International Journal of Advanced Nursing Studies, 3 (1) (2014) 53-58

SPC

International Journal of Advanced Nursing Studies

Journal home page: www.sciencepubco.com/index.php/IJANS
doi: 10.14419/ijans.v3i1.2328
Research Paper

Factors effecting on involvement of nurse leaders in policy making for nursing in Iran: a qualitative study

Akram Aarabi, Mohammad Ali Cheraghi *, Shahrzad Ghiyasvandian

Nursing & Midwifery Faculty, Tehran University of Medical Sciences, Tehran, Iran
**Corresponding author E-mail: mcheraghi@razi.tums.ac.ir*

Abstract

Background: During recent years involvement of Iranian nurse leaders in policy making for nursing has been increased, but still there are many disputations about policy making for nursing in Iran.
Objectives: This study intended to explore and describe factors effecting on Involvement of nurse leaders in policy making for nursing in Iran.
Method: A qualitative design involving face-to-face, semi-structured interviews by 20 nurse leaders and physicians who had key positions in policy making for nursing had been audio taped and transcribed. Using a conventional content analysis approach, data were analyzed.
Results: After open coding and categorizing data three main categories created; include: performance of nurses and nurse leaders; opportunities face to nurse leaders; and conditions governing the healthcare system.
Conclusion: Some factors effecting involvement of nurse leaders in policy making for nursing in Iran do not have wide differences with other studies in this field. Although many factors had been mentioned in this study, frequency of codes showed that performance of nurses and nurse leaders acted as a barrier and have had the most effects on involvement. Meanwhile, despite the obstacles, there are abundant opportunities before nurse leaders to making policies and they should apply them to modify these obstacles.

Keywords: *Health System, Involvement, Iran, Nurse Leaders, Policy Making.*

1. Introduction

Nurses are at the first line of care giving in health system, and this helps them to have unique and valuable views about care of patients (Ferguson 2001). They with their own eyes observe that where and when there are needs for accessing to services, preventing, coordinating of care, and increasing quality and efficacy of care (Barclay 2010). Therefore involvement of nurses in policy making can increase patients' quality of care (Sullivan & Garland 2010). Health policies originate from social needs, economic forces, technology, and public policies. Because of this complexity, nurse leaders have critical role in shaping and developing policies. However, management roles of nurse leaders such as decision making, budget control, staff management, and organizational changes are all less valued by managers of health systems (Carney 2009). Meanwhile because of less notification to nursing profession in local and national policies, existing policies often not cover high quality nursing care and related issues to nursing (Hewison 2008). Thus, if nurse leaders want policies to be reflection of nursing values and issues, they have to effect on policies (Fyffe 2009).
In 2009, when Iran's macro plan of health polices entitled Iran Comprehensive Health Map, had been developed by health politicians as authors, they had requested for the opinions and advises of many health disciplines include nursing, but just few nurse leaders had involved with declaring their opinions.
Oxford dictionary (2006) defines policy as behaviors and procedures which suggested or adopted by government, parties, business or individuals. Mason et al. (2011) define health policies as selections of a society or part of a society or institution with considering health priorities and ways to access resources in order to achieve goals. Today health policy makers believe that the issue of health should be considered in its own social context, because the primary indicators of health and illness are essentially social, political and economic. This means that health disturbances are not separable of disturbances of whole social context (Canadian Nursing Association 2000).
In Iran nurses have many problems in clinical caring, and other professional issues which without active involvement of nurse leaders in policy making eliminating these problems are impossible. One of these problems as pointed out is nursing shortage. Nursing shortage causes nursing workforce and limits time which should be spend for each patient (Thuent & Friedrich 2008). Nursing shortage in Iran is an issue which has continuously been considered by health policy makers in Ministry of Health and Medical Education, but still there is not a serious and efficient action to modify it. What makes it more complicated is that nursing shortage is not just considered as the number of nurses but it is related to the extent of policy making potential for nursing in health system (Zarea et al. 2009). The other problem is about nurses' job description. Nurses' job description in Iran is abstract, not enough clear and not implementable because of conflicts between tasks in various levels of nursing and also nursing shortage (Adibhajbagheri & Salsali 2005). In addition, in recent years we have faced to new nursing roles such as intensive care nurse, geriatric nurse, neonatal intensive care nurse and PhD nurse, without having any clear job description for them in clinical settings. Nowadays there is not any nursing entity to be accountable for correct implementation of nurses' job description. The other prob-

