

Gore and Parker (2019) suggested that when researchers overlook power and ignore a political context, including ideologies and norms, their understanding of why particular policy decisions are made may be inaccurate or incomplete. In the literature I reviewed, explicit discussions about patriarchal and medical hegemony as a barrier to the advocacy and influence of nursing in health policy received little attention. Yet, according to Peart and Mackinnon (2018), when nurses think critically about the social, cultural, and political climates in which they work, it is possible to reflect on why the inequities exist and persist in their professional work environment. Further, this critical thinking may help nurses recognize that hegemonic ideologies are often hidden in the status quo, internalized by nurses as unchangeable facts or the only options, and conferring favor on certain groups over others. Hegemonic ideologies tend to be recreated and constantly renewed, and it becomes difficult to stop the injustices that they generate. However, an awareness of hegemonic ideologies and the oppressive impact they have

on nursing practice, can help nurses think about things differently and examine personal assumptions (Peart & Mackinnon, 2018).

Historically, nursing was viewed as a female occupation, subservient to (typically male) physicians, and engendering a consequent reluctance of nurses to acknowledge and discuss power (Groenwald & Eldridge, 2019; Manojlovich, 2007). This view, it is said, has encultured nursing to accept a lower professional rank to medicine in society and the health care system, and therefore to readily accept less decision-making power (Dubrosky, 2013; Groenwald & Eldridge, 2019). In contrast, social-political structures are imbued with long-standing male dominance, where men are typically seen in positions of power and decision-making (Juma et al., 2014; Ng & Muntaner, 2018). Juma et al. (2014) observed that physicians had more representation on committees and a higher frequency of involvement in policy meetings than nurses, where policy decisions may be made without nursing input. Shariff (2014) noted that most government policy development positions were given to male physicians or other non-nurses, who were then expected to represent the nursing profession in policymaking. In Canada, women remain under-represented in political office, even though the percentage has increased from 4.2% in 1976 to 25.9% in 2009 (Ng & Muntaner, 2018). In fact, among all Organisation for Economic Co-operation and Development (OECD) countries, women are still under-represented in most of the political offices at all levels of government (Ng & Muntaner, 2018). Ng and Muntaner's (2018) findings suggest that even though Juma et al. (2014) and Shariff's (2014, 2015) studies represent observations in an African context, their findings are relevant internationally.

In government and interprofessional hierarchies, many have observed that the dominance of medicine has positioned physicians as policy decision-makers and limited the policy influence

of nursing (Contandriopoulos et al., 2018; Dubrosky, 2013; Fletcher, 2006; Groenwald & Eldridge, 2019; Juma et al., 2014; Tenbensel, 2008). Political and health system structures may indeed favor medical involvement (Juma et al., 2014) and exclude nurse leaders, except on an as-needed basis (Shariff, 2014). Contandriopoulos et al. (2018) revealed that physician unions and medical organizations dominate the health policy field in Quebec and suggested that the power of these organizations was similar throughout Canada. Alternatively, government political ideologies may clash with medical dominance resulting in government political actors exerting their power in decision-making and leaving all stakeholders, including nursing and medicine, out of the policy decisions (Tenbensel, 2008).

Internalized Oppression in Health Policy

Several nursing scholars have suggested that oppressed group behaviours and internalized oppression, has evolved in response to long-standing patriarchal and physician (medical) dominance (Dubrosky, 2013; Matheson & Bobay, 2007; Roberts, 1983). According to Roberts (1983), consistent with the theory of oppression "nurses have been led to believe that it is right or natural for medicine to maintain control of the entire health care enterprise" (p.29). Internalized oppression manifests in many ways. In reviewing the barriers highlighted in the literature I believe that findings such as: nursing leaders lacked assertiveness and exhibited a victim mentality (Ditlopo et al., 2014); nurses are ineffective communicators at policy debates or in articulating issues using political and policy language (Benton et al., 2017); and nursing involvement in policy discussions was seen as self-serving or nursing-centric (Cull, 2016), could be linked back to the concepts of nursing as an oppressed group and as indicators of internalized oppression. As well, although not explicitly labeled as such, many of the findings and barriers I reviewed align with the concept of imposter syndrome. Imposter syndrome is a form of

internalized oppression where nurses internalize negative societal messages about themselves, which can lead to thoughts and feelings of inadequacy and fraudulence, despite their own abilities, achievements, or accolades (John, 2019).

Fletcher (2006) suggested that nursing, as we know it today, remains strongly influenced by the historical development of the profession within hierarchical, autocratic, and oppressive institutional practices. Mahlin (2010) identified these historical factors as related to the challenges to the policy advocacy that nurses experience today. Mahlin (2010) further added that the medical profession has been the main source of oppression of nursing advocacy, exerted through institutionalized sexual discrimination and bureaucracy. Although physicians certainly do wield a lot of power due to structural, gendered, and historical factors, it is perhaps unfair for Mahlin to lay all the blame at their feet, since the gendered oppression of women and care work is a societal construct, which is embedded in, reinforced and perpetuated through all societal institutions. However, it is nurses who have internalized and accepted the oppressive actions, processes, and policies of health care as social norms.

Fletcher (2006) noted that controlling groups have greater prestige, power, and status than oppressed groups. The characteristics of the oppressor are seen as desirable to emulate, and there is a tendency for the oppressed group to internalize these values (Fletcher, 2006). As well, oppression requires an imbalance of power (Manojlovich, 2007). The inability of nursing as an ostensibly oppressed group to challenge the dominant group (in either medicine or politics) results in intraprofessional conflict among nurses, as nurses direct their hostilities towards each other (Manojlovich, 2007; Matheson & Bobay, 2007). It has been observed that the inability of nursing to challenge the dominant group (in either medicine or politics) may be a reflection of oppressed group behavior, which then results in the alignment with the masculine power

(Donovan et al., 2012; Shariff, 2014). This alignment was also noted to influence nursing leaders to display anti-feminist tendencies (hegemonic femininities), including stopping other females from succeeding and deterring other nurses from taking up leadership roles (Donovan et al., 2012; Dubrosky, 2013). The concept of nurses directing their hostilities towards each other is noted in the health policy arena as well. It has been noted in the scholarly literature that nursing organizations (unions, professional associations, and regulators) are often adversaries instead of allies in policy directions, and intraprofessional conflicts exist between the policy needs or wishes of different nursing groups (Groenwald & Eldridge, 2019).

Upon reviewing the literature, I noted that the gendered construction of nursing practice and the underlying hegemonic ideologies (and the resulting oppression) may be continuing to perpetuate the legacy of nursing as a feminine and subservient profession, and to devalue the high level of education, skills and professionalism required in all areas of nursing practice, including health policy. As well, outdated beliefs about nursing may persist within society at large, but they also persist within nurses themselves, which may undermine the professional advocacy and influence by nurses in health policy.

There are many complexities in the discourse about the involvement, engagement, and effectiveness of nursing leaders in their advocacy and influence efforts in macro-level health policy. External and internal barriers abound in the literature, yet the root causes of these barriers are rarely explored. The concepts of power, oppressions, patriarchy, and hierarchy are common in the general nursing literature but are almost non-existent in the health policy literature related to the policy advocacy and influence of nurses. Most importantly to my study, the experiences of nursing leaders in policy roles, from both inside and outside of government are under-researched.

Therefore, several gaps and weaknesses exist in the literature about the policy advocacy and influence efforts of nurses in policy roles.

2.7 GAPS AND WEAKNESSES IN THE LITERATURE

I identified several gaps and weaknesses in the existing literature. First, the term *nursing voice* has not been defined or conceptualized. A clearer understanding of what it means to have a nursing voice in health policy is needed. Exploring nursing voice may shed light on the ongoing dialogue about the lack of such voice in health policy.

Second, in general, there is a lack of empirical research on the experiences of nursing leaders in policy advocacy and influence, from both inside and outside of government. Specifically, research in a Canadian context is rare. Exploring the nature of these experiences and interactions with policy decision-makers will contribute to the knowledge about nursing leaders as policy actors. As well, the importance of understanding the perspectives of policy actors both inside and outside of government is acknowledged in the political science literature (Craft & Howlett, 2012; Evans & Sapeha, 2015), yet is mostly absent in the nursing literature.

Third, barriers to nursing voice in health policy are well established in the literature (Benton et al., 2017; Donovan et al., 2012; Shariff, 2014). However, I suggest a gap exists in this literature regarding the idea of power and its relation to the role of nursing voice in politics and policy. Given the amount of attention in the literature about the perceived powerlessness and oppression of the nursing profession at the hands of patriarchy and medical dominance (Bradbury-Jones et al., 2008; Dubrosky, 2013; Fletcher, 2006; Manojlovich, 2007; Matheson & Bobay, 2007), it is curious that these concepts have not been linked to the literature about nursing influence in the policy sphere. This gap is surprising and warrants exploration. In the political science literature, power is discussed as foundational to politics and policymaking

(Tenbensel, 2008), yet nursing scholars in this area appear to avoid this topic. As well, there is little written about the ways nursing is effectively influencing or informing health policy. A strength-based approach to discovering these drivers is not often used in the literature.

Lastly, I would assess an overall weakness of the nursing literature lies in a general failure to address the ways political knowledge could be applied to research in nursing and enhance the knowledge of the profession. Furthermore, nursing scholars could be incorporating a wider range of perspectives and empirical evidence into their work. Failing to do so may be perpetuating the criticism that nursing voice is nursing-centric, which may hinder the nursing profession's ability to position nursing voice in the context of broader political and health policy structures (Najar & Hubbard, 2008; Shariff, 2014; Waddell et al., 2017)

2.8 CHAPTER CONCLUSION

In summary, empirical literature about the experiences of nursing leaders in advocating for or influencing health policy in a Canadian context is limited. Drivers of effective policy influence by nursing leaders have received little attention in comparison to barriers. Barriers well established in the literature include: ineffective communication (Benton et al., 2017; Donovan et al., 2012), the lack of a strong collective voice and unified perspective (Benton, 2012; Duncan et al., 2014), and the lack of education, experience, and knowledge of both politics and policy (Leavitt, 2009; Shariff 2014, 2015). These barriers are noted to impede the ability of nurses to advance their professional perspective at policy discussions. The perceived powerlessness, oppression, and medical dominance over the nursing profession figures large in the literature (Bradbury-Jones et al., 2008; Dubrosky, 2013; Fletcher, 2006; Manojlovich, 2007; Matheson & Bobay, 2007) yet nursing scholars of health policy appear to pay little attention to this topic. This

is surprising given that the recognition of power dynamics in politics and policy is a mainstay of political science research (Tenbensel, 2008).

Nursing leaders from professional organizations and in formal roles inside government are essential policy actors in the policy arena. Yet, their experiences and perspectives appear to be under-researched and largely undocumented. Political science scholars acknowledge the importance of insider and outsider perspectives in politics and the policy process (Craft & Howlett, 2012; Evans & Sepeha, 2015). To the best of my knowledge no research exists that explores insider-outsider perspectives of health policy in a nursing context. I believe valuable knowledge of policy advocacy and influence is embedded in the experiences of formal nursing leaders from inside and outside of government, experiences that will be the focus of my research.

CHAPTER 3: RESEARCH METHODOLOGY AND METHODS

My purpose in this chapter is to explain my philosophical orientation and describe the qualitative research design and methods that guided my study. I present my guiding research questions and describe my study methods, including a brief explanation of qualitative descriptive design and my rationale for choosing this approach. I discuss my participant sample, selection, and recruitment approaches, as well as the data collection, management, and analysis strategies I used. Finally, I outline the strategies I employed to ensure trustworthiness and address relevant ethical considerations.

3.1 PHILOSOPHICAL ORIENTATION

A researcher's philosophical orientation is a way of answering specific questions about what constitutes the nature of reality (ontology), what counts as knowledge (epistemology), how we attempt to understand reality (methodology), and how evidence can be collected on reality (methods) (Maxwell, 2013). My approach to this study aligns with Maxwell's (2012) realist approach to qualitative research: there is a real-world that exists independent of our perceptions and constructions, and we are limited in our understanding of this reality (Maxwell, 2012). Further, the experiences of participants, and the meaning of these experiences, are ontologically real and exist independent of the perceptions and constructions of the researcher (Maxwell, 2012; 2019). Maxwell's (2012, 2019) realist approach allows for combining epistemological constructivism with ontological realism. A research approach informed by epistemological constructivism allows me to understand that what counts as knowledge is inevitably a construction from our perspectives and standpoints, and that reality is more complicated than "any single construction can adequately capture" (Maxwell, 2019, p.9). Therefore, my understanding of things is partial, incomplete, and fallible (Maxwell, 2019). In Maxwell's (2012)

realist approach, what people think, believe, and feel affects how they behave. As well, Maxwell (2012) asserts causal processes are real and must be considered in qualitative research. Consequently, in my realist approach to this study, I accept that the experiences of nursing leaders and the meaning of those experiences in their health policy work and within the health policy process are real, may be observable, and are reportable. However, I also acknowledge that the experiences of nursing leaders in health policy work are influenced by the socio-political context. Therefore, the methods I employed were aimed at gaining a fuller understanding of *nursing voice* from the contextualized experiences of several nursing leaders who had real-world experiences of bringing their nursing voice to macro-level health policy. These nursing leaders engaged in policy work in different political spheres and shared with me their unique and individual experiences. In this study, I had the opportunity to explore the patterns and commonalities in the descriptions of their policy work, as well as important variations in their descriptions.

My philosophical orientation

I acknowledge that my role as a researcher and as an instrument of research was inherently fallible and value-laden. As such, it was important that throughout the study, I surfaced and reflected on my own biases and assumptions. For example, in my literature review I found the existing research was predominately international in context and largely aimed at bedside nurses. So, it was my assumption that I would glean new knowledge by pursuing a study in the Canadian context and that focused on nursing leaders whose job is, or has been, macro-level policy work. Although my findings did suggest some interesting and different knowledge specific to nursing leaders with extensive macro-level policy experience, many of my findings are congruent with findings in the existing literature. In addition, my perspectives about nursing

practice were integrated into my study design. For example, my view that to overcome the systemic difficulties bedside nurses face the solutions must start at the top of the health care system. As well, integrated into the study were my perspectives on the socio-political structures that affect health care, such as my reluctance to accept the hierarchical and patriarchal nature of health care. These perspectives came from my past experiences during my nursing and academic journeys, my cultural values and beliefs, and how I have made sense of all of these within my life and my career. I must also acknowledge that my beliefs, values, and dispositions were a valuable resource to my study, but at times may have also been a source of distortion or misunderstanding on my part (Maxwell, 2012). I discuss this issue further in my reflexivity section.

3.2 RESEARCH QUESTIONS

My central research question for this study was: What has been nursing leaders' experience of *nursing voice* in provincial health policy in Canada? One sub-question helped frame the study: How do these experiences vary related to occupying policy roles inside or outside of government?

3.3 STUDY METHODS

In this section, I explain my choice of a qualitative descriptive design for this study. I describe the study design, setting, and context. I also outline my sampling methods and my selection and recruitment strategies. As well, I discuss my approaches to data collection, management and analysis, and my reflexivity and trustworthiness strategies.

Qualitative Descriptive Design

I found minimal research about nursing leaders experiences in macro-level policy work, especially within a Canadian context. I chose to begin to address this gap through a qualitative

research approach. In qualitative research, a researcher speaks directly with specific individuals, who have had particular experiences to gain a better understanding of a complex phenomenon (Creswell & Poth, 2018), and a qualitative approach is beneficial when the phenomenon in not well understood, or is under-researched. Therefore, I chose a qualitative descriptive design for my study, to gain insight on the underexplored phenomenon of nursing leaders experiences of *nursing voice* in health policy. According to Sandelowski (2000), a qualitative descriptive design draws from the naturalistic research paradigm. The researcher commits to studying something in its natural state, where there are no pre-selected variables, manipulation of variables, or commitment to any one philosophical view (Sandelowski, 2000). Health policy happens in a social-political environment and this environment represents the natural state where the experiences of nursing voice in provincial health policy occur.

