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Nurse Influence in Policy Development: A Model Using Storytelling

Michele Anderson, PHN

Submitted in partial fulfillment of the
Requirements for the degree of
Masters of Arts in Nursing

AUGSBURG COLLEGE
MINNEAPOLIS, MINNESOTA

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Augsburg College
Department of Nursing
Master of Arts in Nursing Program
Thesis or Graduate Project Approval Form

This is to certify that **Michele (Evans) Anderson** has successfully defended her Graduate Project entitled **"Nurse Influence in Policy Development Through the Use of Storytelling"** and fulfilled the requirements for the Master of Arts in Nursing degree.

Date of Oral defense **January 8, 2009**.

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ABSTRACT

Nurse Influence in Policy Development: A Model Using Storytelling

Michele Anderson, PHN

December 16, 2008

_____ Integrative Thesis

__X__ Field Project

This project will explore how nurses' stories of social injustice can be used to influence legislative action on health policy. Nursing history has proved the profession's roots in political activism and social justice. Role models and trailblazers like Lillian Wald solidified the nursing intervention of political involvement, but somewhere along the way it has lost its value. Using Newman's Health as Expanding Consciousness theory as a guide, nurses can use stories to illustrate the patterns of disruption in the current healthcare system and then lead policy into reform.

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Chapter 1: Introduction

Purpose of Project

Although nursing currently tends to focus on the scientific model of health with a concentration on acute care, nursing grew out of roots of political involvement and social activism. Stanhope and Lancaster (2004) identify policy development as one of the three core functions of public and community health nursing. "Public health nursing practice takes place through assessment, policy development, and assurance activities of nurses working in partnerships with nations, states, communities, organizations, groups, and individuals" (Stanhope & Lancaster, 2004, p.9). A client once told me, "You know since the economy has been so bad, my assisted living home can't afford as much fruit and vegetables, so we have been eating more breads and cereals, and now all of us old people are bound up" (J.K., personal communication, May 21, 2008). He was attempting to illustrate how much the nation's economy affected his ability in his assisted living community to maintain health even though he had the knowledge to do so. In other words, as his nurse, assessment and intervention at the national policy level could improve the health of one client at the individual level.

The idea for the project came out of the response I received from legislators, legislative assistants and other political personnel as I used the stories of social injustices I had witnessed during my work as a public health nurse to advocate for change at the policy level. As I worked with Representative Maria Ruud and with a grassroots democratic group, the Citizen Health Forum, to connect with the marginalized communities who directly feel the effects of health-limiting social policies, it became more and more apparent that as a caregiver and a nurse I had a unique role of storyteller

and cultural broker with vulnerable communities. Through these experiences, I felt as though I was not only changing the legislators' view of nurses as politically uninvolved, but also serving as a great resource to them with an inside view of the human experience of the healthcare system. In sum, the primary issue for this project, to paraphrase Drevdahl, Kneipp, Canales and Dorcy (2001) is that the nursing profession needs to reinvest in social activism. One way to reinvest nursing in social activism and inspire policy reform is through a project that guides nurses in the use of storytelling as a means to persuade legislators to positively reform social policy. This project will describe a process model to guide nurses in the use of storytelling to influence legislative action on health policy at the state level.

Historical Perspective

The profession of nursing originated through social activism and policy development. In colonial Europe and America, care of the sick rested in the hands of each individual's household, usually the women. It was considered a women's unpaid "domestic duty" (Apesoa-Varano & Varano, 2004, p.86). During the Crimean War (1854-1856), Florence Nightingale used her social and political connections to guide the care of ill and wounded soldiers (Stanhope & Lancaster, 2004). She utilized a population-based approach to health improvement that focused on environmental conditions and holistic nursing care. Upon returning from the war, Nightingale shared her experience her friend, a political writer, who then took her story to the press (Buresh & Gordon, 2000). By partnering with the media, she was able to use the power of the public will to further influence the political leaders. Her influence and social activism changed nursing into a profession that was paid and required education (Apesoa-Varano

& Varano, 2004). Through stories of the conditions of the Crimean War soldiers and the success of nursing interventions, Nightingale was able to persuade military and government leaders to change the way injured soldiers were treated.

Like Nightingale, Lillian Wald believed that nurses held great power to influence policy through their relationships with those most greatly affected by it. Wald, a public health nurse, established the Henry Street Settlement and Visiting Nurse Service of New York (Coss, 1989). Through letters, speeches and persistent social and political activism, Wald persuaded government boards and social institutions to expand public health initiatives and defend basic human rights. She both led and served on several municipal and legislative reform committees, like the American Union Against Militarism. Coss recounts that the immigrant community called her "Miss Liberty of the Lower East Side," and the city officials called her "The Damned Nurse Troublemaker" (1989, p.1). Through her respect from both national leaders and the people of the Henry Street community, she reminded the world that nursing care involved social reform. More importantly, Wald used the stories of injustice from her community in the lower east side of New York to influence policy development.

Numerous nurses throughout history have utilized social activism and political involvement to improve the health of their communities and the general public. Other nurses created settlement houses, like Lillian Wald, that served as centers for health care and social welfare (Stanhope & Lancaster, 2004). Nurse leaders like Katherine J. Densford worked tirelessly to develop standards of nursing education and to strengthen the professionalism of nursing (Densford, 1964). Regal and highly regarded by world leaders, Densford believed that nurses were capable of not only caring for individual

patients, but also protecting national health and participating in world affairs. Undoubtedly, the history of the nursing profession is rooted in social reform and political activism.

Barriers to Involvement

Did we, the nursing profession, lose our voice somewhere or are we just no longer very interested in political involvement? In asserting the importance of a political action committee in the hospital setting, Twedell and Webb state, "Nurses are the largest group of health care professionals in the United States and have the ability to wield considerable political power, but historically they have lacked the desire to do so" (2007, p.279). Is this true? I have to wonder if a barrier to political involvement is the lack of political education and training for nursing students, who Rains and Barton-Kriese found "...view policy as rule and inhibitor, rather than as a liberating mechanism for change and empowerment" (2001, p.222). This leads me to conclude that nurses need adequate education about the power and ability they have to exert political force to make change, while at the same time the public needs to begin to view nurses as effective emissaries for voicing health concerns to legislators.

Buresh and Gordon (2000) believe that the nurses must first begin to tell the public what they do, because this is where public force comes from. They believe that a nursing voice has been silenced because the public simply does not know what nurses do, and this is why policy makers rarely seek nursing input for understanding and reforming the health care system. However, Buresh and Gordon (2000) argue that now is a great time for nurses to bring a sound, down-to-earth voice to health care reform and converse with the public in the same way they do in the hospital, using common language and

affable tone. They offer three concrete steps to ending the silence: inform the public about nursing, make communicating with public officials and the media an integral part of nursing work, and overcome internal obstacles (Buresh & Gordon, 2000).