Copyright © 2014 Mohammad Ali Cheraghi. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

lem is organizing nursing care in hospitals. Although some steps such as developing nursing care standards and nursing guidelines, have been directed by nurse leaders in Iran, but still in hospital accreditation programs the process of nursing care audits have not been taken to account. The other problem is the forgotten role of patient advocacy by nurses. According to Taft and Nana (2008), it is just by nurses' involvement in policy making that advocacy role of the professional nurses will come to real. Nowadays there is not any statutory or supportive organization for patient advocacy by nurses in Iran. This problem is especially highlighted when Iranian nurses are not permitted to do nursing interventions according to ethical codes and this result them ethical distress (Atashzadeh-shorideh et al. 2012). This means that auditing process of Islamic Republic of Iran's Nursing Ethic Regulation and therefore nursing ethical codes in which determine who responsible is for provision of patient's bill of rights have not been well described and understood.

During recent years involvement of Iranian nurse leaders in policy making for nursing has been increased, but still there are many disputations about policy making for nursing between nursing system and chief leaders in universities, educational hospitals, and Ministry of Health and Medical Education. Therefore, there is no research study about policy making for nursing in Iran, so this study have been settled to explore factors effecting on involvement of nurse leaders in policy making for nursing in Iran. We also hope that this study give a pictorial presentation of the current status of policy making for nursing in a Middle East country.

2. Methods

2.1. Design

This is a qualitative design with conventional content analysis approach. In general, content analysis is used when the main aim of the study is description of a phenomenon and there are limit ideas (Hsieh & shanon 2005) or fragmented knowledge about it (Elo & kyngas 2007). While the phenomenon of involvement of nurse leaders in policy making for nursing and factors affecting on it has vague aspects, this approach had been used.

2.2. Participants

Like other qualitative studies, key informants who participated in this study were selected by purposive sampling procedure. Of 20 participants whom were selected, 18 were nurse leaders who had key positions in policy making for nursing and 2 were physicians who were members of the Iran's Council for Health Policy Making in Ministry of Health and Medical Education. Nurse leaders who participated in this study were selected from members of the Iran's Board of Nursing, members of the Supreme Council of Iranian Nursing Organization, deans of nursing faculties, and the present deputy manager of nursing in Ministry of Health and Medical Education, and executors of nursing associations. Some nurse leaders were involved in more than one policy making position. For example one may were the member of the Iran' Board of Nursing and also the member of the Supreme Council of Iranian Nursing Organization.

2.3. Data collection

Individual face to face semi-structured in-depth interviews performed for data collection. Duration of interviews varied between 30 and 120 minutes, with the mean time of 75 minutes. All interviews were conducted in participant's offices in a quiet setting after taking informed consents of participants. Interviews first begun with key questions and then in accordance with participants' statements were conducted with additional probing questions. For keeping credibility, all interviews begun with this question: As a senior executive director please tell me about issues you have been faced in policy making for nursing? With the progress of the interview, these questions also had been asked: what are your positive or negative experiences in policy making for nursing? What are your descriptions of involvement of nurses in policy making for nursing? All interviews were recorded and then turned to transcripts immediately.