Sandelowski (2000), described qualitative descriptive research as a method which provides a "comprehensive summary of an event in the everyday terms of those events" (p. 336). When using this method, the researcher provides a rich description from the participants perspective in a "straightforward descriptive summary of the informational contents of data organized in a way that best fits the data" (Sandelowski, 2000, p. 339). In employing a qualitative descriptive method, it was important that I "not veer too far from or into the data" and avoid constructing a "conceptual or highly abstract rendering of the data" (Sandelowski, 2000, p.335). However, I am aware that descriptions always depend on the perceptions, inclinations, and sensitivities of the describer (Sandelowski, 2000). Therefore, it was important for me to be alert to moments when my own perceptions and thoughts had crept into my choices as I analyzed these data. As well, my efforts to describe experiences, involved me exerting control over what I selected to describe, and thus my descriptions are not entirely free from interpretation. My

intention was to write an accurate, compelling, detailed, and contextualized description of the under-researched phenomenon of nursing leaders experience in macro-level policy work that contributed to the very thin evidence-base in an area of nursing activity described ubiquitously as 'crucial'.

Setting and Context

The setting for my research was two western Canadian provinces. I chose western Canadian provinces that share a similar Canadian ideology on health care, yet represent differing political ideologies and health care systems. Each province's socio-political context is unique in the political and policy choices made, the strategic priorities undertaken and in the decisions made about how health care is delivered. Provincial Ministry of Health policy decision-making environments provided context for my study.

In western Canadian provincial Ministries of Health (MoH), nursing representation differs. In Manitoba and British Columbia (BC) MoH departments there are formal Chief Nursing Officer positions. The BC Ministry of Health is unique in that it has a Nursing Policy Secretariat (NPS) led and staffed by nurses. The NPS is further unique as it produces public reports about its work in the ministry and on government policy. In Alberta and Saskatchewan, the positions and roles held by nursing leaders are not always public or visible. Nursing leaders in these provinces hold behind the scenes positions and provide policy information to decision-makers, perform policy analyses and develop policy options.

Professional nursing organizations are also an important means through which nursing leaders engage in health policy. The engagement of these organizations is influenced by their formal structures, rules, standards, values, mandates, and policy positions. Additionally, the ways in which nursing leaders from these organizations engage in policy work is influenced by their

formal positions and expectations of their employing organizations. The structures of professional nursing organizations differ between western Canadian provinces. As nurses are regulated provincially, all provinces have a nursing regulatory body. However, some provinces also have an independent professional nursing association, and some provinces have a dual mandate organization with both regulatory and association responsibilities. In Manitoba and British Columbia, the association and regulatory bodies are separate. In contrast, Alberta and Saskatchewan have dual mandate organizations. However, in both Alberta and Saskatchewan, the provincial nursing organizations are in the process of changing their mandates to regulatory only, and processes are underway to develop new, independent professional associations. Further, each province also has a nursing union. Although nursing leaders from nursing unions do represent an important outside government perspective, nursing unions were not part of the sampling frame for my study to ensure the scope of the current study was feasible within a reasonable time frame.

3.4 PARTICIPANT SAMPLING, SELECTION AND RECRUITMENT

Following ethical approval, recruitment of participants for my study began.

Sampling

In keeping with a qualitative descriptive design, purposeful sampling is used when participants with specific knowledge, experience or expertise in a particular area are required (Corofali & Evans, 2016). I purposefully sampled nursing leaders in western Canada, with an initial 10 individuals selected because of their specific policy knowledge and expertise. A purposeful sampling method was needed for this study because I sought to interview nursing leaders with experiences focused on policy advocacy and influence within the study context of provincial health policy (Bradshaw et al., 2017). As there are relatively few nursing leaders

engaged in these types of roles, I also used snowball sampling to help increase the number of possible participants. I asked participants to identify other individuals that may be appropriate for the study and to pass on my contact information. This resulted in seven more potential participants.

Selection

To be included in the study, the participant had to be a nursing leader who currently held or had previously held a formal policy position. Further, I screened the potential participants according to inclusion criteria for two separate groups: 1) Inside-Government; and 2) Outside-Government. Inside-Government was represented by those who held or had held, formal policy roles within a Canadian provincial MoH. Outside-Government included those with experience in formal policy roles in a professional nursing organization within Canada. Those from the outside government group were required to have had experience liaising with decision-makers about health policy, in a provincial MoH. As discussed in the context and setting section, nursing leaders with policy experience from nursing unions were excluded from the outside government group. However, I am unaware if any participants had previous policy experience from a role within a nursing union. This was not a question I asked, nor did any participant discuss holding a formal policy role with a union during their interview. See Table 1 for participant inclusion criteria.

Table 1

Participant Group Inclusion Criteria

Group	Inclusion Criteria
Group 1 *Nursing Leaders with Inside-Government Policy Experience*	▪ Currently hold, or have previously held, a leadership role in health policy in a provincial ministry of health in Canada. ▪ Due to their leadership role, currently have, or have previously had, access to provincial health policy decision-makers and opportunities to bring "nursing voice" to provincial health policy discussions.
Group 2 *Nursing Leaders with Outside-Governments Policy Experience*	▪ Currently hold, or have previously held, a leadership role in health policy in a professional nursing organization in Canada. ▪ Due to their leadership role, currently have, or have previously had, access to provincial health policy decision-makers and opportunities to bring "nursing voice" to provincial health policy discussions by regularly interfacing with decision-makers. ▪ Currently are, or previously were, expected by the professional nursing organization and provincial health policy decision-makers to bring "nursing voice" to provincial health policy discussions.

Recruitment

Where possible, I directly emailed a Letter of Invitation (Appendix A and B) to potential participants. In the Letter of Invitation, I described the purpose of the study, expected participant time commitment, a request for their participation, and an explanation of the need for informed consent. Alternatively, I sent emails with the Letter of Invitation to organizations where potential participants engage in policy work, and I sought organizational permissions if needed. Along with the Letter of Invitation, I included my Invitation to Participate and Informed Consent form (Appendix C). As potential participants contacted me, I discussed my study, answered any questions they had, and verbally or via email confirmed their agreement to participate. Once agreement to participate was received, I collected the signed consent form from the participant via email, and scheduled a date and time for their interview to be conducted via telephone. It was

challenging to recruit participants and secure interviews with nursing leaders as these individuals have demanding schedules and responsibilities. I also consider the COVID-19 pandemic to have been a major factor in the inability to recruit some key individuals to participate, and to secure interviews with others.

Participant Demographics

The 10 nursing leaders who agreed to participate constituted a broadly experienced sample of individuals with policy experiences from across Canada. I collected a Participant Demographics form (Appendix D) prior to interviews to capture their nursing, policy, and leadership experiences. These nursing leaders represented an incredibly diverse range of policy-intensive areas, educational backgrounds, clinical and work environments. For example, their background preparation and experience included health care leadership, management and administration, public policy and administration, education, political science, and clinical nursing practice, including being a Nurse Practitioner. As well, all participants reported having received specialized training in at least one of the following: leadership, health policy, health systems, or research.

There was a large variation between and within the nursing leaders career paths that brought them to formal policy roles. Their careers can be traced through years of societal, political, and professional nursing changes in Canada. Further, these nursing leaders' knowledge and understanding of how the nursing profession has historically been and currently is situated within organizations, systems and structures provided them a depth and breadth of perspective that is not typical in the profession. See Table 2 for participant demographics.

Table 2

Participant Demographics

Highest level of education obtained	Degree	1	Masters	4	PhD/DNP	5
# of years as a nurse	1-10	-	11-20	2	20+	8
# of years in leadership positions	1-10	1	11-20	4	20+	5
# of years in health policy positions	1-10	3	11-20	4	20+	3
Clinical practice areas named in interviews*	acute, emergency, and critical care, mental health, addictions, operating room, public health, rural health care, women's health, sexual health, oncology, primary care, gerontology, outreach programs					
Leadership titles/areas named in interviews (paid and volunteer)*	clinical supervisor, administrator, manager, senior management, director, executive director, CEO, board member, board chair, board president, ministerial staff, bureaucratic appointment, academia, research					
Health policy areas named in interviews*	workforce planning, primary care, nurse practitioner, MAID, professional association, regulatory body, health system planning, education, COVID-19					

*Note: clinical, leadership and health policy areas were not collected on the demographic form, but were extracted from the interviews or my research into the participants prior to their interviews. Therefore, this does not represent a complete list.

3.5 DATA COLLECTION AND ANALYSIS

Data Collection

Due to the COVID-19 pandemic, changes to the University of Lethbridge research guidelines and provincial public health recommendations required interviews to be conducted by telephone. I conducted all 10 phone interviews between March and June 2020. Interviews lasted 60 to 120 minutes and were digitally recorded with the permission of the participants. I used a semi-structured interview guides (Appendix E and F) to keep the interviews on track, to ensure I

covered the key topical areas, and to explore and probe participants' answers (Sandelowski, 2010). The guide evolved after each interview, as new insights were gained through dialogue. Participants were encouraged to share their understanding of the term *nursing voice* and how they used or did not use their nursing voice, their experiences in health policy work, their experiences working with policy decision-makers, and their perceptions of policy work within political environments. One interview was conducted in early March, as the pandemic was initially evolving in Canada. Therefore, I conducted a follow-up interview with the participant to ensure they could reflect on their experience of nursing voice in the context of a pandemic (as other participants had the opportunity to do). I had brief follow-up conversations with two other participants to gain clarity on a few of their specific interview responses.

Data Analysis

I employed Braun and Clarke's (2019) reflexive thematic approach, and used their six-steps to help ensure a theoretically coherent and consistent analysis of these data. According to Braun and Clarke (2012) the purpose of this six-step approach is to answer the research question by identifying patterns of meaning across a dataset. Using a reflexive thematic approach helped me to stay close to the data so I could provide a rich description of the experience of nursing voice, without veering too far into an interpretation of the data. As the experience of nursing voice has not been previously described in the literature, using reflexive thematic analysis helped me produce a strong descriptive piece of research in this under-researched area. I have listed Braun and Clarke's (2012, 2019) six steps and described the strategies I used within these steps in Table 3. In addition, I used NVivo® v.12 to aid with data management.

Throughout analysis, memos helped capture my thought processes and *lightbulb moments*. Memoing aided in surfacing my biases on politics, policy, nursing leadership, and the

nursing profession in general. Memo review was also valuable in the analysis to help me decide if my reasoning still fit as I got deeper into the analysis and helped me capture insights that sparked discussions. Throughout the analytic process I was fortunate to have opportunities to engage in critical analytical discussions with my expert committee members, as well as a small number of expert informants about the developing categories, themes, and variation in these data and how my research topic was situated in the broader social and political context.

Table 3

Reflexive Thematic Analysis

Step	Strategies for Thematic Analysis
Step 1 *Familiarizing myself with the data*	▪ In data immersion and familiarization, I listened to the digitally recorded interviews, made memos to capture my initial thoughts or ideas of significance in the data, and transcribed the interviews word-for-word. After, I re-read the transcripts and reviewed my reflexive notes from the interviews. I also made reflexive notes on particular words that were repeated, my questions that developed, my thoughts or ideas that emerged, and my biases or assumptions that arose.
Step 2 *Generating initial codes*	▪ Initial coding of the 10 interviews consisted of me sorting or chunking the entire data set into the main ideas relevant to answering my research question and labeling these ideas as nodes. I further analyzed these nodes, split them into sub-nodes and then condensed, shifted, or collated the sub-nodes into new nodes. I then grouped similar or related nodes together to form categories. I also compared the coded transcripts by interview question to help identify similarities or overlaps in nodes. Similar nodes were clustered together, which I then categorized and sub-categorized.
Step 3 *Identifying themes*	▪ I reviewed the categories and sub-categories looking for patterns, and then shifted the categories and sub-categories into themes. I recognize this was an active process that required me to make choices in how to construct and shape themes. My intent was to capture, into themes, what was important about or the core ideas of the data and to uncover meanings and patterns within the data.

Table 3 *continued*

Step	Strategies for Thematic Analysis
Step 4 *Reviewing potential themes*	▪ I reanalyzed and refined the themes to ensure there was a central idea in each theme by combining, splitting, or discarding original themes. Key questions which guided this step were; Is this a theme? Is it a quality theme? Is there enough data to support this theme?
Step 5 *Defining and naming themes*	▪ I identified what was unique about each theme, and ensured themes had a singular focus, were related but not repetitive and directly addressed my research questions. This step involved deciding the fine details of the analysis, choosing what data to quote and analyze in the written report, and naming the themes in relation to my research question.
Step 6 *Producing the report*	▪ During the write up of my research I merged the themes, analytical narratives and data extracts together and then situated the analysis in relation to the existing scholarly literature. I ensured the participants' perspectives and experiences were described in clear and compelling ways, and that my analysis answered the research questions. I made every effort to connect the themes logically and meaningfully in building a coherent description of the data.

Reflexivity

Throughout this study I made every effort to be reflexive by using strategies to acknowledge, unpack, and explore my own biases and assumptions, so that I reduced the chances that these influenced or manifested in my analysis and findings. I made reflexive notes before and immediately following each interview. These included notes from a brief exploration about each of the participants, so I had an overview of their careers, roles and clinical background, and general information on their policy involvement and experiences.

During my research I noted times where my lack of experience in policy, politics and within professional nursing organizations may have hindered my ability to truly understand these data that I had collected. To overcome this concern, I attempted to increase my knowledge by reviewing the websites of government and professional nursing organizations and reading their publicly available policy documents and strategic plans. I attended workshops on policy, Canadian politics, as well as informational sessions offered by nursing unions, and organizations

with regulatory and association mandates. I watched online Canadian federal and provincial legislative meetings and standing committee testimonials on relevant health policy issues. I also enrolled in a graduate level nursing policy course. Although this course did provide a review of basic concepts of the Canadian political and policy processes and cycles, at no point in the course did we pull in past or present macro-level health policies that directly influence the nursing profession or nursing practice. In fact, there was little discussion about how policies affect nurses at all. For me, this highlighted the familiar theory to practice gap in nursing.

I also made analytical memos of any theoretic insights or connections, and any interesting or surprising findings. I knew from the onset that I had only basic academic knowledge and minimal practical understanding of my research topic, while the participants would have years of experience and a much deeper level of understanding of policy work. However, I had not anticipated how far out of my area of interest and expertise I would be, and how concerned I would become with getting my research *right*. At times, I noted what I perceived as errors or inconsistencies in my analysis of the data. These perceptions of being *wrong* about what I was seeing in the data, caused me to question my ability and even the validity of calling myself a researcher. There were times that I considered abandoning the analysis that I had done and starting over. Nevertheless, the experience of writing and rewriting drafts of my findings helped improve my confidence in the validity of my analysis.

In addition, I made reflexive notes on my thoughts, biases and assumptions that arose during my research. For example, the hierarchical nature of nurses (i.e., Registered Nurses are above Licensed Practical Nurses) and the territorial nature of health care providers (i.e., Physicians versus Nurse Practitioners) have been areas of frustration for me over my nursing career. Early on in my analysis I was bothered by the comments of some participants about how

policy work was “not work that just any nurse can do”. I initially equated their comments with a belief in hierarchy and territory often perpetuated by nurses, or to ego or self-promotion by the participants. However, the deeper I got into analysis of the data and the more I increased my knowledge and understanding of macro-level policy and politics, the less I believed the comments were made from a place of hierarchy or ego. In my now more informed opinion, I think policy work is a specialty and not something every nurse can do or should be expected to do.

Trustworthiness

Trustworthiness in qualitative research is guided by and assessed against four tenets of rigor criteria: credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). For researchers, the goal of rigor is to ensure an accurate representation of the participants experiences, and that the final descriptions are supported by their data. Therefore, researchers need to be attentive to three common threats to rigor: researcher bias, reactivity, and respondent bias (Lincoln & Guba, 1985). Researcher bias refers to “any kind of negative influence of the researcher’s knowledge, or assumptions, of the study, including the influence of his or her assumptions of the design, analysis or, even, sampling strategy” (Kriukow, 2017, n.p.). The threat of reactivity refers to any possible influence the researcher has on the study’s context and participants. The threat of respondent bias “refers to a situation where participants do not provide honest responses for any reason, which may include them perceiving a given topic as a threat, or them being willing to ‘please’ the researcher with responses they believe are desirable” (Kriukow, 2017, n.p). In Table 4, I have summarized my efforts to attend to rigor in this study.