Doult explains, "The vocational nature of their [nurses'] careers disinclines them from involvement in the confrontational requirements of political activity" (2007, p.14). Admittedly, ideas like social inequities and structural violence that require nurses to change their thinking about nursing may appear abstract to a profession of 'doing' things. In addressing this barrier, Boyte recognizes that "worrisome trends become concrete and tangible when people organize to address them" (2008, p.50). So, nurses can rally around abstract socio-political ideas with concrete civic action that is not confrontational but conversational.

In addition to the barrier of abstractness and confrontation, Falk-Rafael (2005) also found that nurses feel they do not have the credibility to voice their concerns about policy reform. In contrast to this observation, Gebbie, Wakefield and Kerfoot found that because nurses are highly respected in the community, they serve as credible speakers on divisive issues (2000). Similarly, Buresh and Gordon (2000) state

> If nurses fully appreciate the relevance of their knowledge not only to the patient in the bed but to ailing health care systems, and if they exert the power that comes from compassion and their sheer numbers, they can transform both their public image and the health systems in which they work (p.27).

Nurses must use their strengths as relationship-builders and bring the general public into the conversation about health care reform, just as they bring their patients into the conversation about their individual care plans. Nurses have an ability to see basic human

similarities and this is crucial as we create a system that addresses the health needs of everyone. The media needs reliable and unbiased sources when covering the health care debate, and so nurses can give them real-life stories to support the need for change.

Attempting to create vocabulary for the power nurses have to influence political will, Falk-Rafael (2005) describes the nurse intervention of "empowered caring" as influencing public policies through the voice of those that are silenced by structural powers and social inequities, or "speaking truth to power" (p.220). She goes on to further state that public health nurses are at the "intersection where societal attitudes, government policies, and people's lives meet," and this place in society includes a moral imperative to take action toward changing societal conditions that lead to health inequities (p.219).

Like Falk-Rafael's idea of empowered caring, Apesoa-Varano and Varano (2004) notice the distinct difference between caring and curing, and how this difference influences how the general public views nurses. For elaboration, the word "curing" has a scientific implication that inherently accompanies knowledge, expertise, education and professionalism. On the other hand, the word "caring" embodies a feminine energy that requires no specific skills or competence. Apesoa-Varano and Varano (2004) state

> As it [nursing] sheds the subservient status that was associated with the private sphere and "women's work," care is understood as a valuable political principle alongside scientific expertise and economic efficacy, while broadening conceptions of the professional ideal and social justice (p.99).

The challenge remains to transform "caring" into significant actions at the systems level and bring voice to the consequences of social policies on the lived human experience. This project proposes storytelling as a means to such transformation.

The Unions' Impact

The largest assembly of nurses I ever witnessed at the Minnesota state capitol, during the 2008 session, was on "Nurses Day on the Hill" (February 26, 2008). The event appeared to be completely orchestrated and hosted by the Minnesota Nurses Association, the largest collective bargaining organization of nurses in the state. As I spent the day in and around Representative Maria Ruud's (also a nurse by profession) office, I noticed that the vast majority of the nurse visitors spoke of issues related to hospital staffing, nurse-patient ratios and subsequent work-related injuries. Unfortunately, I never heard a nurse ask Representative Ruud about the social and economic inequalities reinforced by legislative policies that cause health inequities. I found this interesting because as the population grows sicker with obesity and diabetes, the issues of work-related injuries and nurse-patient ratios become more important. Consequently, if nurses began engaging in social activism that addressed social inequalities that produce these health inequities making people sicker, then they would also be addressing the work related injuries that nurses suffer as well.

Admittedly, unions serve a purpose in the defense of nurses' working rights, but have they clouded the role of nurses in the political and policy-development arena? For instance, Apesoa-Varano and Varano explain a nurses' day at the capitol, "...RN Day reflects liberal feminism's reformist impulse to empower women via participation (lobbying) in existing institutional arrangements while simultaneously reinforcing

professionalism's agenda for insider politics" (2004, p.91). Unions may be continuously highlighting labor issues for bedside nurses in the acute care setting, while minimizing the important role of nurses as the eyes and ears of the human experience as seen also in individual homes and communities.

Apesoa-Varano and Varano (2004) explain that the union gives nurses a grassroots democratic venue to voice their concerns about the day-to-day life on the hospital floor and empower them to make changes, but undervalue the need to empower nurses to bring voice to the individual human experience. Apesoa-Varano and Varano clearly state, "...nurses still are a contact point between vulnerable and subordinate groups and larger institutional arrangements of power and privilege within medicine and healthcare" (2004, p.83). So not only is it important for nurses to exercise political power for legislation that affects their training, their salaries and their pensions as a profession, it is also imperative that they exert this same political will for the betterment of the lives of their fellow humans. The union's impact on the political voice of nurses could be discussed in much more depth in a different paper, but for this project it is important to acknowledge that the union plays a considerable role in steering the nursing profession's political voice.

Significance of Project

What happened to the nursing focus on social reform? While interning at the Minnesota House of Representatives, I noticed that in a time of heated discussion about the need for health care reform there really was not much nurse involvement, even though historically the nurse is the eyes and ears of the health care system (Apesoa-Varano & Varano, 2004). Admittedly, there are six nurse legislators currently serving in

Minnesota State government, but when Governor Pawlenty called together the 17-member Health Care Transformation Task Force, four medical doctors were included but not one nurse (Minnesota Department of Health). As another example, Mary Ann Blade, RN, the CEO of Minnesota Visiting Nursing Agency, told me she was the only nurse on the AARP's Health Care Reform committee, and this was after she requested to join (personal communication, May 14, 2008).

As I reviewed the nursing profession's history of social activism and the research about nurses' political involvement, I began to understand the significance of a reinvestment in social activism for nursing, policy makers and the general public. First, as health care reform focuses on prevention of illness and promotion of health, public health nursing interventions can influence this policy and give nurses a voice. If nurses can become more versed in the political process, they will establish themselves as essential participants in the maintenance of public health in the tradition of Lillian Wald and Florence Nightingale. In turn nurses will become experts in health reform. In support of this argument, Gebbie, Wakefield and Kerfoot contend, "Nurses' vivid anecdotes from first-hand involvement in health care were reported as being powerful, not only in debates directed related to nurses, such as entry to practice, but also in general health issues such as access to substance abuse treatment (2000, p.310).