2.4. Data analysis

Researchers didn't use any structure for categorizing data; instead they allowed them to be freely wrapped in categories; so conventional approach for analyzing data had been used. This approach carried out by doing three phases as follow: preparation, organization and report. In preparation phase, each interview had been selected as a unit of analysis. Recorded interviews had been transcribed verbatim, and then been read several times to gain a general impression. In organization phase, unites of meaning for each interview, had been highlighted, condensed, and openly coded. Then codes with similar meanings had been arranged into subcategories and finally into main categories. Finally in report phase the latent meaning of data had been reported (Elo & Kyngas 2007). The first author performed interviews and data coding, and coauthors supervised the coding process. Agreements between authors about data coding were achieved after frequent discussion and negotiation.

2.5. Rigor

In qualitative research data should have trustworthiness. To achieve this, confirmability of findings should be evaluated (Straubert & Carpenter 2007). In content analysis, selection of appropriate unit of meanings, the way of categorizing data and judgment about similarities and differences between categories are very important to achieve credibility of findings (Granheim & Lundman 2004). Accordingly, in this study, credibility of findings was evaluated through spending enough time for data collection and analysis. Member check performed and also the process of data analysis was carried out by the second and the third authors for peer check. In order to enhance dependability, audit trail was employed and the process of categorization and abstraction had been explained, and quotations which represent each category have been reported.

2.6. Ethical considerations

Tehran University of Medical Sciences Research Ethics Board approved ethical consideration for current study (Number: 91/d/130/169, in 2012/25/5). Meanwhile participants were asked to sign a consent form and were informed that withdrawal of the study at any time was possible.

3. Results

Of 20 participants 7 (0.33) were female and 13 (0.67) were male. Mean age of participants were 52.45 year. Level of literacy for 12 of nurse leader was PhD in nursing, and for 6 of them were master degree. 16 participants were academic member. The mean years of management experience for nurse leaders in various levels and/or in policy making positions were 7.84 year. After data analysis three main categories created: 1) performance of nurses and nurse leaders; 2) opportunities face to nurse leaders; and 3) Conditions governing the healthcare system.

3.1. Performance of nurses and nurse leaders

The first main category in the current study is performance of nurses and nurse leaders. Participants believed that the performance of nurses and nurse leaders have created some barriers which have been affected in this regard. This category consists of the following three subcategories: shortcomings in nursing educa-

tion, weak communication within profession, weakness in social and professional development of nursing community.

3.1.1. Shortcomings in nursing education

Participants believed that in Iran nursing education from undergraduate to PhD degree was not appropriate for training qualified, assertive and innovative nurses who can effectively influence in decision making fields in future. In this regard, one of the participants said:

"I mean intellectual development is not formed in our nurses when they are students and they act like robots and don't use their mind; I mean they are just ready to be executors; I blame us." (Participant 1).

Also the participants in the current study believed that nursing students in graduate levels up to PhD level rarely felt that as a person skilled in caring science needed to create change in quality of care, and participate in decisions about nurses. In this regard, one of the participants said:

"I believe a field should be defined for PhD courses, too, I mean, nurses with PhD should be able to deal with oncologists, talk about their comments and remark on healthcare issues as nursing experts." (Participant 12).

3.1.2. Weak intra-professional communication

The second subcategory of the main category of performance of nurses and nurse leaders is weak communication within profession. Participants believed that there was weak communication between nurse leaders and their counterparts, and this weakness in communication was a barrier to participate in policy making effectively. In this regard, one of the participants said:

"Nursing has three parts now, I mean; three groups are responsible for policy making. These three groups occasionally hold meetings with the presence of the representatives of the other two groups… But there isn't a supreme council for these three groups to discuss ways for coordinating nursing policy making… I mean, although they claim that they're working together, they never make policy jointly." (Participant 2).

Some participants noted weak communication between nurse leaders, in that they oppose one another instead of supporting one another. In this regard, one of the participants said:

"Unfortunately, when a problem occurs between us, we won't stop until we destroy each other. When we disagree about an issue, we must realize that outside the meeting we are still coworkers and should see how we can maintain the association… I mean nurses don't support each other they can't work together due to conflicts between them." (Participant 6).