Table 4

Trustworthiness in Qualitative Research

Criteria	Strategies	Ensuring Trustworthiness
Credibility The confidence in the truth of the findings.	Establish rapport	▪ I established rapport with my participants prior to the interview by taking a few moments to informally talk with the participant. This helped ensure they were comfortable sharing their experiences with me.
	Prolonged engagement	▪ I collected, transcribed, and analyzed all data myself. This ensured my prolonged engagement and immersion in the data.
	Peer review and debriefing	▪ I consulted with my supervisor and committee members as content and research experts to gain external reflection and input on my work.
Confirmability The degree of neutrality, or the extent findings are shaped by the participants and not by the researchers' bias, motivation of interest.	Member checking	▪ I employed member checking by sending a synopsis of the central themes to two participants (one from each participant group) who had agreed to review them as to the accuracy of my findings. Feedback provided by these participants supported my findings, and helped ensure that descriptions I used in the write up of my findings correctly captured the participant's experiences.
	Reflexive notes	▪ I made a reasonable attempt to record reflexive notes of my personal thoughts, assumptions, and biases as they arose. I kept reflexive memos about participant interviews, my perspectives on the participants themselves and on my thoughts on the participants' descriptions within the data. Being reflexive also required me to consider my reasons for choosing the research topic and methodology, and my professional and personal experiences with policy advocacy, health system barriers and my interactions with nursing leaders.
	Authenticity of findings	▪ I used actual quotes from the participants to support my findings and to ensure my participants voices were heard in my findings, rather than my own.

Table 4 *continued*

Criteria	Strategies	Ensuring Trustworthiness
Transferability The degree to which the researcher provided details that makes transferability judgements possible.		▪ I established and provided details of the inclusion criteria for participants in the selected sample. As well, I used purposeful sampling and described participants demographics so similar groups of participants could be made. ▪ I provided details of the study context. By doing this, others can assess the relevance of the findings to other contexts. ▪ In the write up of my research methods I attempted to provide enough detail that others could undertake similar research.
Dependability Consistency in procedures across participants over time.	Consistent approach	▪ I demonstrated consistency in my data collection procedures by using a semi-structured interview guide with probing questions. I collected a participant demographics sheet prior to each interview.
	Audit trail	▪ I made a reasonable attempt to maintain an audit trail to capture my decisions around my data collection and analysis procedures. I kept researcher memos which were helpful to me when reflecting on how I was understanding the data, how my understanding was evolving and how my understanding was influencing my thoughts about the data.

3.6 ETHICAL CONSIDERATIONS

All research involving human participants in Canada requires ethics review and approval in accordance with national standards outlined in the Tri-Counsel Policy Statement (TCPS) - Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada Social Sciences, & Humanities Research Council of Canada, 2014). What follows is my summary of the main ethical considerations for the study, including details about ethics approval, informed consent, and my efforts to protect confidentiality, anonymity, and privacy.

Ethics Approval

Before seeking formal ethics approval, I consulted my supervisor and committee members for ethical concerns or revisions needed to my proposal. I then sought ethical review and subsequent approval from the University of Lethbridge Human Subject Research Committee (HSRC) and received the HSRC Certificate (Protocol #2020-17). I then contacted professional nursing organizations and known contacts from provincial Ministry of Health departments to inquire if any organizational or operational approvals were needed. I determined no additional approvals were required for either group of participants.

Informed Consent

I ensured informed consent and voluntary participation by all participants. I provided participants, by email, an Invitation to Participate and Informed Consent document (Appendix C). In this document I explained the purpose of my study, what was required of the participant, any foreseeable risks or benefits to participating, and how I would ensure confidentiality and privacy. I included my contact details, those of my thesis supervisor and the University of Lethbridge Office of Research Ethics, should a participant require additional information before agreeing to participate, or need to express concerns that arose during their participation. I ensured the participants had provided me with a signed copy of the Informed Consent form before beginning the interview. Participation was voluntary, and I reminded participants that they could take a break during the interview, terminate the interview, or withdraw from my study completely at any time, with no consequences. I advised participants that if they chose to withdraw for the study, I would, if possible, remove their data. However, I further advised the participants that removal of their data could be done prior to collapsing all data into themes, but once themes were generated, I would be unable to deconstruct the themes to pull out individual

participant data. No participants requested a break during the interview, terminated the interviews or requested to withdraw from my study.

Confidentiality, Anonymity and Privacy

I endeavored to maintain participants confidentiality while collecting data and in my subsequent transcription, data analysis and write up of the findings. To do this, I communicated and committed to participants that I would ensure that:

i. I did not identify any participant by name, demographics, or position.

ii. I did not use any words, phrases, or language from the interview, in the transcripts, or in the participant quotes in the write up of my findings, that identified either the participant, their professional organization or the province they represented. I changed or eliminated any identifying words, phrases, or language.

iii. I did not identify the provinces from which I recruited participants, and I did not attribute any participant's individual contribution to a specific province.

iv. I did not attribute any participant's individual contribution to a professional nursing organization, or position.

v. I presented information collected and study findings in aggregate form, except for at times I identified the group (inside or outside of government) that the findings came from.

vi. I respected and attended to any participant concerns about the sensitivity of information shared in an interview. For example, some participants expressed concern during their interviews about sensitive information that they had shared,

or frank comments they had made “off the record”. Therefore, I ensured these details were not included in the transcription of their interviews.

To help maintain confidentiality, I encouraged participants not to discuss their responses from our confidential interview with others, although I cannot ensure this was the case. I conducted participant interviews via telephone in a private space. Only I had access to the audio recordings of the interviews. These audio recordings were stored on the original recording device and in a locked drawer. During my research, digital copies of transcripts and demographic forms were kept on my personal password protected computer, and because I used the program NVivo, on the university’s secure server. Upon completion of my thesis, all transcripts and demographic forms will be deleted from my personal computer and stored on a password protected USB flash drive. I did not print any paper copies of the interview transcripts or of the demographic forms I collected. As per the universities suggested research protocol, the recordings and all digital files will be destroyed five years after completion of my thesis.

To help protect participant anonymity and confidentiality, I assigned participants unique identifiers at the beginning of each interview, which I used throughout the transcription, analysis, and write up of my findings in order to provide partial anonymity. However, due to the specific nature of the groups and the small number of participants, I could not guarantee anonymity. In the written findings, participants are identified only by a randomly assigned letter.

3.7 CHAPTER CONCLUSION

In this chapter I have discussed my philosophical orientation as it relates to my research and described the qualitative descriptive design, methods and procedures employed in my study. To study the experiences of nursing leaders in macro-level policy work in Canada, my philosophy and research design aligned with a realist approach. By having the opportunity to

speak with nursing leaders who have real-world experience in macro-level health policy work, I gained an understanding of what the often used, but ambiguous term *nursing voice* meant to them, and how they have experienced their nursing voices in health policy.

In reflecting on the research process, I am left to wonder how my first experience as a researcher might have been different had the COVID-19 pandemic not happened. What different data, if any, would my interviews have gathered? Who else would have participated in my study? Would I have approached my data analysis differently? As well, I wonder how much the stress and anxiety caused by the pandemic affected the perceptions of my participants, and even my ability to do this research.

In conclusion, I believe the greatest lessons I have learned about doing research have come from the process of reflexivity. As I navigated the uncertainty of being a novice researcher, gained experience in analysis and developed a deeper understanding of my research topic, I found that being reflexive helped me see the data in a different light. The lessons learned through reflexivity are significant to my findings and in the discussion of these findings. I describe my findings and discuss their significance in the next two chapters.

CHAPTER 4: KEY FINDINGS

In this chapter I report my findings generated from my thematic analysis of these data collected in my interviews with the 10 participants. My central research question for this study was: What has been nursing leaders' experience of *nursing voice* in provincial health policy in Canada? One sub-question helped frame the study: How do these experiences vary related to occupying policy roles inside or outside of government?

Participants described their understanding of the term *nursing voice* and their experiences of bringing nursing voice to provincial health policy discussions. Three themes captured the participant's understanding of *nursing voice* based on their extensive experiences as nursing leaders working in the policy field. These themes reflected the many subtleties and nuances of the use of the term in the nursing literature, and although each theme had distinct features, the themes are also interrelated.

I begin this chapter with a brief overview of the participants careers with the aim of highlighting the context in which the participants' understanding of nursing voice in policy has evolved. I then present the three themes: Nursing Voice is Perspective; Nursing Voice is a Presence; Nursing Voice is Political. Further, I discuss the similarities and variations of the experiences of the participants from inside and outside of government.

4.1 THE PARTICIPANTS

The 10 participants constituted a broadly experienced sample of individuals with extensive clinical, leadership and policy experiences throughout their careers. The participants reported having experiences from a diverse range of policy intensive areas, including multiple clinical, educational, work, and political environments. There was also a large variation between and within the participants career paths that brought them to formal policy roles. Their careers

can be traced through years of societal, political, and professional nursing changes in Canada. Further, the participants' knowledge and understanding of how the nursing profession has historically and currently been situated within Canadian organizations, systems, and structures, provided them a depth and breadth of perspective that I suggest may not be typical in the profession.

To begin, participants were asked to offer a snapshot of how their careers had evolved. Although this question was intended as an ice breaker, I found the participant's individual demographics and the uniqueness of their career paths were important aspects which informed their experiences in policy work and their understanding and descriptions of the meaning of nursing voice. The participant's career paths often included changing positions, roles, or areas of interest, and leaving clinical, leadership, or public-sector roles in pursuit of opportunities or as new opportunities were offered to them. Reflecting on their careers, most participants described themselves as continually looking for the next challenge or opportunity to be involved in something new: [H] "I've always had some itchy feet to doing other work. You know that non-clinical work, in the exciting world of making change and improving your community, improving health care and policy and all that stuff". Participants recalled feeling driven to seek out or accept new positions because of personal interests or frustration with the health care system. For example, seeing a misalignment between patient needs and the response of the system. In general, the ability to make a difference was expressed as a compelling reason for seeking, accepting, or changing positions:

> [D] Then I got a call to go to [specific agency]… and I've always had an interest in [health care area]. I was actually quite distraught over the fact that we would never ever finance or be allowed to operate a regular health care system the way we've done for [health care area]. You know it's just been underfunded. It was just horrible. I thought, well, if I have a chance to make a difference there, I'll do it!

The experience of being sought out by decision-makers or executive leaders for higher-level positions was reported by seven out of the 10 participants. These participants were recruited to these positions because of their nursing expertise, health care system understanding, political experience, or policy skill. Some participants reported being promoted within their organization or government to leadership or decision-making roles, while other participants reported moving between organizations and governments. Participants described their movement within or between organizations and governments as beneficial to decision-makers and important to influencing policy outcomes. These experiences equipped them to bring their unique nursing voice and perspectives about government and organizational structures, the health care system, policy development and implementation, and clinical practice to their roles.

4.2 NURSING VOICE IS PERSPECTIVE, PRESENCE AND POLITICAL

Nursing Voice is Perspective

Participants from both the inside and outside government groups reported their understanding of policy and political environments as strengthened by both their professional nursing and non-nursing lenses and experiences, which helped develop a broader and deeper system-level understanding. These multiple lenses and experiences resulted in an accumulated perspective that informed their use of nursing voice.

All participants were asked to explain or describe what *nursing voice* meant to them. For several participants, it took time to process the question, or they had difficulty articulating an answer: [B] “Sure … hmmm … so … I don’t think I’ve ever stopped to think about what it means”, or [H] “That’s, that’s good … I think that’s a great question, and I feel myself slightly panicking, you know thinking about it because it’s like this abstract concept”.

Several participants equated nursing voice to using their nursing knowledge and experience, and applying it to how they understand health care systems: [I] “I think it’s taking the knowledge that we have around the health care context or delivery of health care and being able to translate that into what practice is or should be”, or [J] “Nursing has its own specialized body of knowledge and experience … you are framing your specialized body of knowledge and then you don’t shy away from the caring aspect that influences what you’re saying is important”. Whereas two participants spoke of nursing voice in terms of perspective, one succinctly described it as: [E]“It’s what constitutes a perspective that comes from the thinking in our discipline”, and the other understood it to mean:

> [G] It’s really our perspective. It is the perspective that is not medicine focused, not legal focused, not risk-averse, not operational in nature. It has our core values attached to it. So, our core values, as I see them, are making sure that we maintain the focus on the patients and patient outcomes. Some people define that as caring.

Although most participants viewed nursing voice as an important concept, two from the inside-government group offered opinions that clarified the boundaries of this view. These participants suggested that describing their contributions as the use of nursing voice diminished the origins and the attributes of their perspectives, which was also gained from their roles or experiences outside of being a nurse. Further, for these participants knowing why and how they know what they know, and how what they know applied to their positions is what made their perspective meaningful:

> [C] I don’t understand what that [nursing voice] means. I’ve been in the field forever and I don’t understand when people say that … what they’re actually meaning … My problem is I’m not nursey enough. You know, you see her, she’s a nursey nurse, everything begins and ends with nursing, and with me, it doesn’t.

> [D] Why is it that you say nursing voice is important … come up with something that describes it, because it's not the nursing voice. They [nurses] have important contributions to make and not just in health care delivery, but in how you learn about it, how you organize it, how you finance it, all of that stuff. It's not a nursing voice.

These participants considered their perspective valuable to decision-makers, but not just because they were nurses. Their perspectives came from years of hard work and was informed by a multitude of factors. For these participants, their voice was earned and hard-won, and to describe it as nursing voice was to apply [C] “a vernacular that does not resonate with anybody alive that’s not a nurse” and [D] “a very dangerous catchphrase because it then ends up in tokenism”. In fact, these participants suggested that being sought out by decision-makers can be counter-productive or tokenistic if someone’s nursing perspective is simply presumed to be important, and they discussed experiences where perspective and voice had been assumed to be needed just because somebody was a nurse:

> [D] Then you turn around and say, well we're having a committee to discuss this, and they say okay well we're getting a nurse, then you go and ask the association for a nursing rep, then you know it's the individual voice and I feel sorry those reps, you feel sorry for them because they are like, well I’ve gotta go pound the table for the nursing profession. You go no, that's not it.

Although only three participants specifically used the term ‘perspective’ to explain or describe what the term nursing voice meant to them, all participants talked about perspective in their interviews. In general, participants described nursing voice as an accumulating perspective that developed throughout their careers and emerged from multiple lenses that made their nursing voice individual and unique. However, participants also expressed a need to have a nursing voice presence at policy discussions and in policy decisions for their perspectives to matter.

Nursing Voice is Presence

Merriam-Webster’s dictionary (n.d.) defines presence as something that exists or occurs, but may not be visible. It can also be defined as a manner or appearance or being physically present. For participants, their nursing voice brought their individual and unique perspectives to

policy discussions. However, to achieve this, participants agreed that they had to have opportunities to be present, to surface their perspectives and make their presence felt in discussions:

> [F] For me it's a presence in the conversations, it's not an afterthought, it's a presence in the conversations. It's being part of the committees, councils, you know whatever discussion is going on around health care reform or changes that are needed in the system. Nursing should be there.

All participants spoke about opportunities and experiences they had when they were present at policy discussions. Being present at policy discussions, is often referred to by nursing scholars as *being at the table* (Duncan et al., 2014; Groenwald & Eldridge, 2019; Leavitt, 2009). However, most participants, from both groups, alluded to the fact that being at the table was a bit of a misnomer or was just a metaphor. Being at a table during a formal policy dialogue process where policies are debated and decided and direction is set, is a scenario that does not necessarily exist. For example:

> [F] They [nursing leaders] need to get to the table, figure it out and of course when I say table, I mean you know the hallway, virtual table, committee, whatever … I think really being at the table means being part of decision-making committees, being part of formal and informal. It's not only formal committees, also informal discussions, and informal groups of people. I think the table can be anywhere where you're influencing decision-making.