Secondly, the reinvestment in social activism by nurses is equally significant to policy makers. My internship with Representative Maria Ruud taught me that policy makers need constituent support. They need people, or the general public, to support their ideas and their bills, or the special interest firms will continue to hold all the power. If nurses learn how to tell an effective story that can be used by policy makers as they

push for a reform bill, then not only has the legislator been able to advocate for what is right, but the nurse has been established as a resource for future bills and actions. Often Representative Ruud would tell me that she wanted to support a certain piece of legislation but she simply did not have the constituent backing, and therefore she was forced to vote against it (personal communication, February 26, 2008). Nurses could have larger voices than special interest groups simply because of their number. Imagine what kind of an impact even one story could have on important legislation if it had the backing of ten nurses versus two corporate lobbyists.

Lastly, the reinvestment in social activism by nurses is also significant to the general public, especially to the marginalized public. Through their work, nurses have direct contact with vulnerable and marginalized populations, and these are the people most often affected by institutions having power through legislation. Nurses can tell the stories of structural violence in order to illustrate to policy makers how their policies are negatively affecting the health of marginalized populations. Ultimately, the general public will benefit from more socially just policies, and the public will know that nurses are, in fact, effective emissaries for health at the policy level. This project intends to show how nurse work with marginalized people can be shaped into a story that would be engaging and powerful in its presentation of a reality unknown to mainstream legislators.

Let me share a story. I participated in a voter discussion panel during which homeless men spoke about the reasons why impoverished people rarely vote. One man suggested it may be that they never see any benefit from legislation or policy. In other words, they never get positively reinforced when they do vote, so they figure, "what is the difference if I do or do not?" It made me wonder: if a poor man felt that he could talk

to his nurse about some of the social issues that he was passionate about, and that nurse could bring these issues, in the form of a story, to the policy maker who worked to change the injustice, then perhaps the poor man would become more inclined to vote. In sum, this project is significant to nurses, legislators and the general public, because everyone benefits from nurses learning the power of storytelling as means to influence social policy reform.

Conceptual Framework for the Project

Margaret Newman's Health as Expanding Consciousness theory uses the idea that a human and his/her environment are in an endless exchange, in which each interaction can lead to expanded consciousness (Newman, 2005). As a person interacts with his/her environment and the universe, s/he develops patterns of relationships that make up the unitary whole (Newman, 2008). Newman defines pattern as "a dynamic relatedness with one's environment, both human and nonhuman" (1999, p.228). Patterns expose meaning in life experiences. According to Newman (2005), disease and illness are simply disruptions in a person's pattern, and, therefore, can instigate an expansion in consciousness as a whole (Newman, 2008).

Furthermore, Newman's Health as Expanding Consciousness theory defines caring as the nurse's ability to partner with the client and aid in pattern recognition, which then leads to greater opportunity for transformation in the form of health as expanding consciousness (Newman, 2005). Newman recognizes that during episodes of chaos and disorder, a person has the opportunity to gain insight into his/her personal behavior and thought patterns. The nurse has the opportunity, through relationship with the client, to partner with them through the episode of disorganization and the emergence

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of order (Newman, 1999). It becomes the nurse's responsibility to partner with and maintain a caring-relationship with the client during these times of disorganization, and use the client's life stories to reflect patterns that can lead to transformation and higher consciousness.

Newman's theory will be used in this project as a conceptual framework to provide guidance in exploring the use of storytelling as a means to influence legislation. As the current health care system is in a state of *chaos*, Newman would suggest that this is a great time to become cognizant of patterns and look for areas of potential transformation. Newman (1999) continues to articulate that pattern recognition leads to growth. Nurses can partner with politicians and policy-makers and draw on their caring partnership with the lived experience of everyday people. Through this dual partnership, nurses can use stories as a means to educate politicians and influence policy development, or as Newman (1999) says, partner in uncertainty. Furthermore, stories "fulfill a profound human need to grasp the patterns of living- not merely as an intellectual exercise, but within a very personal, emotional experience" ("Storytelling" 2003, p.52). In the end, this project will lead to the expanded consciousness of legislators through the awareness of unhealthy patterns in current policy as demonstrated in nurses' stories of people's lived injustices.

Chapter 2: Review of Literature

Social Justice

In exploring nurses' use of caring and storytelling as a means to influence policy development, it is important to define and identify key concepts. The first concept is *justice*, more specifically *social justice*. Drevdahl, Kneipp, Canales and Dorcy define *justice* as a concept rooted in ethics that "...addresses the social relationships of human beings and the distribution of rights and responsibilities within a society" (2001, p.22). *Social justice* narrows *justice* into the realm of collectivism over individualism, which distributes the burdens and benefits of society. Nurses must be conscious of *social justice,* because access to the benefits of society, like the healthcare system, directly affect and relate to the maintenance of health. Social policies enable or hinder each individual's ability to reap the benefits of society and how they bear the burdens. *Social injustice* is the barriers or oppressors, like cultural imperialism and structural violence, which unfairly disadvantage and marginalize certain communities or individuals (Drevdahl, Kneipp, Canales & Dorcy, 2001).

In an attempt to understand why justice receives little attention in nursing literature, Liaschenko (1999) reflects on the possible conflict of the act of caring, which involves personal values and emotions, and social justice. She declares that nurses' ability to have caring emotions allows them to "see, hear, and understand the distress of others, in this case, distress produced by social conditions of injustice" (1999, p.46). As she argues that both care and justice are relational concepts, Liaschenko defines, "Justice is a relational concept binding together people from different social positions within a certain social order" (1999, p. 46). She encourages nurses to remember that when they

care for individual patients they also must see that patient as part of a social group, because once this mindset occurs, then the concepts of care and justice intersect. It is at this intersection, a nurse can be an effective social activist who sees the oppressive powers of social order in the experience of one individual. These oppressive powers directly affect health, and therefore social justice and care are important for the nursing profession. While acknowledging that the health care system has the ability to respond to certain actions of injustice, like rape and domestic abuse, Liaschenko concludes, "Justice requires, then, that nurses move beyond the bedside and into the political arena both as nurses and citizens" (1999, p.47).

Social Determinants of Health

As it relates to social justice and nurses' relationship with marginalized populations, it is important to explore the concept of social determinants of health. Fryers, Melzer and Jenkins clearly state, "People of lower socio-economic status, however measured, are disadvantaged and tend to live in communities and cultures that are disadvantaged. This has already-known policy implications" (2003, p.236). According to Fryers, Melzer and Jenkins (2003) communities with low income, less education and more unemployment have higher rates of common mental disorders, one aspect of poor health. Consequently, they argue that poverty reduction and social equity must be a political agenda in the plight to improve mental health care.