3.1.3. Weakness in social and professional development of nursing community

The third subcategory of the main category of performance of nurses and nurse leaders is weakness in social and professional development of nursing community. Participants in this study strictly emphasized on the weak support of associations by nurses and believed that nurses without social and professional development had no reason to join nursing associations, but in fact the opposite is true and membership in such associations would be a factor for nurses' social and professional development. In this regard, one of the participants said:

"Unfortunately, nurses just want to work and get paid. They don't think about the social role of a nurse and don't care for Iranian Nursing Organization (INO) or other associations. If they come to vote for INO election, they say out of favor "I came to vote for you"! But they don't say "I must have actively participated in elections, I must have helped more, I must have chosen more people, and I must have nominated myself". (Participant 4).

Also participants in the current study believed that the atmosphere governing nursing in the country including clinical nursing and academic nursing is an atmosphere of arrogance instead of a professional-oriented atmosphere; and these cases totally made the level of nurses' social participation low in promotion of public health. In this regard, one of the participants said:

"You know, unfortunately, when we're in particular social positions, we prefer not to talk as we should just to keep our interests in the professional position. How come the majority of thinkers and researchers with good background only think about themselves? This is because 'I' is important here. This 'I' has secluded him/her and just thinks about him/herself! They don't care about others. (Participant 17).

3.2. Opportunities face to nurse leaders

The second main category of the current study is opportunities face to nurse leaders. Participants believed that there are some opportunities faces to nurse leaders which often they do not use them appropriately. They believed that despite all obstacles mentioned above, the way of progress is open in front of nurse leaders and they should make the best use of opportunities by using the existing contexts and provide the entry requirements to policy making positions for nursing. This main category consists of two sub-categories; one is the optimal utilization of available opportunities and capacities and the other is acquiring the eligibility requirements to obtain policy making positions.

3.2.1. Optimal utilization of available opportunities and capacities

Some participants believed that whenever we have seen opportunities, we have been attained our goals; In this regard, one of the participants said:

"Whatever we've achieved so far is because of our efforts and we're to blame for whatever we haven't. Suppose a ship in which the wise boards it and will reach his/her destination, others may want to go on foot. In nursing community, most want to go on foot. We boarded the ship and that's why we could discuss establishing the Iranian Nursing Association with our colleagues. That is, we made the most of being with some senior executives in the front, and we couldn't do so till we boarded the ship." (Participant 4).

3.2.2. Acquiring the eligibility requirements to obtain policy making positions

The second subcategory of the main category of opportunities face to nurse leaders is acquiring the eligibility requirements to obtain policy making positions. Some participants believed that for acquiring the eligibility requirements to reach policy making positions, nurses should have sufficient knowledge and good executive experience. In this regard, one of the participants said:

"You know well that the people who want to make policy or strategic plans should have a wider vision did we believe in our senior executives' abilities to elect them? Has my thinking developed already if I want to become a minister counselor, a deputy, or a head of nursing association? I've worked in lower ranks; that's why I'm at this position now." (Participant 11).

A number of participants believed that persistent awareness of society needs by nurse leaders is another important eligibility requirement to obtain policy making positions. In this regard, one of the participants said:

"A nurse leader first should have a clear definition of what expectations the society has from a nurse. What is my own expectation as a leader from a nurse? Then we should gathering consensus. I knew that we have had good occurs about nursing during recent years, but still society needs have not been covered by our decisions and policies." (Participant 8).

3.3. Conditions governing the healthcare system

Many nurse leaders who participated in the current study believed that the healthcare system had developed a context that nurses could hardly participate effectively in policy making for nursing.

This main category consists of the following three subcategories: paternalism, the healthcare system centrality, and weak interdisciplinary teamwork.