Additionally, participants who had the most experience working in policy and political spheres were concerned that calls to install a nurse at as many policy tables as possible showed little insight into the complexities of government and even less understanding of the way policies are formulated and decided upon. In fact, these participants cautioned nursing scholars against perpetuating the myth of being *at the policy table*. They expressed concern that focusing on simply having a chair at the table during discussions puts the nursing profession in danger of

being included out of tokenism, which would ultimately lead to a lack relevance. One participant suggested the continued use of the term *at the table* showed a lack of forethought:

> [C] I think what we don't do is spend the time to actually articulate exactly what you're trying to get at underneath, so what does that [at the table] actually mean? So, there needs to be a nurse at the table. So, we will put a nurse at every table everywhere - and that means what?

Instead, these participants insisted that the nursing profession should be more concerned with having a meaningful presence and strategic position during any formal or informal discussions, whenever or wherever they take place. Indeed, some participants deemed having an opportunity for meaningful participation in discussions as essential and as more likely to lead to effective engagement with decision-makers. During their interviews, participants expressed what constituted having a meaningful presence, strategic position, or meaningful participation during policy discussions. However, what determined if their engagement with decision-makers was effective was not clear. During formal policy discussions, participants were not necessarily invited to attend, but that did not mean that nurses and the nursing profession were not considered at these discussions. Therefore, as participants from the outside government group explained, informal conversations with decision-makers were crucial. Informal conversations provided opportunities to insert nurses' capabilities, expert knowledge, and value in the health care system into policy discussions. Both participant groups described the importance of informal contact with decision-makers as a mechanism for valuable input into discussions, and as a way for participants to have external, yet meaningful participation related to policy decisions.

Participants also described strategic positioning as integral to formal leadership roles, essential to influencing decision-makers and powerful in shaping policy. Strategic positioning also included important governance structures that supported nurses to inform policy:

> [F] To truly be able to effect change as a profession you need people from the profession in places of power in decision-making. You can't do it otherwise. You really do need those leaders to be able to move those pieces forward.

Some participants from inside government credited formal policy roles with bringing legitimacy to themselves, their perspectives, and their presence in policy discussions:

> [I] A voice in government legitimizes a nursing voice. I think you have influence over, and that voice lends itself to shaping the direction that your deputy minister or ministry goes in and supports, and with that comes resources and all sorts of things.

> [A] I think having a position in government legitimizes your voice, and you are sought-after in a very different way… a legitimate position within government, within government as nurses, gives you much more clout … it is important being in, and having this legitimate position and then taking opportunities to participate.

Yet, even with being present and having meaningful participation, participants from both groups reported experiences when their perspectives were not heard or utilized by decision-makers. One participant offered this explanation for not being heard: [A] "Nurses have always had voices. It's who chooses to hear and how and at what point in time depending on the receptivity of the audience…if people don't hear us … then we can't influence". Some participants suggested this was due to the complexities of policy decision-making within political environments or reflected deeper system level issues:

> [C] I think at those policy tables, whatever they are, you need to be aware that there's a political agenda. All governments have an agenda … at the end of the day they actually make the decisions, and your job is to give them the best advice you can. Then they will decide ... a lot of policy decisions are made at the political level, and that actually is their job.

> [F] There are still plenty of conversations I'm in where nursing is a second thought … there's a whole room full of physicians and there's one nurse and that's me. So, you know has the power completely shifted? Absolutely not.

> [E] I think there's a real sense that health professional self-interest is a thing that leaders need to be very cautious of and so that idea has helped them justify that we should not have someone at the senior table who's there to represent nursing or speak on behalf of nursing.

When meaningful participation resulted in policy outcomes that reflected the participants' expectations, goals or wants, the policy outcome was viewed as a policy win. However, participants related that even with meaningful participation, policy decisions may not be what nurses wanted or expected. In other words, they noted that just because participants had been asked to provide their perspective on specific policies, it did not mean their perspective was or should have been accepted: [G] "Some of the suggestions [we have made] have been utilized. Some are still under advisement. Some have been rejected. I think that is par for the course on any good policy development".

Participants described how being strategically positioned within policy discussions and having opportunities for meaningful participation in those policy discussions were important aspects needed for them to shape policy decisions or directions. Further, they communicated a strong sense that their perspectives and their presence needed to be political. Next, I discuss the theme "Nursing voice is being political".

Nursing Voice is Political

According to Merriam-Webster (n.d.) political is defined as of or relating to politics or government or interested in or active in politics. Political can refer to an institution or actions. Political actions are "actions designed to attain a purpose by the use of political power or by activity in political channels" (Merriam-Webster, n.d). The participants described many ways in which their nursing voice was political and instigated political action.

When describing their experiences, participants referred to their many purposes during policy discussions: to translate *nursing speak* to non-nurses, to educate non-nurses on what nurses do, to focus their message to be impactful, to inform or advise others as to the complexity of nursing practice and scope and the value of nurses in health care, to help the government

frame and situate health care transitions, to advocate for populations needs or to advance the nursing profession. Although participants often used the terms advocate, influence, inform and advise interchangeably when describing their experiences in policy work, they generally agreed that these terms reflected the main activity in being political with their nursing voice in policy work:

> [G] Nursing voice is about nurses having that voice to participate, articulate and influence in whatever they are trying to do. Whether it's policies, whether it's changes in system design, whether it's a service delivery, whether it's the scope of practice.

Several participants from both groups expressed concerns that policy discussions, directions and decisions often lacked a clinical perspective from any discipline. Consequently, these participants considered one of their purposes to be ensuring that clinical knowledge was shared in policy discussions and represented in policy decisions. Further, participants noted that having a clinical understanding of the complexities of delivering health care helped them illustrate the legislative and regulative constraints faced by nurses. This also allowed them to make visible the places where nurses working to full scope of practice could help alleviate some of the issues with health care access and availability. Some participants described how their ability to connect several aspects of the nursing profession to the health care system helped other policy actors, decision-makers, and stakeholders better understand how policy decisions might affect the profession:

> [I] Having a really strong professional practice background, I feel very grounded in that, and constant about understanding scope of practice and standards of practice and how that aligns and translates from what is our legislative and regulatory requirements, to the college level what is the standard, practice, the ethics, and then alignment with education and what does that look like to [government].

For some participants, political action was described as speaking up for patient welfare when using their nursing voice. They suggested the proximity of nurses to the patient experience

afforded nurses an intimate and privileged line of sight into that experience. For a few participants this perceived deep understanding of the patient experience created a responsibility to ensure a patient perspective was represented in discussions. Participants spoke of their purpose in using nursing voice as being patient-centered or they discussed their concern with policy options that negatively affected patient outcomes: [A] "Nurses are the individuals who have the largest responsibility in helping the patient navigate the system to a successful outcome. So, the nursing voice is ensuring that that doesn't get lost in the system" and:

> [H] We look at clinical policy and programming, and pass that nursing lens on it. Which inevitably ends up being the patient lens because I think that's what makes nursing unique. We are usually interested in what the patient experience is. How do we hold that space for them, structure things so their needs are being best met?

Even though participants largely agreed that patients should be a central concern of the health care system and policy decisions, a few took issue with nursing representing itself and its professional voice as being uniquely patient centered:

> [C] I think one of the most offensive things that I have ever heard is, nurses are patient centered. What does that say for the rest of our colleagues?... I don't want to hear that the gift that you give is that you are patient centered. If I was a physician or a physiotherapist or a nutritionist, I would be deeply offended.

Another political action identified by participants was challenging the status quo or speaking up about issues in the health care system or difficulties with health care delivery, and to provide relevant solutions for these issues and difficulties. For some participants this was done by being persistent, communicating clearly, and gaining support over time from decision-makers:

> [E] We need to be focusing our efforts on what they think their [decision-makers] problem is, rather than something obscure they haven't heard about. They want solutions for their problems. If nursing can come forward collectively with solutions for things that they recognize as their problems, then you have an opportunity to be heard.

> [I] I can't tell you the number of times where I shared messaging around a certain way to think about something … but it often takes a good 3-7 times before it'll sink in. You know you've been successful when they start talking like it's their own idea. You go…"ya"!

Several participants reported an imperative to align themselves with the political party in power, and the party's strategic directions or political ideologies. For example, participants with inside government experience noted that they had a clear understanding that their purpose in policy work must align with the governing party's platform. Yet, there was also an expressed belief that speaking truth to power was part of their purpose and several participants noted that they did not shy away from uncomfortable conversations with decision-makers about the ramifications of policy directions or decisions: [B] "because I work for the government, I have to look at that political lens. Not that any of us are really afraid to speak truth to government, it's how do you do it and then doing it". Aligning with the governing party's platform was also described as a way to build or maintain government relationships. All participants discussed how part of their purpose in policy work was to build and maintain trusting and credible relationships with decision-makers, politicians, and other stakeholders. These relationships took time, effort, and commitment to cultivate: [H] "it comes down to relationships between you and your partners and government … a lot of it has been relationship finessing". One participant suggested it took time and skill to build and maintain relationships:

> [E] It's a long slow hard process to build up that relationship with government… bringing nursing policy perspective into public health policy decision-making, that requires credibility and relationships with decision makers in government and health authorities. It requires the establishment of a base of nursing expertise in that regard.

Although participants discussed having built strong and solid relationships with decision-makers, many participants suggested that decision-makers still value or privilege one profession over another.

4.3 CHALLENGES IN HEALTH POLICY

Medical Dominance and Intraprofessional Challenges

Participants spoke about the issue of medical dominance in policy decisions, where decision-makers prioritized medicine as the dominant health care profession over all other health professions including nursing. Some participants suggested that this prioritization of medicine by decision-makers left little room for them to be engaged in collaborative discussions or provide input into policy directions or decisions. As well, several participants described concerns and frustrations they had about ongoing hierarchical power structures and patriarchy within policy and political environments:

> [J] We know that there is a power differential between nurses and doctors. That has existed for some time. If you look on any org chart, there continues to be an inequity between the medical and nursing structures. That's just a fact.

> [A] We [nurses] should be asked for our opinion on all sorts of things, but we're not ... doctors will often be asked for their opinion … but why aren't we asked for comments on those things [policies that address Social Determinants of Health]?

> [H] When I'm at a table, and we'll call it mixed, with physician colleagues or bureaucrats who, I'd say kind of, not really knowing why nursing is useful to have around versus those that are just the interest of physicians … at the big boys and girls' table … I feel like I'm the slow cousin who got to sit at the table. And you know, it's like, oh you said something that's cute.

The notion of medical dominance, hierarchy and patriarchy in health policy is readily discussed and accepted as fact in the scholarly nursing literature (Groenwald & Eldridge, 2019; Manojlovich, 2007). Yet, discussions that provide practical advice or solutions about how the nursing profession can overcome these concerns are rarely mentioned. Indeed, none of my participants discussed ways they successfully navigated medical dominance at health policy discussions or times when hierarchy or patriarchy did not affect their ability to provide advice to decision-makers. Participants only discussed what happened to them at policy discussions, or the

negative affects to their efforts to influence policy, due to their perception of medical dominance, and hierarchy and patriarchy in health policy.

Intraprofessional Challenges

Depending on the perspective it seems to me that some political action, such as challenging the status quo, was used to advance nursing goals, while other action was used to obstruct nursing goals or avoid nurses creating trouble for a particular political direction. At times, the political actions participants chose might be seen as concerning or controversial by nurses in general. A few participants discussed how one of their purposes was to devise plans to *handle* nurses, or manage overt nursing disagreement with policy decisions.

> [D] In some cases we'd say we're not going to engage them [professional nursing organization] at all because we know they're going to be a problem. But you still have to know who's going to be impacted by whatever it is you're talking about and then you have to manage it … what we have to do is develop a strategy for handling them.

In addition, a few participants indicated a reluctance to consult with nurses on many policy issues and suggested that ensuring policy changes was part of their role, regardless of what nurses would think about the policy:

> [A] We don't do formal consultations. We will do informal consultations, or we just get feedback … We didn't go out and consult [on a specific policy] because employers for a long, long, time have told us that we need this, we need this, we need this, so we made it happen. Anyway, that's the joy of my job.

Many participants expressed annoyance with nursing unions, noting that nursing leaders from unions are often unhappy with policy decisions. Participants noted that they often purposefully avoided consultation with nursing unions due to concern about push back:

> [C] You cannot count on them [nursing unions] … I've had many discussions, and I would tell you, you can take to the bank what somebody from [health authority] told you. Whereas the union would say "we completely agree with this, but we've got a job to do. We completely agree with this, but we will fight you to the death on it".

In a few instances, participants described their role in government policy as dominate over the concerns of nursing regulatory bodies:

> [C] Everybody starts with the "I can't, or I won't" … I always say, "you have 5 seconds to lose your mind" about what I'm going to tell you … you have to do this because it's government policy or for some particular reason. They [regulatory body] said "were going to have a decision support tool and they're [nurses] all going to have education". I phoned them and I said, "you guys, in about two seconds you're going to be told that that's the stupidest things we've [government] ever heard".

In addition, to avoid push back from professional nursing organizations (unions or associations), some participants from inside government reported that they occasionally reached out to nursing leaders outside of government only after a policy direction had already been set or a policy decision made: [F] "sometimes I throw them [professional nursing organization] a bone on something I'm working on. I'll send it to them for their thoughts". Further, a few participants from outside government suggested that consulting with nurses on policy issues was not a priority. In fact, as this participant indicated consulting with nurses throughout the province could undermine a professional nursing organization's effort to influence policy:

> [E] They [nurses] would say "we have to talk to all the nurses" as if there is ever going to be anything that all nurses would agree upon. Frankly that doesn't exist. If you hold that kind of diplomatic view … then you end up in a spin cycle that we [professional nursing organization] can't do or say anything.

Although, most participants were supportive of the notion of consultation between nursing leaders both inside and outside of government, and more broadly with nurses throughout the provinces, there appears to be a contradiction in the data. Despite the generally positive views expressed about the need to consult, most also expressed that they didn't think that broad consultation was effective or important enough to do consistently. This is an interesting finding, as a tendency by participants to avoid consulting with other nurse's risks perpetuating the notion

that nursing voice is invisible, limited or lacking in health policy. It also supports the notion that nurses are the implementers of policies and not the developers of policies.

4.4 SIMILARITIES AND VARIATIONS BETWEEN PARTICIPANT GROUPS

In general, the three themes nursing voice is perspective, nursing voice is presence, and nursing voice is political, were consistent across both groups of participants (inside and outside government). For example, participants from both groups indicated that their perspectives were crucial to influencing health policy, that being present by *being at the table* was a misnomer, and their policy work was often political in nature. One similarity that was surprising to me was the notion that nursing leaders from both groups often avoided seeking out consultations with nursing organizations or nurses in general. This avoidance came from their concern with a perceived (or real) risk of disagreement or resistance to policy decisions. Yet, simply avoiding disagreements instead to addressing the concerns raised by these disagreements may perpetuate the ongoing narrative that nursing voice is lacking at policy discussions or in policy decisions. Throughout the findings section I also pointed out some of the variations between the participant groups. For example, the descriptions by participants about how they go about injecting their perspectives into health policy differed. Participants from inside government were explicit in their understanding that their policy roles must align with the governing party's ideology and strategic plans, and that their policy work was done in an advisory or informing capacity. Further, they indicated that the advice or information they gave to decision-makers reflected their larger health system lens. Whereas participants from outside government were more inclined to describe their policy work as advocacy, and their advocacy efforts were directed at advancing the profession of nursing. This was not an unsurprising variation, as professional organizations often have mandates to advocate for nurses or advance the profession of nursing.

Although I set out to explore the similarities and difference between the two groups (inside and outside), I found the greatest variations in these data came from participants with the most experience in macro-level health policy and the highest level of government roles. These participants described concerns with the call for nursing voice, the insistence on nurses being present at policy discussions and the risk of tokenism. They also expressed a greater understanding and acceptance that at times health policy decisions which are good for populations, may not be good for the nursing profession.