In their 1994 article, Hall, Stevens and Meleis define marginalization as "the process through which persons are peripheralized on the basis of their identities, associations, experiences, and environments" (p.25). As marginalization relates to poor health, the authors conclude that marginalization leads to vulnerability, which is defined

as "the condition of being exposed to or unprotected from health-damaging environments" (p.33). Consequently, socio-economic factors put a marginalized person at risk for illness and poor health. Furthermore, strategies created to address poor health often need to be changed in order to be effective for those living in the "harsh conditions of the periphery" (p.36). Therefore, nurses can improve the health of people affected by the social determinants of poor health by assisting them in acquiring "political and economic resources to ensure their basic needs and the social legitimation and respect necessary to make decisions affecting their health" (p.34). They state how marginalized communities tend to have voice through their stories. So nurses can use these stories to give power to those affected by the social determinants of poor health.

One review of scientific studies exposing social determinants of health identifies a direct correlation of high relative risk of mortality and low employment and education levels (Adler, Boyce, Chesney, Cohen, Folkman, Kahn & Syme, 1994). Even when health behaviors are controlled, lower social position leads to poorer health. Adler et al. also found that in households with lower education levels, stress levels are higher and consequently negatively effect health status resulting in poorer health outcomes and higher risk for illness. "Social class is among the strongest known predictors of illness and health and yet is, paradoxically, a variable about which very little is known" (Adler et al., 1994, p.22). Furthermore, Sorlie, Backlund and Keller (1995) completed a longitudinal study of economic, demographic and social effects on mortality in the United Sates. Sorlie et al. findings directly linked characteristics of lower social class (employment status, occupation, income, marital status and education) with higher rates of mortality in men and women under age 65 years. They concluded that people with

lower income and education have less power to purchase health services and create healthy behaviors, yet are most in need of health care.

By studying the world's most marginalized populations, Farmer (1999) declares that the world's most common infections and diseases persist through social inequalities. Farmer (2005) firmly believes that the world's political and economic structures that reinforce inequities actually create and sustain disease and illness. Farmer affirms that even if marginalized people have the knowledge and will to create healthy environments, they cannot do so because of the structural powers that violently suppress them. Farmer (2005) states

> Certainly, people who define themselves as poor may control their own destinies to some extent. But control of lives is related to control of land, systems of productions, and the formal political and legal structures in which lives are enmeshed (p.158).

Health is a basic human right that is greatly affected by one's placement in the societal and world order. These structural powers and social determinants can be clearly described through a story, and the story can persuade change in the policies and laws that allow social inequities to endure.

'Citizen Nurse'

Bill Doherty, a well know family therapist, has taken on the role of 'citizen professional.' Through years of civic action with several of his own communities, Doherty has been able to describe the process of becoming a 'citizen professional.' He is currently in the process of creating the Citizen Professional Center out of the University of Minnesota. At this center he takes students and grounded professionals and coaches

them as they become 'citizen professionals.' He believes that it takes about two years before one can completely expand his/her identity beyond that of doing for others to that of partnering with others to solve public problems. This idea works closely with Newman's (2008) theory of partnering with people as they expand their consciousness into a place of health. Doherty (personal communication, September 10, 2008) explains that in order to become a citizen professional, you must begin to see private problems as public issues.

Doherty believes that nurses, like any other profession, can be "agents of change and not just a critic of what's not changing" (in press, p.2). Nurses have first-hand experience with the signs and symptoms of poor health and health inequities in individual people. We take full health histories when patients are admitted to hospitals, clinics or home health agencies, during which time we ask for the patient's health story. We, then, look at all the details and identify health problems. So, as Doherty urges, we need to strive to see these individual health problems as larger societal problems. Nurses have to begin to see themselves outside of the therapeutic role and partner with their fellow community members to make change. As Doherty, Mendenhall and Berge put it, "We moved away from the language of 'intervention' to that of 'citizen work'" (in press, p.4).

Boyte (2008) suggests that citizen solutions are stronger than political ones. Boyte notices that the public has moved away from community life where people work together on mutual everyday problems, to trained professionals who serve people to solve other's problems. This has stripped community members of civic power and voice. In response, Boyte urges people to join their communities in civic action. However, this

movement involves a mind-set shift of all citizens, especially ones in social services. To elaborate, Boyte states

> It involves a shift in the role of professionals, including civil servants, nonprofit managers, teachers, health providers, clergy, and elected office-holders, from being providers of services and expert solutions to being partners, educators, and organizers of cooperative action (p.15).

He offers ten civic skills that a citizen must have in order to become an effective citizen professional, or citizen nurse.

One skill Boyte identifies is bringing voice to issues and discovering what fellow community members identify as issues. This fits well with nurses. When nurses get together they often tell stories about patients, doctors, disease processes and co-workers. My model facilitates nurse in telling stories beyond casual exchange to an intentional process of informing community leaders and legislators.

Political Involvement

Another important concept is *political involvement*, or social activism. Rains and Barton-Kriese (2001) identify six actions or characteristics that define political involvement: (1) acknowledging nursing involvement in policy decisions, (2) being globally aware, (3) influencing politicians through actions like voting or writing letters, (4) recognizing how policy affects health care delivery, (5) working as political activists, and (6) advocating for policy that promotes health. Political involvement is more than voting; it is "...moral appraisal of policies endorsed by those for whom one votes" (Liaschenko, 1999, p.47). In other words, political involvement means using the nursing

connection with the human experience to educate legislators by telling stories of injustice.

Through interviews with politically involved nurses, Gebbie, Wakefield and Kerfoot (2000) sought to describe ways nurses are and are not active in the development of health policy. They found that, "Nurse involvement in policy includes speaking for patients, their families, and community members in the areas where many of those in need of care have no voice or limited voice" (p.308). Inspired by mentors, many of the politically active nurses discovered that the "people skills" they mastered through nursing aided them in the creation and influence of health policy (p.309). Moreover, the interviewed nurses concluded that the problem-solving skills they learned as nurses (assessment, planning and intervention) mirrored that of the basic process of democracy. Although the nurses noted barriers of nurse political involvement as lack of education and a female-dominated profession (disrupted career paths), they all concluded that increased nurse involvement in policy development is needed. Calling attention to the direct experience nurses have with policies that adversely affect marginalized communities, the authors assert "nurses should bring to the attention of policymakers stories from their own practice" as they work to shape health policy (p.314).

Similar to Gebbie, Wakefield and Kerfoot (2000) exhortation for nurses to include political involvement in their professional work, Milstead (2003) uses her knowledge of government processes to educate nurses and motivate them to participate in the creation and reform of public policy. She urges nurses to become "policy entrepreneurs" that work to keep issues from disappearing on political agendas (p.143). As advocates for their patients and the services they need, nurses have the opportunity to provide policy

makers with reasons and outcomes that support the continuation of current government programs. Milstead reminds nurses that public policy will be created whether nurses participate or not, so it is their professional responsibility to promote policy that supports positive health outcomes.