3.3.1. Paternalism

The participants believed that one of the conditions preventing nurses to participate actively in policy making was paternalism governance in the healthcare system. Physician long term bureaucracy in approval of nursing curricula and policies resulted in nurses, to feel marginalized. In this regard, one of the participants said:

"When a curriculum is set or reviewed by the board, it is sent to the Supreme Council for Planning After that, the program is given to a specific council which is a subset of the Supreme Council for Planning. Then it is sent back from the specific council, to the expert committees. When the program is approved, it is repeatedly sent to the Supreme Council for Planning. I mean in some cases, a program will take five years to be approved. As time goes on, they are stricter on nursing the board is not autonomous." (Participant 17).

3.3.2. Healthcare system centrality

Healthcare system centrality is the second subcategory of the main category of conditions governing the healthcare system. Iranian nurse leaders believe that although the pillars of healthcare system are based on three axes of prevention, treatment and rehabilitation, the healthcare system in Iran is a treatment centered system and huge percentage of the costs belong to treatment. In this regard, one of the participants said:

"A large amount of health budget is funneled toward treatment. Why? If we consider prevention centers in our health system, we observe they're working more in treatment area instead of prevention area, i.e. they're screening what has been done in rehabilitation area? No services are provided. It's clear that nurses don't participate in these conditions" (Participant 5)

3.3.3. Weak interdisciplinary teamwork

The third subcategory of the main category of conditions governing the healthcare system is weak interdisciplinary teamwork. Participants believed that although every healthcare system includes multiple teams that should be interrelated; commitment to democratic behavior in policy making is not observed as teamwork and there is a lack of interdisciplinary decision-making teams on macro policy making. In this regard, one of the participants said:

"I think we need decision constructors comprise people with different professions from various disciplines who construct and prepare decisions which finally should be presented to decision makers I think the problem is here. I think the lack of decision constructors is a missing link which leads to improper policy making." (Participant 13).

4. Discussion

Factors effecting on involvement of Iranian nurse leaders in policy making for nursing have been discussed here. The first main category in the current study is performance of nurses and nurse leaders. Most nurse leaders believed that the nurses themselves were in fact the main barrier for weak participation in policy making. They believed that nursing education in Iran was not eligible for training nurses who could be powerful to benefit from macro policies of the healthcare system in future and be effective in formation or could change those policies. Boswell et al. (2005) also suggested two major barriers for nurses' participation in policy making; one of these two barriers is nursing curriculum framework that keeps away nurses especially from social activities in the healthcare services. Also Conger & Johnson (2000) in a study on the impact of nursing education methods on political participation of nurses concluded that nurses' education in all three undergraduate, master and doctoral degrees was weak. They believed that in undergraduate level there was a deficiency in courses related to community health nursing, in master level, there was a deficiency in training nurses to accept social responsibilities as leaders for developing healthcare system, and in PhD degree, there was a weakness in training policy analysis, research in policy making area and how policy was made. Also, Buerhaus & Needleman (2002) have suggested that one of the inhibiting factors for policies to promote clinical nursing is that nursing education follows medical education. The weakness of communication within the nursing profession is also another nurses' performance-related obstacle obtained in the present study. Hughes (2005) also has referred to the need for closer communication between nursing managers and networking. He believed that effective communication is the key to successful policy making, implementation of policies and considering issues in policy making agenda for nursing. It seems that communication disturbances in this study are both intra-professional and inter-professional. Weakness in social and professional development in Iran's nursing community is another result in the present study, where one of its most important indicators is the weak support of nursing associations. Based on evidence mentioned by one of participant, nurses' participation in the last Iranian Nursing Organization (INO)'s elections were less than 20 percent. Accordingly, in the first round of elections of INO in city of Isfahan, of 5000 nurses in the city 1700 nurses were members of INO; of them only 300 people participated in the election. At the end of the second round, the number of members from 1700 reached to 4600 people, i.e., it was almost three times but participation in elections reached only to 700 people; i.e., in fact, the participation percentage even dropped compared to the previous round (The board of director of Isfahan Nursing Organization, 2012). Iranian Nursing Association (INA) is the other nursing NGO in Iran and according to one of the participants; it has been eight years since its last election. As mentioned before, in the study by Boswell et al. (2005), two main barriers were suggested for weak participation of nurses, one of which was referred to. The second major obstacle according to Boswell et al. (2005) is weakness in participation in nursing organizations. He believed that participation in nursing organizations guaranteed professional nursing, and professional nursing possible entering nurses into policy making. Beauregard et al. (2002) also reported that although there were almost 2.6 million certified nurses in the United States, less than 7 percent were members of nursing organizations and therefore, the ability of nurses and their image as people with political effectiveness have been reduced.