4.5 CHAPTER CONCLUSION

Overall, the experiences of nursing voice in health policy shared by the participants all reflected a deep and broad system level understanding. I found that when the nursing voice of participants was informed by perspective, had a presence in policy discussions, and was politically active, participants experienced meaningful participation in shaping policy. In general, all participants described nurses as having been and as continuing to be involved in shaping provincial health policy. By helping to shape health policies, the participants described the ways their nursing voice brought about supportive polices that could advance the nursing profession. But more importantly to the participants, by helping to shape health policy, they described how their nursing voice was instrumental in improving care, access, and equity within the health care system. The participants in this study were all nursing leaders who are or have been actively engaged in and strongly committed to genuine transformation and reformation of the health care system.

CHAPTER 5: DISCUSSION

In this chapter I discuss my findings related to the research questions: What has been nursing leaders' experience of *nursing voice* in provincial health policy in Canada? How do these experiences vary related to occupying policy roles inside or outside of government? These findings add to and extend the small amount of existing literature about nursing leaders and their experiences in macro-level policy work. In addition, my findings help add clarity to the term nursing voice, and provide insight into how nursing leaders describe their roles and work in health policy. In general, I found the term nursing voice to be reflective of a complicated and dynamic process of the accumulation of knowledge, experience, insights, and opportunities to see things in a broader and deeper way. The three themes I generated were: Nursing Voice is Perspective, Nursing Voice is Presence, and Nursing Voice is Political. What follows is a discussion of the role that perspective, presence, and the political aspects of nursing voice play in health policy from the perspective of nurse leaders who do policy work inside provincial governments, or outside government in nursing organizations. Further, I share an exploration of participant perspectives as they relate to the prevalent nursing narrative about the profession's lack of influence in health policy. As well, I situate these findings in multiple areas of scholarship, and reflect upon how these findings may indicate that contributions to policy decision-making of nursing perspectives, presence, and political involvement in health policy are being limited. Finally, I discuss how the aspects of power and oppression might be reflected in the findings.

5.1 THE PERSPECTIVE OF NURSING VOICE

It is well documented in the scholarly literature of many disciplines that addressing health care system issues requires the consideration of perspectives from multiple stakeholders, interest

groups, politicians, and decision-makers (Bryant, 2017; Contandriopoulos et al., 2017; Craft & Howlett, 2012; Disch, 2019; Tenbensel, 2008). According to Hoplock and Lobchuk (2020), the process of seeking other perspectives and then integrating those perspectives into your own, helps an individual understand something in a different light and leads to a greater understanding of others. In general, the findings revealed nursing voice to be a complex amorphous concept which is informed by multiple historic perspectives and contextual factors, making the nursing voice of each individual participant unique. As a result of years of experience in multiple clinical nursing areas, leadership roles, policy work, and political arenas, their cumulative individual perspectives enabled nurse leaders to effectively advise or inform decision-makers on current nursing and health system issues.

Indeed, some of the barriers to influencing health policy reported in the nursing literature reflected the need for an accumulation of perspective by nurses working in policy roles. For example, some scholars have noted that barriers to nursing influence such as the lack of policy leadership experience, education about policy processes, opportunities to participate in policy development, and understanding about health systems and political processes (Juma et al., 2014; Shariff, 2014). Further, scholars have noted that overcoming these barriers is necessary to improve the influence of the nursing profession on policy. The nursing leaders in this study suggested that they had overcome these barriers over the course of their careers, and the resultant perspectives were an important part of their successes in influencing health policy by enabling them to navigate the political and policy environment. However, they also contrasted their personal influence with decision-makers throughout their policy work with the general and consistent lack of influence of the nursing profession in policy matters. This notion of personal, individual influence versus the influence of the profession in policy was an interesting concept

that arose in the findings. In general, the participants placed a heavy emphasis on the importance of their personal perspective and experiences in their policy work. For example, participants with little political or policy experience continued to work in clinical roles. They suggested this was a way to ensure that their contributions were relevant and timely from a nursing perspective. In contrast, participants with many years of political and policy experience suggested that these experiences along with perspectives they had gained from other non-nursing activities were more important than having current nursing practice knowledge. In general, the longer a participant had worked in policy, and the higher up the health care, policy, or political ladder they had moved, the more system-focused their perspective became. Indeed, it seemed that the broader and more varied the accumulated perspective of the participants was, the less nursing-focused they were in their responses, and the more they saw limits to nursing voice and nursing-focused perspectives on policy. I wondered if in this case the participants were accrediting knowledge to themselves as a way of separating themselves from the collective profession. However, they are part of the profession and therefore their perspectives are part of the effectiveness of the profession in terms of policy work. I also noted undertones of oppressed group behavior when participants suggested they knew more than the rest of the profession about system-level policy knowledge and that the more removed they were from clinical practice, the more effective they were. This perspective is also a gendered, i.e., patriarchal perspectives place care work in the realm of the feminine and of lesser value, while managerial and business perspectives align more with the masculine and are therefore assigned more power (Prime et al., 2009).

In general, the findings revealed a reluctance to seek out timely, novel, or differing perspectives from other nurses, nursing organizations, health care groups or policy actors. Many participants reported purposefully avoiding direct engagement with nurses, nursing groups or

nursing organizations on policy matters. They expressed concern that policy directions would receive resistance, pushback, complaints, or disagreement. To avoid such resistance, those from an inside-government perspective suggested an approach where outreach happened only after a policy direction had been set. When seen from an outside-government perspective, such an approach only confirmed the perception that nurses lack influence in policy roles inside of government. Yet, those from outside-government also indicated the same type of limited approach to interacting with nurses in their province. To avoid resistance, they chose not to seek the perspectives of the province's nurses on policy matters, because these perspectives may hinder their ability to accomplish their organization's policy priorities. Consultation also takes time and can be difficult, so participants from both inside and outside government often avoided the inevitable complexity associated with extensive consultation with the profession at large. Consequently, this approach had the potential to both exclude the collective professional nursing voice, and deny nurses the experience of policy engagement that is said to be necessary for the profession to be effective in policy influence or advocacy. The scholarly literature about the role of nursing organizations as policy advocates or influencers suggests that the perspectives of nurses at all levels and from all areas of health care should be consistently included in their policy work, which was focused on meeting the profession's policy priorities (Mathews, 2012). The perception in the findings that avoiding engagement with nurses, nursing groups or nursing organizations was necessary to progress policy work, and the resulting avoidance of such engagement may reinforce the prevalent narrative that nurses and the nursing profession lack influence in policy matters.

Data from this study also reinforced the longstanding perceptions among nurses that the perspective of physicians as the dominant influence on policy decisions, and that organized

medicine remains the main resistor to nursing-proposed policies. Further, many participants noted that physicians often saw nursing policy recommendations as threatening to the territory of medicine; therefore, they refused to listen to or accept their nursing perspective. However, data from this study did not reveal any attempts to seek out physician perspectives, nor any suggestion that seeking and/or understanding the physician perspective on a specific policy could be an important strategy to enhance their policy influence. These findings also revealed that in general it was rare for participants to seek out the perspective of decision-makers so they could understand why their policy advice was not accepted. Further, efforts to incorporate any feedback that was received from decision-makers into their perspective and into their future policy advice was not a common strategy of the participants. It is possible that participants did seek out the perspectives of nurses, nursing organizations, physicians, decision-makers, or other policy actors in their policy roles, but these reflections were not shared in their interviews. However, findings from this study suggested that the participants often relied heavily on their personal perspectives in their policy roles, and that they may have missed opportunities to better understand the perspectives of their nursing colleagues, physicians, and decision-makers. Therefore, is it possible that nurses in policy roles who depend primarily on their personal perspectives to advise or inform decision-makers are unintentionally limiting the perspectives available to inform their decision-making? As well, would it not follow that this approach risks the provision of options to decision-makers that do not reflect the priorities of the profession? Couldn't such an approach also be perpetuating the ongoing narrative that the nursing profession lacks influence in health policy (Benton et al., 2017; Duncan et al., 2014)? Scholars from other health care disciplines express the same concern — i.e., their professions lack influence in health

policy, and their perspectives are limited, ignored, or overlooked by policy decision-makers (Denis & Van Gestle, 2016; Miller et al., 2017).

By way of contrast, in the political and policy science literature, scholars suggest that the key to understanding health care systems and issues and their interdependencies is to look at them from multiple perspectives (Craft & Howlett, 2012; Tenbensel, 2008). As well, the inclusion of perspectives from both inside-government and outside-government in policy decisions and development are recognized as important to the success of a policy (Evans & Sepeha, 2015). In addition, according to theories from the behavioral and organizational literature, perspective- seeking can help ensure an individual understands opposing ideas or positions, which is necessary for successful problem-solving (Hoplock & Lobchuk, 2020). Indeed, it is usually easier for groups to solve a problem when individuals (or groups) feel involved, understood, and respected. Furthermore, problem-solving requires an ability to realistically assess common and opposed interests so that the common benefits, concerns, advantages, goals, and needs are agreed upon (Johnson, 2019; Tenbensel, 2008). Considering these observations, I found the findings around the reluctance to engage in alternative perspective-seeking quite surprising. I assert that the findings revealed that nursing scholars need to gain a better understanding of the perspective-seeking behaviours of nurse leaders in policy roles. I found myself wondering if perspective-seeking could have helped the study participants generate more ideas or better negotiate policy directions that supported mutually beneficial solutions within nursing groups and among nursing organizations or health care groups. Could an emphasis on perspective-seeking also have assisted decision-makers to better understand the whole picture, including the root causes and the possible solutions to issues? It seems to follow that for nursing leaders in policy roles to be able to carry out a realistic assessment of common

and opposed interests, it would be important for them to understand the situation from the perspective of multiple other individuals or groups. In fact, policy scholars suggest that health policy leadership requires a new approach including educating policy leaders on how to adopt broader policy approaches by understanding policy through interdisciplinary lenses (Heiman et al., 2016).

The findings of this study highlighted that when nursing leaders aligned their policy work with the perspectives of the nursing profession, they were sometimes seen as biased towards nurses and nursing goals by decision-makers. At times, this alignment with the nursing profession risked undermining their policy work and alienating other policy actors, which made it difficult for them to do their jobs. Nursing leaders inside of government were required by decision-makers to have a broader focus on the complex workings of the health care system, and as such their advice needed to reflect system-level thinking, even when that was at odds with the nursing profession's goals. Further, nursing leaders inside-government are government employees, therefore they an obligation to attend to the government's priorities and political platforms. This means that they may also be required to work towards priorities that might be contrary to the priorities of the nursing profession as a whole, whether they agree with policy decisions, or not.

In contrast, those outside of government indicated that their policy activities reflected their organization's mandate to advocate for the profession of nursing; therefore, they were obviously very nursing-focused. Nursing scholars have suggested that locating advocacy roles inside nursing organizations' can be a barrier to policy influence, by perpetuating the perceptions of decision-makers, politicians, and other health care groups that nurses are self-serving in their policy goals (Juma et al., 2014; Shariff, 2015). The findings of this study did not shed any light

on why policy goals of the profession were often viewed as self-serving by others, and provided little insight into why nursing perspectives were often dismissed as biased. Similarly, the scholarly literature suggests that nurses' work in policy is often viewed as self-serving or biased by decision-makers or other policy actors (Cull, 2016; Juma et al., 2014), but no examples or reasons were offered or explored. Further, it appears to me that the nursing profession has internalized this *fact* as a unique threat to the professions' ability to influence others. However, the idea that policy actors in other domains are seen as biased or self-serving can be found across other areas of scholarship including policy studies (Nair & Howlett, 2017) and political science (Tenbensel, 2008). In the policy studies literature, the idea that policy makers see individuals or groups as self-serving or biased often arises during the policy making process and is linked to the concept of uncertainty in decision making. According to Nair and Howlett (2012) decision-makers experience uncertainty in many parts of the decision-making process, such as when they consider the policy options available, as they assess the information available to them, or as they deliberate the values of multiple stakeholders, including other decision-makers. Therefore, it is not just the nursing perspective that is at risk of being viewed as being self-serving or biased.

5.2 THE PRESENCE OF NURSING VOICE

Scholars from diverse disciplines have suggested that successful macro-level policy-work and large system-level problem-solving requires representatives from all stakeholder groups to be at policy discussions (Contandriopoulos et al., 2017; Norris et al., 2017). Further, beyond just a mere presence, all stakeholder groups should be meaningfully engaged throughout the discussions and their perspectives should have a presence in policy decisions (Contandriopoulos et al., 2017). In the nursing literature the prevalent narrative is that nurses are notably absent from health policy discussions, decisions, and reforms, in comparison to other health care

groups, policy actors or health system stakeholders (Ditlopo et al., 2014). However, as exemplified by the participants in this study, nurses do indeed hold macro-level policy positions, participate in policy discussions, influence, inform, or advise decision-makers, and are often successful in shaping policy decisions and direction. Perhaps the contradiction between the prevalent narrative and what appears to be the actual case may be related to the lack of visibility of the places and ways nurses are present and have a presence in macro-level policy. For example, this perception may be a function of the small number of policy positions held by nursing leaders combined with a general lack of awareness surrounding the policy work that nursing leaders do in their roles. The lack of visibility may also be attributed to their behind-the-scenes presence and the confidential nature of their work, which often necessitates closed-door discussions. Perhaps the lack of transparency among nurses in policy positions about their involvement in policy discussions and decisions undermines the understanding by the general population of nurses about, and confidence in, the policy influence of nurses. This lack of visibility and transparency may be two factors that perpetuate the narrative that nurses are not present at policy discussions or that policy decisions lack a nursing presence or perspective (Abood, 2007; Salvage & White, 2019).

The findings of this study revealed the importance of nurse leaders being both present at and having a presence in policy discussions and decisions, as these were crucial to their policy work and influence. One of the facilitators of nursing policy involvement is believed to be the availability of formal policy roles (Fyffe, 2009). The findings of this study suggest that these roles do provide a platform for nurse leaders to legitimately engage in policy work within the government and health care systems and make policy contributions. However, these findings also raised questions as to whether the general demands by the nursing profession to have access to

formal policy roles and policy tables may lead decision-makers to respond to these demands in tokenistic ways. Tokenism has been noted to be a political and policy strategy used by politicians or decision-makers, where those in power allow stakeholders to share information and participate in policy discussions but limit their ability to have input in the decisions or to have their views considered (Norris et al., 2017). Therefore, even though nurses may be awarded a seat at decision-making tables, providing such access tokenistically may undermine nursing presence in policy discussions and cause the nursing perspective to be devalued, overlooked, or ignored by decision-makers — even though nurses may have much to contribute to policy decisions and outcomes. The participants in this study did not view their formal policy roles as tokenistic, but rather as legitimate opportunities for them to engage and collaborate with decision-makers and other policy actors on many policy decisions. Nursing scholars suggest that successful collaboration between nurses and decision-makers (and other policy actors) requires the inclusion of nurses as full partners who share the responsibility for developing or reforming policies (Norris, et al., 2017). However, the findings of this study suggest that decision-makers and other policy actors were often not inclined to collaborate or partner with the nursing profession more broadly. It is also unclear whether the nursing leaders inside government, who were interviewed for this study, reinforced this non-collaborative approach with their own reluctance to reach out more broadly for policy perspectives from their outside-government colleagues.

Nursing scholars also suggest that a strategic advantage of formal policy roles for nurses inside-government lies in the inherent opportunities to connect and engage with nursing leaders from professional nursing organizations (Salmon & Rambo, 2002). Therefore, it was surprising to me that inside-government participants were not leveraging their formal positions to create

opportunities for nursing organization leaders to be present at policy discussions. The participants highlighted strategic positioning as important to getting their perspectives into policy discussions and heard by decision-makers. However, the findings lead me to ask: would it not be the case that having nursing leaders from outside-government collaborate with nursing leaders inside-government during policy discussions be considered strategic positioning? As well, nursing scholars suggest that a unified voice across nursing organizations and groups could strengthen the influence of the nursing profession on health policy (Benton, 2012; Duncan et al., 2014). However, my findings revealed a strong resistance to the idea of seeking collaboration between provincial nursing organizations, and a view that presenting a unified front to decision-makers was simply not possible. Even though nursing leaders have an allegiance and obligation to their employers, wouldn't it make strategic sense to employ meaningful engagement efforts across nursing groups or organizations as policies are discussed and developed? Such an approach, in my view, would ensure decision-makers had access to broader perspectives and policy contributions by nurses. This engagement may also create the potential for all nursing groups involved to demonstrate a united front at policy discussions. I return to this idea later in this paper.