Storytelling

Storytelling becomes the next concept requiring identification. Storytelling is a form of persuasion that can creatively uncover meaning(s) and transformations for both teller and listener (Preston 2005). Storytelling is not only an ancient form of passing on oral history, but various professions have also utilized storytelling as a form of persuasion and communication strategy (Carberry, 2001). Carberry explains that storytelling is "...considered to be the medium best able to locate health and illness discourses within a social and political discursive context..." (2001, p.83).

Sanne Magnan, the Minnesota Department of Health commissioner, urged health care professionals at a forum about the effect of food on health to "put a face on public health issues to influence policy makers" (personal communication, September 26, 2008). Magnan was articulating the persuasive power of storytelling.

The stories in this project are about examples of lived injustices experienced by people with whom nurses have a professional care-giving relationship. The intention is that these stories will impact a policy-maker more significantly than just statistics and facts.

Similarly, Pink (2005) argues in his book *A Whole New Mind* that the human mind is evolving into the right brain, which governs expression and how things are said and interpreted, mainly relationships. Pink recognizes that as globalization ensues, the

need for right brained thinking increases. For instance, he notices that medicine is transforming from symptom analysis and diagnosing to relationship building and empathic 'narrative medicine' that involves diagnosis through patient storytelling. Pink goes on to identify and describe the six main senses important to right brain thinking: design, story, symphony, empathy, play and meaning (p.65), several of which nursing already utilizes regularly. Pink states, "Stories are easier to remember- because in many ways, stories are *how* we remember" (p.101). In this way, he declares that storytelling has the ability to detect patterns, and therefore acts as a strong persuasion tool with an "emotional punch" (p.103).

Newman (2008) also highlights the recognition of patterns of health and illness as a means to expanded health consciousness, and storytelling, then, can enhance this recognition. Although Pink recognizes that nurses already excel at the right-brained skill of empathy, he also notices that "stories can be pathways to empathy," by enhancing objective information within the context of a situation or experience (2005, p.168). More importantly, as the use of 'narrative medicine' becomes more prevalent, nurses will have the ability to describe health care to legislators in the language used through stories.

Simmons (2006) devotes an entire book to describing the power of storytelling. Simmons declares, "Storytelling is the most valuable skill you can develop to help you influence others" (p.26). She believes that story has the power to inspire and persuade with trust in the motive. My experience with attempting to make contact with legislators has shown me that they are difficult to get in touch with and often fail to respond to me. With this in mind, Simmons trusts that stories require less follow-up and continued persuasion, because as people retell stories they recall what the teller wanted them to

learn. According to Simmons, when someone tells a story they do more than give an example, they give an example with the emotional impact that continues to influence into the future.

During my observation of the health and human services committee hearings, I noted that most people attempted to make their voices heard with statistics and facts. It appeared as though legislators were bombarded with numbers and facts all day long, and I began to wonder if and how they kept them all straight. Representative Ruud told me most legislators simply did not. Simmons (2006) reminds people that

> Facts need the context of when, who, and where to become Truths. A story incorporates when and who- lasting minutes or generations and narrating an event or series of events with character(s), actions, and consequences (p.33)

In other words, stories have the ability to include facts while also creating a venue for which the facts have meaning or make sense.

My father, a mathematician, used to always say, "You can make statistics say whatever you want." This being said, not only do legislators need to remember facts and stats, but they also need to delineate which ones are true. By interlacing facts into a relational background, stories, whether true or not, can influence people's values and behaviors.

As stories relate to the nursing profession, Carberry (2001) speaks of the use of nurse's stories as a way to describe the work that nurses do in the community setting. Believing stories augment nursing theories, SmithBattle, Diekemper and Drake (1999) stress the importance of using clinical storytelling to prepare nursing students to practice as public health nurses with the a broad scope of social activism. Both articles provide a

reflection on the use of stories to teach nursing students the community engagement involved in public health nursing interventions. This is done through examples, and stories provide the examples. The stories can not only paint a picture of what public health nurses do, but also uncover the institutional constraints of the current health care reimbursement system that does not foster the growth of social activism in public health nursing.

As storytelling is described as an effective pedagogical tool, Razack (1993) discusses the importance and complexity of storytelling across race and culture. Reflecting on storytelling in both the law and educational setting, the author reminds the reader that stories of oppressed and marginalized people can reveal concepts that objective data misses. However, when marginalized persons are asked to share their stories in front of the dominant culture, the story can be generalized or stereotyped unless the listener is cognizant of the moral vision of the storyteller. In other words, the marginalized storyteller is faced with several questions of how to tell the story, how to reveal his/her identity and what context to use, when he/she is asked to resist dominance with his/her subjectivity intended to provide great meaning. Therefore, the author points out that all stories need to be critiqued and not just seen as the valid voice of the oppressed. For this project, nurses will learn to tell the stories of the oppressed and marginalized people with whom they work closely. Consequently, the nurse can act as the bridge between the dominant society and the marginalized society, by pulling together the meaningful themes that the stories uncover and use these to influence policy makers, thus taking the burden off the marginalized teller.

According to Razack (1993), storytelling can also instigate social movements. In this regard, Guzik and Gorlier (2004) discuss how stories and narratives can be used to better understand and describe feminist activism in Mexico. However, Polletta (1998) warns that stories of social movements may mask differences within a group or experience, because of the ambiguity of some stories. This danger of oversimplifying is why nurses must first identify one or two issues that they wish the story to illustrate and also identify one or two major reformers or policy makers with whom to share their stories. Although 'once upon a time' stories work to capture business or theatrical audiences, as Polletta (1998) cautions, these stories can be discredited because of a lack of specificity provided by statistics and facts.

Not only is there substantial research regarding social activism as a nursing intervention, there is also research about the use of and power of storytelling as a means to educate, articulate and persuade. Therefore, in combining the two concepts within the profession and community of nursing, an argument can be made that nurses' stories of injustice can effectively influence legislators and policy development. If nurses are well versed in the political process, then they should be able to help individuals navigate not only the healthcare system but also the political system. More importantly, nursing education should include courses on politics and storytelling. Hopefully, as nurses become more knowledgeable about the political process and more confident in their ability to effectively tell stories, they would begin to reinvest in their role as social activists.

Chapter 3: Development of the Project

The purpose of this project is to provide a process model that guides nurses in social activism through stories about how social injustice affects poor health. The model will focus on public health nurses (PHN) because public health nurses are trained to think about larger social issues when assessing people's health, often focusing on housing, nutrition and stress management. Participants will be invited from Minnesota Visiting Nurse Agency (MVNA) in Minneapolis, Minnesota. Experience from the PHN's professional work will be shaped into stories to be taken to policy makers. Leadership in the model will emphasize nurse as citizen in an egalitarian manner. As Doherty (personal communication, September 10, 2008) suggests, one person would be designated as the 'citizen nurse' to lead the group in the work towards civic action and facilitate the entire process. I will act as this person. As facilitator, I will serve as a resource rather than an expert in order to counteract hierarchical expectations (Boyte, 2008).