The second main category in the current study is opportunities face to nurse leaders. Nurse leaders in this study believed that there had/have been optimal opportunities in the past and present and whenever nursing managers used the opportunity properly, they could increase their role and impact on nursing policy making and conversely wherever they did not use the opportunities, opposite results happened. What is certain is that seizing the opportunities is vital for policy making. Kingdon (1995) and Longest (1998) had separately developed models design in that shows effective factors in applying issues in policy making agenda. They call one of the most important factors 'opening the windows of opportunity' and believe that sometimes conditions are in such a way that in a certain range of time, windows of opportunity are open and alert policymakers should regularly look for the windows opening for easier acceptance of the issues raised from their side (Ferguson 2001 & Milstead 2008). Also Rafferty (2004) in a study on necessary influential factors of nurses on research policy making in the UK, refers to three factors, one of which is to make good use of opportunities that he calls 'using chance'. Choosing senior managers based on valid indicators as well as passing specific empowerment courses after the appointment of senior management are other facilitators that nurse leaders have noted in the current study. Recently, some courses called the Leadership for Change (LFC) are held by INO for Iranian nursing managers. These courses are supervised by the International Council of Nurses (ICN) (Benton

2012). The fact that nurse leaders need to pay attention to society needs is another facilitator discussed in this study. In fact, nurse leaders who are aware of the current needs of the society can convince senior policymakers much easier to put issues raised by them on the agenda for policy making. In contrast, leaders who pay less attention to the society needs have nothing to say in policy making meetings. Villeneuve (2008) in his study entitled 'the main responsibility of nurses around the world' writes: 'We have attempted repeatedly to achieve something in the field of health care, but in fact we achieved what we wanted to. But what are important is the people we serve and their need guides us what to achieve'. In another study on nurses' performance development strategies by Canadian Nurses Association; also one of the most effective strategies is considering the groups directly affected by underlying policies. Nurses' participation in the national media is another facilitator that has been supported in some studies conducted in the field of nurses' participation in policy making (Fyffe 2009).

The third main category in this study is conditions governing the healthcare system. Nurse leaders believed these conditions are beyond manipulation of them. In fact they have to make policy in the present context that has made conditions difficult for active participation by nurses. According to Kowalic & Yoder (2010), in centralized systems, unlike decentralized systems, power distribution is in such a way that nurses are not allowed to participate prominently in policy making and workplace issues. Healthcare system in Iran has a centralized structure. Thus, characteristics of centralized structures particularly superior's high monitoring are conspicuous, and physicians have long been in charge of all matters related to healthcare. Results of a study by Salsali et al. (2009) on organizational factors affecting knowledge transfer into practice in Iranian nursing context depict that ineffectual organizational structure especially hierarchy of authority was one of the barriers to knowledge transfer into practice. Boswell et al. (2005) also verify that, the sense of powerlessness is one of the barriers to nurses' participation. In addition to the healthcare system structure, the concept of interdisciplinary teamwork in Iran has not been defined and there isn't an integrated and acceptable concept in all disciplines. It seems that this is an extended issue which not allocated just Iranian healthcare system. Sullivan & Garland (2010) in this regard writes: nurses and physicians have different outlooks on the concept of interdisciplinary teamwork and this makes accepting nurses as members of the treatment team difficult for physicians. The concept of interdisciplinary teamwork in view of physicians is the relationship between various medical specialties such as neurology, orthopedic, cardiac and thoracic specialties for better patient treatment. While the concept of interdisciplinary teamwork in view of nurses is the relationship between nursing, medicine, pharmacology, nutrition, and other related fields, for better patient care. Any way how do we interpret teamwork we cannot ignore nurse's role in development of health policies. Result of the study by Irajpour et al. (2012) on challenges of inter-professional collaboration in Iranian mental health services depict that poor inter-professional communication especially between nurses and doctors was one of the main barriers. Whereas results of a study on the effects of primary care teams on community health shows that consulting with nurses with adequate knowledge and skills about the key areas of service delivery and policy making has been effective in promotion of primary services and community health (Dowswell et al. 2002). Using the national media to introduce nurses' solutions to solve or mitigate the problems of public health, prepares public opinion particularly senior policymakers to accept nurses' power in providing useful ideas on public health. However, in the current study only one of the participants noted the media's role as a facilitator for nurses' participation in policy making.