Nursing scholars also suggest that when nurses, as stakeholders, are present through formal policy roles, they still need to have a presence that is meaningful and engaged with and by decision-makers, policy actors and other health care groups who may be present at the discussions (Abood, 2007; Disch, 2019). This idea of meaningful engagement with decision-makers is consistent with literature from diverse scholarship areas about stakeholder involvement in policy (Contandriopoulos et al., 2017; Evans & Sepeha, 2015; Tenbensel, 2008). According to the findings of this study, the opportunity to be physically present at policy discussions was not

always made available, therefore the participants sought out other ways they could meaningfully engage with decision-makers and influence policy. Informal and trusting relationships with decision-makers provided a genuine opportunity to relay their perspectives to decision-makers without being physically present *at the table*. The idea that developing informal and trusting relationships between decision-makers and other policy actors as a crucial way to influence policy decisions is not unique to nursing, and is noted in many areas of scholarly literature (Craft & Howlett, 2012; Jiwani, 2011; Tenbensel, 2008). These findings caused me to wonder if one of the elements missing for nursing influence in policy was a network of informal and trusting relationships between these inside and outside-government nursing colleagues, so that the perspectives offered to decision-makers came from a broader viewpoint. Might facilitating such a network lead to a more meaningful nursing presence in policy discussions and influence in policy decisions? This idea is indeed supported by Evans and Sepeha's (2015) research about insider-outsider networks, where outside-government groups engaged in macro-level policy discussions via their inside-government connections. These authors also indicated the importance of informal and trusting relationships between the groups, to ensure outside groups were meaningfully engaged in policy decisions. The policy science literature expands on this idea of networked groups and individuals. Networks are described as essential to addressing policy problems, finding a range of viable policy solutions (Head, 2014), and as needing cross-silo connections to pool knowledge, expertise, and resources (Carey & Crammond, 2015). However, establishing and maintaining these cross-silo networks may be challenging since fostering trusting relationships between groups and individuals is complex, and often burdened by preconditioned relationships, miscommunication, mistrust, and political dynamics (McConnell & Hart, 2019).

5.3 THE POLITICS OF NURSING VOICE

It is impossible to talk about macro-level policies without discussing the political context in which they are developed. The way government decision-makers problematize an issue, what they choose to do, or not do, about an issue, and the way they respond to the drivers of policy action or inaction are beyond the scope of this research. However, the political context in which policies are developed is significant to the way nurses in formal policy roles go about their policy work. The findings of this study revealed many ways in which nursing voice needed to be political to instigate policy action. Although participants often used the terms advocate, influence, inform and advise interchangeably when describing their experiences in policy work, they generally agreed that these terms collectively reflected the main purpose in being political with their nursing voice. As well, participants provided examples of some of the political attributes that scholars have suggested are vital for nurses to influence policy. For example, the participants indicated that their policy work required political skill, which has been described in the context of health policy as "personal competency, self-belief and self-efficacy that is strongly associated with enhanced personal performance and career development" (Clarke et al., 2021, p.5). Participants also suggested that they demonstrated political astuteness in their policy work, which has been described as the ability to understand behaviours and situations, and use this knowledge to their advantage (VandeWaa et al., 2019). Further, the participants described the ways they applied political acumen in their policy work, for example when they used multiple policy and political competencies to analyze formal and informal relationships that affected their policy influence. These attributes were developed over time and through experience and understanding, and were required for the participants to actively participate in the way governments prioritize and organize the delivery of health care. In addition, the political actions

taken by the participants in this study included such things as engaging in dialogue with other policy actors or providing evidence-based advice to decision-makers. However, in describing their political actions in policy work they also shed light on instances of their policy inaction.

The nursing literature about the role of nurses in policy is largely focused on the activities nurses should undertake to advocate or influence health policy through policy or political action. Therefore, an interesting finding was that at times the participants chose policy inaction. Policy inaction by any individual or group involved in policy is defined as the deliberate decision to not take action or to not act immediately (McConnell & Hart, 2019). At times, policy inaction can be a good policy decision. However, policy inaction may also have negative effects on policy. For example, if policy inaction is a result of problematic power dynamics, conflicting policy agendas, and/or the manipulation of policy decisions, alternative policy perspectives may be eliminated from discussions. Ultimately, policy inaction may reinforce the status quo in political and policy power structures (McConnell & Hart, 2019). It is beyond the scope of this study to analyze the impact of policy inaction on nurses and the nursing profession, but it is pertinent to point out a few instances in which policy inaction by the participants may have had negative effects on policy processes or outcomes..

Nursing scholars are prolific in their assertion that nurses (at all levels of the health care system) and the nursing profession (through the leadership of nursing organizations) should be engaged in health policy (Abood, 2007; Benton, 2012; Duncan et al., 2014; Leavitt, 2009). However, the findings from this study framed outreach to nursing organizations and nurses in general as minimal or tokenistic. From an inside-government vantage point, a strategy of broad outreach to nurses in general would be a difficult and time-consuming task. However, given the emphasis on consultation in the literature, it seems reasonable to expect that inside-government

participants would, at minimum, reach out to the leadership at nursing organizations to bring the outside-government perspective into government discussion. Indeed, the mandates of these nursing organizations included bringing an outside-government voice to policy discussions — a difficult mandate to fulfill if such invitations are not extended from their inside-government colleagues. Further, it also seems reasonable that efforts by these nursing organizations to reach out to the general nursing population for perspective would be an essential component in fulfilling their mandate to advocate for nurses and the needs of the nursing profession in health policy — but the findings revealed reluctance to take this consultative step. The minimal or tokenistic approach to consultation described by the participants was an area where policy inaction might have been intentionally and strategically used to actually limit the nursing perspective and presence in policy discussions.

According to the prevalent nursing narrative, nurses are often seen by decision-makers and other policy actors as the implementers of policies, rather than as contributors to policy development (Ditlopo et al., 2014). In the findings of this study, strategies were described that were intended to "handle nurses", to manage resistance, and ensure that policy decisions were implemented. What was notably absent was any discussion of alternative strategies, such as outreach to nurses or nursing organizations for their perspectives, or to explain why a policy was developed and needed. Might such strategies counteract the resistance to policy implementation, and prevent the need to "handle nurses"? The disclosure by the participants of efforts to "handle nurses", prompted many questions during my analysis. Was this approach a political strategy by the participants to maintain their status and presence in discussions, or to appear collaborative with other policy actors? Or did this strategy reflect a system-level perspective, where a policy was best for the system but not necessarily best for nurses? If the latter was the case, the policy

would indeed be more difficult to implement if nurses, nursing leaders, or nursing organizations were aware of the policy decision prior to being asked to implement it. Do nurses in formal policy roles generally consider their perspectives to be more well-informed than those of other nurses, and believe that the majority of nurses would not understand the reasons for the policy decisions? Whatever the reason behind employing the strategy to "handle nurses", it could be argued that what seems like a good idea from a policy perspective may have weaknesses in its exclusion of the perspectives of nurses who are going to have to implement the policy, and who may see pitfalls these participants did not recognize. This strategy to "handle nurses" seems rooted in the ideas of nurses as implementers and resistors. Policy inaction may have been rooted in the participants' reluctance to challenge the status quo of nurses as implementers and resistors. This inaction may have also insulated the participants from the risk of being labeled by decision-makers or other policy actors as policy resistors themselves.

The nursing literature suggests that complicated intraprofessional relationships within the nursing profession often make it difficult for nurses to be successful in influencing policy (Benton et al., 2012; Ditlopo et al., 2014). In these findings, the need to navigate difficult relationships and mistrust between nursing organizations was noted. As well, the level of difficulty and mistrust in these relationships appeared related to the participants' personal experiences, negative interactions or historical grievances arising from issues with an organization. In this regard, acting in accordance with their personal perspectives may have caused the exclusion of certain organizations or individuals, which may ultimately have led to policy inaction related to needs identified by these organizations. Nursing scholars recognize the value of including the collective perspectives of nursing associations, unions, and regulators in policy decisions (Benton, 2012; Duncan et al., 2014; Juma et al., 2014). Scholars also suggest

that through organizational coalitions across these three domains of the profession, nursing leaders can harness the "power in numbers" of the largest health care workforce (Abood, 2007, p. 5). Exerting this collective and collaborative power has been suggested as a political and policy strategy to ensure that the policy advocacy and influence efforts of nurses are more effective (Ditlopo et al., 2014). However, it seems that for nursing, actually harnessing this potential power and applying it in the political and policy context has been elusive — which makes it difficult to determine if the theory of power in numbers for nurses is true (Abood, 2007). Further, it has been suggested that the fragmentation of nursing's voice across professional nursing organizations is in the best interest of other policy actors and decision-makers who can step into the gap and decide what is best for the nursing profession (Groenwald & Eldridge, 2019). Perhaps a strategy for nursing leaders in policy roles could be to facilitate collaborative engagement across nursing organizations in a collaborative dialogue, to help ensure that a more well-rounded and inclusive perspective on a policy is presented by a cohesive nursing collective. Scholars seem to talk about this kind of collaborative strategy a great deal, but there appears to be little inclination by nursing leaders to put this strategy into action.

This study's findings also revealed the complex connections between politics and policy, and the need to navigate the governing political ideology in an environment of fiscal constraints, while still proactively identifying and taking the opportunities to present ideas that could reform health care systems. For example, all participants described a rapid shift in policies at the start of the COVID-19 pandemic. They suggested that this reflected the ability of governments, stakeholders, and policy actors, including nursing leaders, to act quickly under pressure and to collaborate on innovative solutions and health policies to meet the urgent needs of the population. Circumstances like the pandemic seemed to cut through the typical policy inertia and

facilitated rapid change. The findings also revealed that policy change was typically incremental — and that policy influence was often hindered by institutional, patriarchal, and hierarchical power structures within their policy and political environments. According to the findings of this study, the long-standing power differentials between medicine and nursing remain in place. Many participants were specific in their remarks that decision-makers prioritized medicine and physicians in the health care system over all other health professions, and this negatively affected their own ability to influence policy decisions. Indeed, physicians have been placed at the top of the professional hierarchy in health care and the power of medicine has been structurally embedded in the health care system (Tenbensel, 2008). The prioritization of physicians and the unquestioned power of medicine in the health care system is consistent with themes in the nursing literature about perceived powerlessness by nurses in the face of physician and medical dominance and influence in health policy (Disch, 2019; Ditlopo et al., 2014; Groenwald & Eldridge, 2019). I will return to the ideas of institutional, patriarchal, and hierarchical power structures in the section on oppression and nursing voice later in this paper.

A key gap in the nursing literature is the lack of empirical study of how nurses go about challenging the prioritization of physicians and medicine by decision-makers. The findings of this study did provide some insight into this issue, by suggesting that questioning the status quo around medical dominance in particular was part of the policy role. The findings further indicated that some of the key successes in policy outcomes, or work on policy goals, involved challenging this status quo by speaking truth to power. However, openly questioning the status quo of prioritizing medicine in health policy in a dialogue with decision-makers and physicians was seen as a politically risky strategy. As a result, a less confrontational strategy of incrementalism in policy shifts was pursued, where policy changes were championed over time

as political will and population needs shifted. A good example of incrementalism that surfaced in the data included policy development around the increasing role of nurse practitioners in health care delivery and their move towards autonomous practice, which has been evolving very slowly in Canada since the mid-1960s (Kaasalainen et al., 2010). However, the COVID-19 pandemic rapidly shifted the political will of governments to expedite the implementation of nurse practitioners, with increased scopes of practice and roles, to meet the urgent needs of the population (McGilton et al., 2021). In the context of the huge demands placed on health care systems during the COVID-19 pandemic, an immediate change to policies occurred within a few short months. Indeed, decision-makers already had an evidence-base for the implementation of nurse practitioners, but policy to support the change had not moved forward appreciably prior to this health care emergency. Perhaps nursing leaders could further leverage the opportunity for rapid change that the pandemic has brought to the political and policy context in Canada, and work to shift the long-standing institutional, patriarchal, and hierarchical power structures. The findings of this study highlighted that there are areas where the status quo is not being challenged, including speaking the truth *about* power. There was a notable reluctance by the participants (and by me, as the researcher) to speak the truth about power and how it shapes policy action (or inaction). In this reluctance, a pattern of non-intervention is accepted as a policy option. What if instead of using a more passive, incremental approach to shift the status quo, and accepting non-intervention in policy, nursing leaders were willing to risk challenging these longstanding power differentials? If nursing leaders sought the perspectives of decision-makers about their prioritization of medicine in policy decisions, or directly engaged with physicians about their dominance in policy decisions, what might be the political consequences be for nursing presence and perspective in future policy discussions?

5.4 OPPRESSION AND NURSING VOICE

One gap I identified in nursing scholarship is that the experiences of nursing leaders in health policy has only minimally been investigated. A further gap lies in how the oppression of nursing as a group might be a factor in the way nursing leaders engage in health policy work. These gaps in the literature, as well as the participants' reluctance to speak the truth about power, caused me to wonder what these finding revealed about the effects of power dynamics on nursing leaders in policy roles. The participants and I only minimally touched on the general concepts of power or oppression during the interviews. In fact, there were no discussions about how these concepts might influence the way that participants went about their policy work. Even though I did not approach this study with a critical theory or feminist lens, I believe it is important to question how power and oppression might be reflected in these findings. In reflecting on my role as a novice researcher, I now see it would have been illuminating if I had pursued opportunities that arose to question the participants more deeply in these areas. However, some of our conversations did lead me to reflect more deeply on the implications of power and oppression on the phenomenon of nursing voice.

In the context of this study, I see it as important to reflect upon the ways hierarchical and patriarchal hegemony has affected traditional nursing practice, because health policy is a growing area of practice for nurses. Historically, nursing has been viewed as a female occupation, subservient to (typically male) physicians (patriarchal hegemony). These societal perspectives likely encultured nursing to accept a lower professional rank in relation to medicine in society and the health care system; thereby accepting less decision-making power (hierarchical hegemony) (Dubrosky, 2013; Groenwald & Eldridge, 2019). Reinforcing this assignment of nurses to a lower rank in society is the historical gender-based stereotyping which has assigned

women to a *take care* position and men to a *take charge* position (Prime et al., 2009). Donovan et al. (2012) were among the very few scholars to make the observation that these hierarchical ideas of leadership, gender-based stereotypes, and anti-feminist tendencies can be seen in the characteristics of nurses in macro-level policy roles. They further suggested that these characteristics may contribute to a perceived lack of personal power by nurses in policy roles, or their perception that they lack the ability to influence change in political and policy environments. Interestingly, the participants in this study did report feelings of personal power in their policy work, and in their ability to make changes through their personal influence. However, some of their observations could also be viewed and framed as hierarchical ideas of leadership or even as anti-feminist tendencies. For example, acceptance of traditional ideas of hierarchical leadership in health policy were visible as the participants expressed their beliefs that physicians and medicine were prioritized over nurses and the nursing profession. There were also indications of hierarchical ranking by the participants; where system-focused policy nurses expressed the view that they were higher in rank than nursing-focused policy nurses, where inside-government perspectives were viewed as more important than outside-government perspectives, and where both inside and outside of government perspectives were viewed as more important than those of the general nursing population. As well, some of the findings illuminated actions that could be considered as arising from anti-feminist tendencies. For example, I noted the way participants navigated difficult or adversarial relationships with nursing organizations by limiting or undermining opportunities for meaningful engagement, thereby preventing their policy contributions. This type of anti-feminist behavior has also been noted in the scholarly literature, where fellow nurses are often described as adversaries instead of allies in policy directions, and where intraprofessional conflicts exist between the policy goals of

different nursing groups (Groenwald & Eldridge, 2019). It was not an explicit goal of this study to explore the potentially hierarchical or patriarchal behaviors of nursing leaders in policy roles, and due to the qualitative and descriptive nature of this study it is not possible to draw any conclusions about how the findings relate to these complex ideas. However, the observations from this study and the lack of empirical evidence about the role and influence of power dynamics on nursing leaders in health policy highlight that this is an area of scholarship that could benefit from a deeper exploration of how nurses in health policy roles speak the truth about power.