Participants- Minnesota Visiting Nurse Agency

Public health nurses are state certified in public health nursing after completion of an accredited baccalaureate program. PHNs have frequent contact with marginalized populations and work closely with the reality of daily life for individuals living in poverty. The Minnesota Visiting Nurse Agency began in 1902 serving low income, marginalized people in need of health care. The majority of MVNA's nurses are public health certified. They work in the private homes of individuals who are suffering from conditions related to poverty, like subsidized and sub standard housing. PHNs develop a close working relationship with people they see week after week. Further, PHNs who have been working with the same people for years have a relationship with the entire

family. Through these relationships numerous stories emerge.

Doherty acknowledges that it takes about two years to establish an expanded identity as a 'citizen professional,' and so it is important to start with experienced professionals who are already grounded and well-respected in the core concepts of that profession, so as not to further convolute the transformation (personal communication, September 10, 2008). This project will only begin this process of transformation. Nevertheless, this model will focus only on experienced nurses from MVNA. "Experienced" is defined as having at least three years of work experience and a passion for social activism.

In addition to nurses' access to the daily life story of people suffering the health effects of inequitable policies, several of the leaders at MVNA have already been coached in storytelling. According to Janet Benz, the director of MVNA home health, the agency hired a professional storyteller to coach a few of the nursing supervisors in how to tell stories of their clients to potential donors and the board of directors (personal communication, October 7, 2008). Supervisors were taught to capture the essence of the story with vivid details that would take the audience to the client's home by using lay language instead of medical terms and by focusing on as many details as possible.

Benz described how she once told a story of one of her hospice clients to the board of directors in an attempt to explain what a hospice nurse does. After finishing the story, she looked up and several of the board members were crying. She said, "Boy I sure was not prepared for that reaction, even though [the professional storyteller] told me that you know you told a good story if you get a reaction out of the audience" (Janet Benz, personal communication, October 7, 2008). This example shows how MVNA leadership

values the power of storytelling, and therefore have a basis to support my process model.

Description of Process Model

The process model I am proposing occurs in a sequence of six steps. The steps proceed from the identification of stories with nurses to the intersection with state legislators.

Step one.

To begin this process, I will both post a flyer and verbally invite MVNA nurses to a "storytelling support group meeting." This meeting will use the power of story to bring together nurses interested in solving social issues affecting the marginalized people whom MVNA serves. Boyte (2008) calls this "breaking the silence" (p.43). This discussion, according to Boyte, "shifts the focus of action from what expert might fix the problem, or what government should be doing, to what people like us can actually do to address this question" (p.58). I want the nurses to have a time and space to share their stories and release some of their frustration about nursing work. Most importantly, I want nurses to feel supported within their community and see the personal impact storytelling can have. Buresh and Gordon (2000) argue that the first step towards collective nursing voice is to start speaking to each other and ending the silence.

I will hold this meeting in a public location, like a local café. In hopes of stimulating networking capabilities, I will choose a local café that is frequented by policy makers. In changing their image as being remote from policy makers, the nurses will benefit from an informal environment where policy makers are commonly seen. Furthermore, I have found that public places full of people conversing about public policy and social issues have a contagious inspirational energy. The key factor in

choosing the café setting is for the comfort of the nurses. I do not want them to feel like work supervisors will judge them or their patients/clients will feel betrayed by them. Over a cup of coffee or tea, we will engage in communal storytelling, remembering to not use any client names.

Step two.

Step two will occur a week after step one. After each nurse has had the opportunity to share his/her stories of witnessed social injustice (step one), in step two I will lead the group in a dialogue about issues we want to address with political action, or as Doherty calls them, "social pressure points." (in press, p.17). Keeping in mind that individual clinical problems are connected to larger public issues, we will name the issues about which our nursing community and the people we serve are passionate about (Hennessey, Smith, Esparza, Hrushow, Moore & Reed, 2005). This conversation will be the beginning of identifying ourselves as citizen nurses (Boyte, 2008). As we move the dialogue from private stories to public issues we will be adding another layer of protection for client privacy; personal details will become generalized experiences.

Acting from my experience with policy makers, I will serve as a resource for this group, offering suggestions of issues, policies or legislators. However, it will be important for me to let the nurses in the group steer the conversation. At this point we will end the meeting with the intent to meet again in one week after everyone has had time to reflect on the identified pressure points.

Step three.

Between our second and third meetings, I will contact some of the legislative assistants with whom I have established a relationship over the two years of my work

with community activism and policy. My internship with Representative Maria Ruud, my work with the Citizens Health Forum out of the Humphrey Institute, my service on the Minnesota Public Health Agency (MPHA) policy committee, and my appointment to the University of Minnesota Social Concerns committee has allowed me a space to create and solidify relationships with other like-minded policy and social activists, and mentors. Through my established relationships with these people, I can help to connect the MVNA nurses from the project group to the appropriate policy developers.

Using my knowledge of the political process, I will ask a few legislative assistants to come to the group's next meeting in order to listen to the stories of the nurses, suggest some legislators that are also passionate about the identified pressure points, and review the current legislative agenda. Furthermore, having spent many hours in the state capital's library during my internship with Representative Ruud, I do know how to research and locate past, present and future policies at national, state and city levels. Sharing this knowledge will be included in this step.

Step four.

One week after the second meeting, the group will reconvene and converse with the legislative assistant(s) about the social issues, the stories, the legislators and the current legislative agenda. As the leader, I will describe procedures to use when interacting with legislators that I have both learned through experience and from experts.

Specifically, Blubaugh, Minnesota Health and Human Services Committee assistant, advises that when a citizen is trying to influence a specific policy, she/he will be most effective if she/he identifies the legislator that authors that bill or policy and address that legislator individually (personal communication, September 3, 2008). The

Health and Human Services Committee is currently chaired by Senator John Marty, who receives a lot of both public and media correspondence, and so Blubaugh warns that during session, he only responds to his district's constituents.

Furthermore, Dahl, a wise and seasoned lobbyist, recommends that legislators are impacted most by individual people who want to speak with them directly about one issue or policy (personal communication, October 3, 2008). Dahl also suggests that sometimes the best people to target are commission members who are guaranteed to be passionate about the same pressure point, like the Minnesota Poverty Commission. If the nurse chooses a commission as his/her audience, Dahl would suggest that each nurse speak directly with one member of the commission (personal communication, October 3, 2008).

Additionally, Simmons (2006) suggests that in order to be most effective in persuading someone with a story, the storyteller must first identify what the listener has in common with him/her and what all humans have in common, like a need for belonging or purpose. Finding a policy maker with the same pressure point is extremely important. With these recommendations, along with the legislative assistants' input, I will lead the group in purposely identifying one or two issues, the corresponding policy, and either a commission and/or the nurse's district legislator.

Step five.

The next step in the process model is practice telling their stories. Upon meeting the first time, each nurse had the opportunity to practice telling his/her story to fellow nurses. Then, during our third meeting with interested legislative assistants (step four), each nurse was again able to practice telling his/her story to the staffers. Prior to

practicing for the final time, I will present seven key ingredients of effective storytelling to the group. They are as follows.

First, stories of injustice need to include possible policy ramifications or solutions (Gebbie, Wakefield & Kerfoot, 2000). Each nurse in the group must be able to describe how the injustice illustrated through the story has a solution that inspires policy reform.

Second, with authenticity the number one priority, each nurse must believe the story he/she is telling. Simmons enforces, "If you can't persuade yourself, you can't persuade others" (2006, p.90).

Third, each nurse must remember to have natural facial expressions and gestures. Although they are telling a story, they should not look like they are putting on a production.

Fourth, the nurses should describe or mimic sounds, smells and tastes that help the listener go to the story's setting (Simmons, 2006). Sometimes what would normally be considered irrelevant details ultimately influence the listener's decision making. Generalizations are boring.

Fifth, pauses are essential, because pauses give the listener time to feel the emotion that sets stories apart from facts and statistics (Simmons, 2006). Knowing that the end goal of this project is that policymakers will begin to recognize unhealthy patterns in social policies, pausing throughout the story will allow the listener time to participate and process the connections between health circumstances and social policies that the story reveals.

Sixth, the storyteller's tone is extremely powerful. Simmons warns, "Your tone communicates the emotion and thus the scene of your story" (2006, p.102). She

elaborates to explain how the storyteller's emotion towards the listener can overpower the emotion of the story. To illustrate, if the nurse disrespects the legislator or feels anxious or needy, this will be shown in her/his tone, and then her/his influential abilities are meaningless. Consequently, each nurses' awareness of his/her emotions towards the policy maker is essential, because his/her tone is as potent as the story.

Seventh, upholding client privacy is essential. Therefore, as the nurse tells other's personal stories of lived injustices, it will be critical that the nurse explain any social circumstances, like housing or social networks, in a way that maintains identity privacy.

After I explain the seven key ingredients of effective storytelling, we will practice, practice, practice. There are several ways to practice. Benz remembers that the professional storyteller hired by MVNA encouraged the nurses to write their stories down first, so that they could rehearse them until they felt comfortable sharing them with others. Each nurse can also videotape him/herself telling his/her story, so as to become cognizant of facial expressions, gestures and other non-verbal forms of communication (Simmons, 2006). Additionally, each nurse can practice his/her storytelling in front of the group, so that we can collectively train ourselves to have natural looking gestures and body language. Understanding that speaking to a legislator is often intimidating, practice is key, but realistic expectations are equally important. Imperfections in delivery make the story real.

Step six.

The next step will be to tell the story to the policy makers. If possible, I would like the storytelling to take place outside of the legislator's office or state capital grounds. Dahl reminded me that often the anxiety and neediness dissipates once the storyteller and

policymaker are on neutral ground (personal communication, October 24, 2008). If the legislator's schedule is simply too busy for this to happen, the nurses will have go to the state office to tell their stories.

When preparing the nurses to share their stories with the policymakers, I will remind them to introduce themselves with their first and last name and identify themselves as nurses. To uphold professionalism and expertise, I will recommend that each nurse greet the policymaker with a firm handshake and maintain eye contact. Just as most people visiting state or city offices, I will suggest that the nurses wear professional clothing and not scrubs. These are all steps towards establishing nurses as knowledgeable and qualified members of the healthcare system who have much to share with those with the power to make decisions (Buresh & Gordon, 2000).

Another venue for nurses to share their stories is the media. I will urge each of them to write his/her story as a letter to the editor. Representative Ruud often read letters to the editor in an attempt to get the closest thing to the public's opinion on issues. Hennessey et al. (2005) found that media is a powerful persuasive strategy. Moreover, Buresh and Gordon (2000) suggest writing letters to the editor and op-eds as a means to influence both the media and the public on healthcare issues. They even recommend using narratives followed by a specific policy change or recommendation. This suggestion is exactly what we would do.

This last step is what Boyte (2008) calls "taking action." Civic action takes careful preparation. Reflecting on my experiences and relationships with policymakers and community activists, I will guide the nurses in preparing for and taking action. I have learned that networking and relationship maintenance are key to effective civic action.

Nurses can sustain their new relationships by following-up with people after meeting with them and summarizing the discussions. I have discovered that policymakers and activists are most moved by authentic passion that is reinforced with follow-up and creativity. Just as mentors have coached me, I will coach my fellow nurses in their work towards influencing healthy policy with their stories of witnessed injustices.

Chapter 4: Evaluation

Evaluation of any project is important, so that changes and improvements can be made. Through the use of storytelling, the project's aims are to reinvest nursing in social activism and inspire policy reform.

Newman (2008) states that if you are looking for outcomes that are based on theory, you must evaluate the person's new understanding of life patterns. The project's model should initiate the nurse's transformation to citizen nurse with a new awareness of policy-focused nursing interventions. I will ask each nurse how she/he believes the project prompted an incorporation of social activism in her/his professional work. I want to know if the nurses believe that they will either repeat the steps of the model on their own in the future or will lead another group of nurses in the completion of the model. Replication is an indicator of success. If even one nurse becomes inspired to encompass storytelling and other forms of social activism in her/his daily nursing work, then the project accomplished one of its goals.

Furthermore, every storyteller should ask the listener for feedback (Simmons, 2006). Following this insight, I will ask each nurse in the group to ask the policy maker who listens to her/his story to give feedback. This can either be done right after the storytelling, or it can be done as follow-up several days or weeks later. For purposes of improvement, the nurse should ask the policy maker what he/she could do to enhance the delivery of his/her story, as well as the persuasive content of the story.

Another goal of this project is that the policy maker will have expanded consciousness through the awareness of unhealthy patterns in current policy as demonstrated in nurses' stories of people's lived injustices. Newman (2008) maintains

that outcomes based on theory are found in the client's understanding of their life patterns and their actions. For this project, the "client" is the policy maker. Remembering that stories often influence the listener long after they are told, I will anticipate that legislators and policy makers will share the stories they heard to their colleagues and the impact will continue. As the policy maker is sitting in a committee or planning meeting, he/she will have no choice but to remember the emotional effect the story had on them as they create and reform social policy. This illustrates the broaden awareness that would be evidence of success but would take another project to document.