Power is often identified as a key concept in the general (non-nursing) discourse around policy advocacy and influence. Sriram et al. (2018) suggested that power manifests, implicitly or explicitly, in interactions between diverse health policy actors. The interactions between these actors are dynamic and reflect negotiations about resource distribution and health policy priorities to shape health policy actions, processes, and outcomes. It is beyond the scope of my study to assess the many ways that nursing leaders implicitly or explicitly manifested power within their interactions with other policy actors. However, the participants indicated that they did have power in their policy roles, even if it was limited at times. In addition, some findings from this study suggested that nursing leaders in policy roles might be intentionally limiting the power of other nursing perspectives and presence in health policy. For example, the findings revealed that these nurses made choices about whether to seek the perspectives of other policy actors, or not. They made choices to engage with other nurses or nursing organizations on policies, or not, and choices to openly question the status quo, or not. They made choices to "handle nurses" to manage resistance, or not. These all represent moments of power, revealed by the choices of nursing leaders in their policy roles. This caused me to wonder how other nurses

perceived how these participants used their power. Further, if the participants knew how other nurses perceived their use of power, would some of their choices in their policy roles have been different?

The theory of nurses as an oppressed group (Dubrosky, 2013; Roberts, 1983) posits that nurses internalize their perceived domination and powerlessness and "develop disdain for themselves and a belief in their own inferiority that leads to a lack of pride and feelings of low self-esteem" (Roberts et al., 2009, p.289). These internalized views lead nurses to exhibit oppressed group and internalized oppression behaviours (Roberts et al., 2009). According to Roberts' seminal paper about nursing and oppressed group behavior (1983), there are two factors that interact to create and maintain a state of oppression in nurses. These factors are the external situation created and maintained by the oppressor, and the internalization of the dominance of the oppressor, by the oppressed. Glimpses of both factors surfaced in my findings. Externally, there appeared to be a belief that the longstanding status quos in the political, policy and health care system were virtually intractable. Internally, there seemed to be a general acceptance of these status quos as barriers to their personal influence with decision-makers and to the influence of the nursing profession in health policy. It is perhaps instructive to note that scholars have suggested that "in the resisting of the status quo, nurses and, by extension, the nursing profession will begin to resist their own status quo" (Dong & Temple, 2011, p.174).

In the nursing literature, the concept of oppression has been applied to many areas of concern in the profession (Fletcher, 2006; Matheson & Bobay, 2008). However, there is a scarcity of empirical evidence about the connection between the understanding of nurses as an oppressed group and how the attributes and consequences of oppression are seen in the context of health policy work and politics. This gap highlights unexplored questions about nursing

leaders in macro-level policy roles, and any connections to oppressed group or internalized oppression in their policy work.

5.6 CHAPTER CONCLUSION

Reflecting on the research questions of this study, the findings revealed that the experiences of nursing leaders in policy roles, and their understanding of *nursing voice* in health policy, were similar for those inside and outside of government. Both groups of nurse leaders shared that *nursing voice* within their experiences in health policy included the elements of perspective, presence, and political. *Perspective* was an important aspect of policy roles, and important to influencing decision-makers. Personal perspective was accumulated over a nursing career, and I have asserted that personal perspective could be further enhanced through perspective-seeking and perspective-taking behaviours. *Presence* required both having a presence at policy discussion and a presence in policy outcomes. Nursing presence in health policy discussion was obtained as a consequence of formal policy roles or informal relationships with decision-makers. I have suggested that the presence of nursing in health policy could be improved through meaningful engagement with nurses more generally, by nurses in policy roles and with decision-makers. *Political* included the many purposes, expectations, and strategies of nursing leaders in formal policy roles. The findings also revealed that perspective, presence and political are connected and iterative, and therefore nursing voice was refined and adapted over time and through policy work. In addition, the political actions or inactions that occurred in policy work reflected complex and complicated political and policy environments. I assert that these complex political and policy environments are further complicated by hierarchy, patriarchy, power, and oppression, and are areas of study where there are significant gaps in the

nursing literature about how these factors affect the influence and participation of nurses in macro-level health policy work.

In closing, I found the term *nursing voice* to be reflective of a complicated and dynamic process of the accumulation of knowledge, experience, insights, and opportunities to see things in a broader and deeper way. Nursing voice in health policy through perspective, presence, and political was often described as successful in personal efforts to influence policy decisions. However, nursing voice was also discussed as being limited by other policy actors, and exercised in ways that limited the provision of more diverse perspectives to decision-makers. These limiting factors may contribute to the perpetuation of the prevalent narrative about the lack of influence of nursing in health policy.

CHAPTER 6: CONCLUSION

In this chapter I summarize my thesis, including my problem of interest, literature review and research design. I then briefly recap the main findings and discussion points of the study and provide a short discussion about the implications of the study for nursing practice. Finally, I suggest some of the limitations of this study, recommend areas for future research, and describe my plan for dissemination of this research.

6.1 THESIS SUMMARY

My problem of interest for this thesis was the prevailing and long-standing narrative in the nursing literature that nurses are mostly absent from, or invisible at, policy discussions and that health policies lack the input of *nursing voice* (Cohen et al.,1996; Duncan et al., 2014; Rasheed et al., 2020). Similarly, there is a common narrative used to make the case for why nurses, individually and as a profession, must increase their involvement and influence in health policy. This narrative submits that nursing is the largest health care profession, and nurses have the most direct experience of the implications of health policy — therefore, nurses have crucial contributions to make and are among the ideal leaders to inform and advise policy decision-makers (Benton, 2012; Rasheed et al., 2020). However, the findings of this study confirm that nursing leaders do indeed work in formal policy roles, and do have opportunities to inform, advise, and influence policy decision-makers. Further, nursing leaders from professional organizations, and those occupying formal roles inside government, are indeed essential contributors in the policy sphere. Yet, their experiences have been under-researched or undocumented.

In my literature review, I noted repeated calls by scholars for nursing leaders to improve their policy involvement so that the profession would have a greater voice in policy decisions (Al Rifai, 2017; Benton, 2012; Donelan et al., 2012). However, I also noted a scarcity of literature

about the experiences of nursing leaders, who do work in formal policy roles and who do contribute to macro-level policy. In addition, I noted that nursing scholars often write from a deficit perspective about the involvement of nurses in health policy. Scholars often focus on the barriers nurses face to their involvement and influence in policy, with minimal literature highlighting the involvement and successful policy work by nursing leaders (Abood, 2007; Benton et al., 2017; Salvage & White, 2019). The perceived oppression of nurses and medical dominance over the nursing profession figures large in the general nursing literature (Bradbury-Jones et al., 2008; Dubrosky, 2013; Fletcher, 2006; Manojlovich, 2007; Matheson & Bobay, 2007), just as power dynamics in politics and policy are a mainstay of political science research (Tenbensel, 2008). However, nursing scholars of health policy appear to pay little attention to these power dynamics.

Two questions guided my research: What has been nursing leaders' experience of nursing voice in provincial health policy in Canada? and How do these experiences vary related to occupying policy roles inside or outside of government? To answer these questions, I employed a qualitative descriptive approach to explore the experiences of 10 nursing leaders from two Western Canadian provinces, who have engaged in provincial health policy work. I recruited participants to two groups, nursing leaders with formal policy roles inside and outside government. I gathered data through semi-structured interviews and transcribed the recordings verbatim. I then analyzed these data using Braun and Clarke's (2012) approach to thematic analysis.

6.2 MAIN FINDINGS AND DISCUSSION POINTS

In this study I explored how nursing leaders in formal macro-level policy roles understood or described *nursing voice* in the context of policy and political environments.

Further, I explored how they used their nursing voice to inform or advise policy decision-makers, to contribute to policy discussions about health care system and nursing issues, and to influence policy decisions within political environments. I generated three themes from these data that reflected the experiences of nursing leaders: Nursing Voice is Perspective; Nursing Voice is Presence; and Nursing Voice is Political. These findings revealed that perspective, presence and political are inter-related and iterative — therefore, nursing voice was refined and adapted over time and through policy work. In general, the three themes were consistent across both groups of participants (inside and outside government). However, there were some notable variations between the groups. These variations included how their perspectives were inserted into health policy, the inside government expectation to be aligned with the governing party's ideology and strategic plans, and whether their policy work was done in an advocacy or advisory capacity.

I found that perspective was an important aspect of policy roles, and important in influencing decision-makers. Personal perspective was accumulated over a nursing career, and included their understanding of the value, capabilities and needs of nurses and the nursing profession, and of the complex workings and needs of provincial health care systems. An important aspect of nursing voice was the ability to apply this nursing perspective to health care system issues and then to advise on policy matters, even though such an approach risked nursing leaders being seen as biased or self-serving. However, a heavy emphasis on personal perspective by nursing leaders in policy roles meant that the perspectives of other nurses, or nursing organizations, were often shared in a limited way in terms of policy contributions. As well, nursing leaders seldom sought the perspectives of other policy actors and health care groups. Therefore, I suggest that the personal perspective of nursing leaders could be further enhanced

through perspective-seeking and perspective-taking behaviours. These activities could, I believe, be helpful to problem-solving and policy decision-making.

In this study, presence was explained as requiring both a presence at policy discussions and a presence in policy outcomes. Nursing presence in health policy was obtained as a consequence of formal policy roles or informal relationships with decision-makers. Nursing presence could be enhanced through strategic positioning or could be limited by the actions, or inactions, of nursing leaders or other policy actors. Therefore, the presence of nurses in discussions and nursing perspective in health policy could be improved by nurses in policy roles through meaningful engagement of other nurses or nursing organizations, and with decision-makers. As well, building networks between stakeholder groups may be a way for nursing leaders to create cross-silo connections, which are essential to addressing policy problems and negotiating solutions.

I found that political included many choices, actions, purposes, expectations, and strategies of nursing leaders in formal policy roles. Further, the choices made by nursing leaders to take action or to refrain from taking action reflected the complex and complicated political and policy environment, and had an influence on policy. At times, their choices also appeared to limit nursing perspective and presence in health policy. In addition, these data suggested that these complex political and policy environments were further complicated by hierarchy, patriarchy, power, and oppression. However, how these factors connect to the understanding of nurses as an oppressed group and how the attributes and consequences of oppression are seen in the context of health policy work and politics were not explored in this study.

In general, I found the seeming simple term *nursing voice* to reflect a deceptively complicated and dynamic process of the accumulation of knowledge, experience, insights, and

opportunities to see things in a broader and deeper way. The successful use of nursing voice in health policy through perspective, presence, and political was often described in personal efforts to influence policy decisions. However, nursing voice was also discussed as being limited by other policy actors and exercised in ways that limited the provision of more diverse perspectives to decision-makers. These limiting factors may contribute to the perpetuation of the prevalent narrative about the lack of influence of nursing in health policy.

6.3 IMPLICATIONS FOR NURSING PRACTICE

A prevailing narrative in the nursing literature is that nurses lack influence in health policy (Abood, 2009; Benton, 2012; Rasheed, 2020). Findings of my study challenge this narrative by suggesting that nursing leaders in macro-level policy roles in Canada often consider themselves to be successful in their policy work. They are engaged in policy discussions, provide advice on policy decisions, and do indeed influence health policy. These findings begin to address the gap in research about the experiences of nursing leaders in health policy in a Canadian context. To influence the prevailing narrative that nurses lack influence in health policy, findings such as these should be highlighted in the nursing literature, celebrated as an area of advancement by the nursing profession, and examined and deconstructed to provide a strength-based account of the way nurses do influence health policy. As well, highlighting the work of nursing leaders in policy roles through scholarship or media reports would help make their roles and contributions visible to all nurses. Nurses in Canada are aging, and so are the country's nursing leaders. Therefore, succession planning for roles in nursing policy leadership is crucial.

Nurses at all levels of policy work could benefit from a better understanding of the perspectives of diverse health care groups and policy actors. Therefore, nurses in policy roles

would benefit from further developing their skills in perspective-seeking. Perspective-seeking behaviours may assist in broadening the perspective that nursing leaders bring to policy work.

There appears to be a theory-to-practice gap for nurses in health policy. For example, theory predicts that a collaborative and unified front by nurses and nursing organizations will increase their policy influence because of the "power of numbers" in the profession (Abood, 2009; Benton, 2012). Without purposeful structures designed to bring nursing organizations together for meaningful engagement to discuss and negotiate policy options, achieving the goal of power in numbers may not be possible. Along the same lines, consultations with the general nursing population must also reflect meaningful engagement. Therefore, the policy influence of the profession may be enhanced by the efforts of nursing leaders in formal policy roles to advocate for, and engage in broader consultation with nurses at large, and nursing organizations.

6.4 LIMITATIONS OF THE STUDY

There are limitations to this study related to the research setting and context, and the COVID-19 pandemic. This study did not include the experiences of nursing leaders from nursing unions, even though they represent an important outside-government perspective for health policy. I acknowledge that the inclusion of nursing union leaders would have added another important perspective to these data. I also consider the COVID-19 pandemic to have been a major factor in the inability to secure interviews with some key individuals. In addition, the policy changes, development, and implementation that were rapidly taking place during the pandemic were also happening at the time of the participant interviews. This context may have affected the way participants described their policy work and their influence in health policy. The concepts of power and oppression surfaced in relation to discussions about hierarchy and patriarchy, but none of these factors were formally explored in this study. As a novice researcher

it is likely that I missed opportunities to ask questions that might have helped shed more light into some areas. Further, as a requirement of my educational program I completed the data collection and analysis on my own. Therefore, I acknowledge that this research could have benefited from the perspectives of other researchers, beyond my supervisory committee.

6.5 FUTURE RESEARCH

The findings from this study revealed that nursing leaders are influential in macro-level health policy. Therefore, it would be important for researchers to further explore how nursing leaders use their perspective and presence to influence policy decision-makers. As well, research that determines what policy success looks like to the nursing profession might help the profession better articulate policy goals, identify what level of policy participation is desired, and define how meaningful participation in policy is measured by the profession. Research to gain a better understanding of the role of perspective-seeking behavior in policy work may also be helpful to point out the areas where this approach is not being utilized, and where it could be helpful. Further, it would be interesting to explore the effects of enhancing the skills of perspective-seeking (and taking) in nursing policy work, particularly as related to the prevailing bias in the literature that nursing policy advocacy is self-serving (Juma et al., 2014; Shariff, 2015). As well, future research that links the policy education nursing leaders received and the formal policy roles they occupy, with their perceived level of influence, might shed greater insight into the prevalent narrative that health policies lack nursing voice (Rasheed et al., 2020).

In addition, research that considers the intersections of nursing and health policy with knowledge and theories from political, policy, organizational, and behavioral studies might better inform and strengthen the efforts of the nursing profession in policy advocacy and influence. As well, I suggest that considerations for future research include an exploration of how the factors of

hierarchy, patriarchy, power, and oppression intersect with the policy work done by nursing leaders. Finally, a deeper exploration into how nursing leaders in policy roles experience these factors in their day-to-day work would benefit from the application of a critical or feminist lens.

6.6 DISSEMINATION OF RESEARCH

To disseminate my research findings, I plan to seek opportunities to present my findings at meetings and events where nursing leaders who work in policy roles are present, such as the Florence Nightingale Foundation Annual Conference or the CNA Biennial Convention. I will submit requests to share my findings on various other platforms, such as through podcasts or webinars, where the target audience is not limited to nurses but also includes other health care disciplines. I also intend to weave my findings into the development of a policy course for nurses (students or practicing) that has a political and policy science foundation and incorporates organizational and behavioral theory with a nursing perspective.