Another form of project evaluation is following through with the policy or social issue of interest. In other words, the nurse or the entire group should track the bill or policy as it moves through the government process. In doing this, Dahl notes the true impact of the story will be seen (personal communication, October 3, 2008). If the policy maker changes his/her approach to pushing a bill through committee or if he/she changes his vote towards a bill currently on the table, then the nurse will know that his/her story made a difference.

After all stories have been shared with appropriate policy makers, I will hold a final meeting with all the nurses. Again using the power of story, I will ask each nurse to share his/her story of his/her interaction with the policy maker. What went right? What when wrong? What empowering things happened? What embarrassing things happened? Would you do it again? I will ask questions like these to illicit reflection and find areas for improvement. I want to discover if the capacity of the nurses as change-makers at the policy level has increased (Hennessey et al., 2005).

Chapter 5: Discussion

Implications for Advanced Nursing Practice

Any movements toward increased social activism have implications for advanced nursing practice. This project gives nursing an opportunity to reinvest in social activism through storytelling. By understanding the social structures of powerlessness, marginalization and cultural imperialism, the MVNA nurses are able to construct stories that educate policy makers on the real life effects of social policies that lead to poor health outcomes. As the participating nurses create and refine their stories in this project not only will they expand their own consciousness about social conditions of injustice but they will also foster this same awareness for the policy makers.

Another implication for advanced nursing practice relates to networking. This project both enlarges the scope of the nurses' networks and also enhances their ability to make and sustain the relationships. Although the MVNA nurses in the project work together, they are able to bond during the first meeting over a shared interest in taking action towards minimizing health inequalities. Then at our third meeting the nurses are able to connect with and create relationships with sympathetic legislative assistants. From my experience with Representative Ruud, I discovered that legislative assistants are powerful allies with the ability to strongly influence the legislators. So, this relationship will be useful for politically active nurses. Furthermore, when the nurses both share their stories and follow-up with the policy makers they will be establishing a network with policy makers who share common social pressure points.

The network of significant relationships built throughout this project will also lead to yet another implication of advanced nursing: an empowerment of nursing voice.

As the nurse tells people stories of witnessed injustices, the process both empowers voice and spreads awareness of what nurses do. Buresh and Gordon (2000) exhort nurses to tell the public what they do. Once the public has a better understanding of the role of the nurse in not only the institutions of health care but also the community, then the nurse's power to bring voice to social issues will strengthen. With the public support behind them, policy makers will employ nursing input as they create or reform social policies.

The project's final implication for advanced nursing practice is the creation of citizen nurses. Both Boyte (2008) and Doherty (personal communication, September 10, 2008) urge all professionals, nurses included, to widen their identify beyond their work into the realm of community mobilizing. Doherty believes nurses, like other health and social professionals, have the training to work with diverse groups and discover similarities that lead to community change for the better of all. As the nurses in this project interact with policy makers and witness the impact their stories have on the policy maker's decision-making process, they will begin their journey of broadening their role as nurses to that of citizen nurses.

Implications for Decreasing Health Inequities

The project's implications for advanced nursing practice parallel those of decreasing health inequities. The social structures that marginalize certain people are either reinforced by or created from social policies and laws. The nurses' stories of witnessed social injustices give voice to the marginalized populations and communities. Rains and Barton-Kriese declare, "Political involvement represents a valid and valuable nursing activity that promotes health and encourages positive change by modifying sociopolitical, economic, and environmental factors that determine health" (2001, p.219).

By storytelling, the MVNA nurses share their insider view of the human experience of health care with policy makers. With this insight, the policy makers can make more socially just policies and laws that decrease the marginalization that brews health inequities.

Understanding what nurses do, the public can begin to see nurses as political emissaries. Since nurses are a profession of great numbers, this new image of nurses as political emissaries will likely expand the voice of the marginalized. My experience with Representative Ruud showed me that legislators try to respond to the needs of the public. However, they only know the needs of the people who communicate with them. Accordingly, policy makers can work to decrease health inequalities with the awareness they gain from the MVNA nurse's stories of witnessed injustices.

Chapter 6: Conclusions, Recommendations, Reflections

Social activism is an essential part of nursing. As the current U.S. health and social service system continues to be broken and ineffective, it is even more imperative that nurses begin to exercise their power and their voice in the development of reform. Public health nursing defines one of its core interventions as policy development (Stanhope & Lancaster, 2004). Nursing leaders like Drevdahl (2001) urge the nursing profession to reinvest in social activism. And the nursing profession's roots are embedded in traditions of Lillian Wald and Florence Nightingale who used social activism as a key nursing intervention. Given these fundamentals of the profession, there needs to be a process in place that allows nurses to use social activism as a primary intervention and maintain their role as politically involved.

Both research and history proves that storytelling is an effective tool for persuasion and teaching. It is important to prevent this powerful art from disappearing as electronic media takes over. Newman's (2008) theory is very congruent with this project, because Newman speaks of stories as a means of recognizing patterns in order to reach an expanded consciousness. Stories of lived injustices aid both the nurses and the policy makers in recognizing the patterns that exist as a result of social policies that sustain poor health outcomes in marginalized communities. As the nurse tells the story and the policy maker listens to it, both parties are increasing awareness of the effects of social policies on the human experience of health care, and this new awareness prompts an acknowledgment for the need for new behaviors and patterns in the form of policy reform. Newman (2005) notes that disruption in patterns shows the person that new patterns must be created, because the old ways are not effective anymore. Obviously, our

current health care system is not effective, and the proven social determinants of poor health are the disruption in the pattern that is illustrated by the story of lived injustices.

Newman's (2008) theory as a conceptual framework highlights the need for reflection and action that leads to freeing transformations in our understanding of the world, as well as the life patterns embedded in it. Through the process of pattern recognition and the evolving relationship between nurse and policy maker, personal transformations occurred for both nurse and policy maker. It is during this time that a transformative relationship between nurse and policy maker is monumental. The nurse is able to see herself as an effective social activist, and the policy maker and the general public also view the nurse as knowledgeable about both the health care and political systems.

Even if just one of the participating nurses in this project become inspired to continue to participate in policy creation and reform, then at least one nurse has found a means to reinvest in social activism. Ideally, that one nurse will continue to create and maintain relationships with policy makers and community leaders, and coach his/her colleagues and friends in projects like this one. Really, whatever action is taken is a step toward empowering the voice of nurses as knowledgeable members of the health care community who care about policy that results in healthy outcomes.

Nursing history points nurses in this direction. Sheer numbers put nurses at a certain advantage. Morally obliged or not, nurses need to believe that their role in the community is perfectly positioned to effectively influence policy makers who need expert input on matters that affect the marginalized members of society. This project presents a process that lets nurses wield their persuasive power with the art of storytelling. Granted,

nurses face barriers to political involvement, but these barriers will weaken when nurses begin to create a space within their professional identity that highlights their role in policy development.

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