6.7 CHAPTER CONCLUSION

In this qualitative descriptive study, I explored the experiences of nursing leaders in provincial health policy in Western Canada, particularly as related to their understanding and use of *nursing voice*. The findings of this study revealed the elements of nursing voice to be perspective, presence and political, when used in macro-level health policy work. The findings also revealed that nurse leaders in policy roles were actively engaged in policy discussions, did have opportunities to influence policy decision-makers, and did consider themselves to be successful in influencing health policies. However, this influence may be limited due to factors that are both internal and external to nursing leaders in policy roles.

The nursing leaders in my study described policy work as driven by personal interest and as taking a great deal of personal investment to gain the knowledge and experience needed to be

credible, influential, and successful in their roles. Indeed, the nurses in this study revealed that it took an enormous amount of time, effort, and energy to accumulate nursing and system perspective, garner a formal policy position, and hone their knowledge and skills to be purposeful and influential in policy work. My study is one of only a handful of studies found in the nursing literature that focuses on the experiences of nursing leaders in macro-level health policy, especially in a Canadian context. Therefore, it is my hope that this study will encourage nursing scholars to question the foundations of the prevailing narrative that nurses and nursing voice are absent or invisible in policy discussions, and that nursing lacks influence in policy decisions. In questioning this long-standing narrative, nursing scholars could reflect on the way the profession is choosing to view their influence in health policy. As well, there are internal and external limitations that the profession must address directly, openly, and honestly to overcome these limitations.

Policy influence and the presence of nursing voice are not binary in nature, that is either fully present or fully absent. The expression and visibility of policy influence through nursing voice are context-sensitive, experientially influenced, affected by underlying power dynamics, and situated in complex political environments that shape the choices made by nursing leaders in policy roles. Therefore, perhaps we need to be more thoughtful about the reality we create when we reduce the discourse on policy influence to one or the other and perpetuate the idea that nursing voice lacks influence.

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Appendix A: Letter of Invitation for Nursing Leaders with Outside-Government Experience

University of Lethbridge
Faculty of Health Sciences

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

http://www.uleth.ca/hlsc

Dear_____,

My name is Robin Richards, I am a Master of Nursing student at the University of Lethbridge. My research interests are in nursing leadership, health policy and health care transformation. More specifically, I am interested in how these all fit together. To better understand this complex area, I have decided to start by exploring the experiences of nursing leaders around 'nursing voice'. Therefore, my thesis is focused on 'nursing voice' and its use in influencing and informing provincial health policy. My study will follow a qualitative descriptive design that attempts to answer the question: *How do nursing leaders in formal policy roles, inside and outside of government, experience 'nursing voice' in Canadian provincial health policy work?*

I will explore nursing leaders' perspectives and experiences of 'nursing voice' in health policy from two vantage points: from the perspective of those outside of government who work with provincial ministries of health, and from those with experience working inside a provincial health ministry. To do this I am seeking nursing leaders, such as yourself, who have access, opportunity and expectation to interface with a provincial ministry of health, on health policy. As well, to provide an inside government lens, I will be seeking nursing leaders who have held (or currently hold) leadership roles within a provincial ministry of health. It is my intention to recruit participants from two Western Canadian provinces. However due to the small number of possible participants, I may need to broaden my recruitment to include other Canadian provinces.

I am writing to ask if you would be interested, as a nursing leader, in sharing with me your experiences and perspectives on 'nursing voice' in influencing and informing provincial health policy. This research will be conducted through a one-on-one, in-person or telephone interview, expected to last between 60-90 minutes, at a place and time that is mutually agreeable. To build a richer understanding of the data, there is a possibility that a second interview will be needed to confirm accuracy, clarify your response or ask you to elaborate on your perspectives. This second interview, if needed, will be conducted via telephone.

The information I collect from this study will be presented in a paper as a partial requirement for the Master of Nursing program at the University of Lethbridge. My findings will be shared in my thesis, with the intent to eventually publish manuscripts in peer-reviewed

scholarly journals. As well, I intend to present my findings at meetings and events where nursing leaders in policy roles may be in attendance.

Ethics approval from the Health Research Ethics Board through the University of Lethbridge Research Ethics Board has been obtained. I will contact you shortly to discuss participation in the research study, and if agreeable, we can arrange for the interview. If you have any questions or concerns, please e-mail me at xxxxx.xxxxxx@uleth.ca or call me at XXX-XXX-XXXX. I look forward to speaking with you soon.

Sincerely,

Robin Richards BN, RN
Graduate Student
Faculty of Health Sciences
University of Lethbridge

Appendix B: Letter of Invitation for Nursing Leaders with Inside-Government Experience

University of Lethbridge
Faculty of Health Sciences

4401 University Drive
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I will explore nursing leaders' experiences and perspectives of 'nursing voice' in health policy from two vantage points: from the perspective of those with experience working inside a provincial health ministry, and from those outside of government who interface with provincial ministries of health. To do this I am seeking nursing leaders, such as yourself, who have held (or currently hold) leadership roles inside of a provincial government. As well, to provide an outside of government lens, I will be speaking with nursing leaders from professional organizations who have access, opportunity and expectation to interface with provincial ministries of health, on health policy. It is my intention to recruit participants from two Western Canadian provinces. However due to the small number of possible participants, I may need to broaden my recruitment to include other Canadian provinces.

I am writing to ask if you would be interested, as a nursing leader, in sharing with me your experiences and perspectives on 'nursing voice' in influencing and informing provincial health policy. This research will be conducted through a one-to-one, in-person or telephone interview, expected to last between 60-90 minutes, at a place and time that is mutually agreeable. To build a richer understanding of the data, there is a possibility that a second interview will be needed to confirm accuracy, clarify your response or ask you to elaborate on your perspectives. This second interview, if needed, will be conducted via telephone.

The information I collect from this study will be presented in a paper as a partial requirement for the Master of Nursing program at the University of Lethbridge. My findings will be shared in my thesis, with the intent to eventually publish manuscripts in peer-reviewed scholarly journals. As well, I intend to present my findings at meetings and events where nursing leaders in policy roles may be in attendance.

Ethics approval from the Health Research Ethics Board through the University of Lethbridge Research Ethics Board has been obtained. I will contact you shortly to discuss participation in the research study, and if agreeable, we can arrange for the interview. If you have any questions or concerns, please e-mail me at xxxxx.xxxxxx@uleth.ca or call me at XXX-XXX-XXXX. I look forward to speaking with you soon.

Sincerely,

Robin Richards BN, RN
Graduate Student
Faculty of Health Sciences
University of Lethbridge

Appendix C: Invitation to Participate and Informed Consent

University of Lethbridge
Faculty of Health Sciences

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

http://www.uleth.ca/hlsc

INVITATION TO PARTICIPATE AND INFORMED CONSENT FORM

Study Title: Nursing Voice in Provincial Health Policy - The Experiences of Nursing Leaders Inside and Outside of Government

Dear Participant,

You are invited to participate in my thesis research study, where I will explore nursing leader's experiences of *'nursing voice'* in informing and influencing provincial health policy in Canada. The purpose of my research is to learn about your experiences with a Provincial Ministry of Health when engaging in health policy discussions. The information I collect from this study will be presented in a paper as a partial requirement for the Master of Nursing program at the University of Lethbridge. My research will be shared with my supervisor and committee members initially, and will be subsequently shared in manuscripts as part of my thesis, with the intent to eventually publish the manuscripts in peer-reviewed scholarly journals. As a participant, you may ask for a copy of these manuscripts.

What is Required of You?

I would require a one-to-one interview with you, either in person or via telephone, at a mutually agreeable time and location. My interview will take about 60-90 minutes of your time. During the interview, you will be asked about your experiences and perspectives as a nursing leader on the topic of 'nursing voice' in informing and influencing health policy at the provincial government level. I will audio-record the interview with your permission. If you do not wish to be audio-recorded, I will take written notes during the interview, with your permission. Additionally, I may contact you for a second, shorter (15 minute) telephone interview to confirm accuracy, clarify your responses or ask you to elaborate. I may also ask you to review my initial findings and provide feedback. If you decide to participate in my initial interview, you are under no obligation to participate in a second interview or a review of the initial findings. You are free to review your own transcript, the initial findings, or to provide feedback to me, by contacting me at the phone number or email provided on this form.

Potential Benefits and Risks of my Study

There are no direct benefits to you from participating in my study; however, you will be contributing to a better understanding of the experience of using nursing voice to inform and influence health policy from a nursing leaders' perspective. Although there are no anticipated risks to my research, it is unknown if your participation in my study could result in any

professional or personal risk. As I outline below, I will take all reasonable steps to protect your confidentiality, anonymity, and privacy, during the interview(s), transcription, data analysis, write up of findings, and dissemination of findings.

Confidentiality, Anonymity and Privacy

To maintain your confidentiality and anonymity, I will assign you a unique participant identifier prior to beginning an interview. I will be the only person who will have access to your unique identifier. I will use this unique identifier on your transcript and demographics, and during data analysis and write up of findings, including any quotes that I may use. As well, any directly identifying information (name, demographics or position) and any words, phrases or language that could identify you will be removed from all transcripts and data, and will not be used in the write up of my findings. I will present all findings as aggregate data; except I will be identifying the province (AB, BC or Other) and the group (inside or outside of government) that participants belong to. However, due to the specific nature of participants, and the small sample size, I will not be able to guarantee anonymity. As well, there is a possibility that the combination of indirectly identifying information, such as the naming of the provinces, the limited number of professional organizations, and the use of certain words or phrases (ie; dual mandate) may lead readers to presume identification of participants.

Our one-to-one interview (either in person or over the phone) will take place in a private area. The audio-recording will not be used for any purpose other than data collection. I will be transcribing the interview and will anonymize your transcript by removing any personally identifying information. Only myself and my thesis supervisor will have access to your transcript. After the audio-recorded interview has been transcribed and saved as a word document, the audio-recording will be destroyed. I will encrypt all electronic data and document files related to my research, and store these on my personal password-protected computer. I will store all physical research documents in a private locked drawer in my home office, including hand-written notes or memos, informed consent and participant demographic forms.

Any datasets that I generate and analyze will not be publicly available. Should I disseminate my findings through events or scholarly journals, I will keep your personal information confidential. All transcripts and research data collected will be confidentially destroyed after five years as per the University of Lethbridge research ethics requirements.

Voluntary Participation

Your participation in my study is completely voluntary. Your continued participation should be as informed as your initial consent, so please feel free to ask for clarification or ask any questions that arise during your participation. You may choose to not answer any question, or you may stop the interview, any time for any reason with no consequences. You may withdraw from the study at any time by verbally informing me.

Need further information?

If you require additional information about my study, please contact me at XXX-XXX-XXXX or xxxxx.xxxxxx@uleth.ca. You may also contact my thesis supervisor, Dr. Shannon Spenceley, at XXX-XXX-XXXX or x.xxxxxxxxx@uleth.ca. Questions regarding your rights as

a participant in this research may be directed to the Office of Research Ethics, University of Lethbridge at 403-329-2747 or research.services@uleth.ca.

If you are agreeable to participate in my study, please read and sign the Informed Consent below.

Thank you for your consideration.

Robin Richards BN, RN
Graduate Student
Faculty of Health Sciences
University of Lethbridge

Study Title: Nursing Voice in Provincial Health Policy - The Experiences of Nursing Leaders Outside and Inside of Government

Informed Consent

This research project has been reviewed for ethical acceptability and approved by the University of Lethbridge Human Subject Research Committee. This consent form will be collected prior to any interviews, and you will receive a copy via email.

INFORMED CONSENT

1. I have read (or have been read) and understood the above information regarding this research study and consent to participate in this study.

Date _____

Printed Name of Participant _____

Signature _____

2. I agree to the audio-recording of my interview.

Date _____

Printed Name of Participant _____

Signature _____

Signature of Researcher _____

Appendix D: Participant Demographics

Date of Interview: _____

Unique Participant Identifier: _____

Level of Nursing Education Obtained:

- Diploma _____ Degree _____ Masters _____ PHD/DNP_____
- Specialty Education in Leadership/Health Policy/Health Systems _____

Number of Years as a Nurse: _____

Total number of years in nursing *leadership* positions:

- 1-5 _____ 6-10 _____ 11-15 _____ 16-20 _____ 20+ _____

Total number of years in *health-policy related* positions:

- 1-5 _____ 6-10 _____ 11-15 _____ 16-20 _____ 20+ _____

If you are comfortable doing so, please list any positions in leadership or policy work that you have held in your career:

- _____
- _____
- _____
- _____
- _____

If you are comfortable doing so, please list any continuing or formal education opportunities you have engaged in that you believe have contributed to your work in health policy:

- _____
- _____
- _____

_____

Appendix E: Interview Questions for Outside-Government Participants

1. I would like to start with you briefly introducing yourself and telling me about your current/previous policy roles.
   Probes: -How did your nursing career evolve into you holding this position?
   -How would you describe your role in health policy?

2. When I say the term 'nursing voice', what does that mean to you?
   Probes: -How would you describe nursing voice?
   -What has been your experience of nursing voice?

3. What does having a nursing voice in provincial health policy look like to you?
   Probes: -What do you think is the value of 'nursing voice' in health policy?

4. In your current/previous role, can you tell me about your experiences of 'being at the table' where policy is made?
   Probes: -How often are/were you asked or expected to participate?
   -What does 'being at the table' mean to you?
   -What is the process or structure of the meetings?
   -Who is typically at the table with you?
   -What is the climate of these meetings? (Collaborative, argumentative)
   -Do/did you feel included and able to provide a nursing voice?
   -How do you think others perceive nursing voice at policy discussions?

5. Can you tell me about a time during a policy discussion that you believe;
   i. you had a nursing voice?
   ii. your nursing voice was heard and valued?
   iii. your nursing voice was silenced or not heard?

6. Can you give me an example of an existing health policy where you believe nursing voice is absent? Where nursing voice is evident?

7. Can you tell me about your perspective on, or experiences of, the state of 'nursing voice' in your current provincial political climate?
   Probes: -How do you think different political climates affect 'nursing voice' in health policy?
   -What is/has been helpful or contributed to you having a 'nursing voice' in health policy?
   -What challenges have you experienced in having a 'nursing voice' in health policy?

8. What would you like nurses, policy makers or the public to know about 'nursing voice'?

Appendix F: Interview Questions for Inside-Government Participants

1. I would like to start with you briefly introducing yourself and telling me about your current/previous policy roles.
   Probes: -How did your nursing career evolve into you holding that position?
   -How would you describe your role in health policy?

2. When I say the term 'nursing voice', what does that mean to you?
   Probes: -How would you describe nursing voice?
   -What has been your experience of nursing voice?

3. What does having a nursing voice in provincial health policy look like to you?
   Probes: -What do you think is the value of 'nursing voice' in health policy?

4. In your current/previous role, can you tell me about your experiences of 'being at the table' where policy is made?
   Probes: -How often were you asked or expected to participate?
   -What does 'being at the table' mean to you?
   -What is/was the process or structure of the meetings?
   -Who is/was typically at the table with you?
   -What is/was the climate of these meetings? (Collaborative, argumentative)
   -Do/did you feel included and able to provide a nursing voice?
   -How do you think others perceive nursing voice at policy discussions?

5. Can you tell me about a time during a policy discussion that you believe;
   i. you had a nursing voice?
   ii. your nursing voice was heard and valued?
   iii. your nursing voice was silenced or not heard?

6. Can you give me an example of an existing health policy where you believe that nursing voice is absent? Where nursing voice is evident?

7. Can you tell me about your perspectives on, or experiences of, the state of 'nursing voice' in your current provincial political climate?
   Probes: -How do you think different political climates affect 'nursing voice' in health policy?
   -What is/was your experience of nursing voice in the provincial political climate?
   -What do you think is/was helpful or contributed to you having a 'nursing voice' in health policy?
   -What do you think are/were the challenges to you having a 'nursing voice' in health policy?

8. What would you like nurses, health policy makers or the public to know about 'nursing voice'?