5. Limitations of the study

Although the participants in this study included a considerable number of nurse administrators and leaders, the clinical leaders were not highlighted due to special look of this research to macro and middle level of policy making. Fitness of the results were checked with several expert nurses who did not participate in this research, however, transferability of the findings, at least within the similar context same as Middle-Eastern healthcare context is supported. But since the effectiveness of nurse leaders is not the same in different countries, like other qualitative studies, the findings of this study should be generalized cautiously.

6. Conclusion and recommendation

There is not much time since nurse leaders entered policy making areas in Iran, and still they have long way ahead. Most factors which influence on involvement of nurse leaders as barriers are related to deficiency in performance of nurses and others are related to the characteristics of the healthcare system in Iran. Reviewing the literatures showed that some affecting factors like shortcoming in nursing education and weak support of associations are general factors in many contexts, but some other factors like conditions governing healthcare system, lack of teamwork, weak intra-professional communication, and effectiveness of nurse leaders are more specialize for Iranian context. It seems that nursing education needs to be moved towards improvement of professional aspects of nursing instead of just practice and knowledge of nursing. By this way in future we will be more hopeful to have nurses who are more sensitive about their profession and are more willing to act throughout associations and have active presence in community. Despite the obstacles, there are abundant opportunities before nurse leaders to make policy. But nurse leaders have so far used fewer opportunities. They should find these opportunities and more actively participate in community and in policy making positions.

Acknowledgement

The authors sincerely appreciate all nurse leaders and physicians who participated in this project, as well as their secretaries who all made this research possible in various stages.
This research was funded by Tehran University of Medical Sciences.

References

[1] Adib Hajbaghery M, Salsali M, (2005). A model of empowerment of nursing in Iran. BMC biomed central research, 5(24), 1-11.
[2] Atashzadeh shorideh F, Ashketorab T, Yaghmaei F, (2012). Iranian intensive care unit nurses' moral distress: A content analysis. Nursing Ethics, 19(4), 464–478.
[3] Barclay L, (2010). Nurses should play greater role in health policy planning, management. Medscape Medical News, [Online] 2 Feb. <Available at:http://as.medscape.com/js.ng/params.richmedia>[Accessed on 22 Jan 2014].
[4] Beauregard MA, Deck DS, Kay KC, Haynes J, Inman R, Perry M, Richardson S., Rose BA, Silver KN, White C, George E,(2003). Improving our image a nurse at a time. The Journal of Nursing Administration, 33(10), 510-511.
[5] Benton D, (2012). Advocating globally shaping policy and strengthening nursing's influence. OJIN, 17(1), 05.
[6] Boswell C, Cannon Sh, Miller J, (2005). Nurses' political involvement: Responsibility versus privilege. Journal of professional nursing, 21(1), 5-8.
[7] Buerhaus PI, Needleman J, (2004). Policy implications of research on nurse staffing and quality of care. Policy, Politics, and Nursing Practice, 8(5), 160-166.

[8] Canadian Nursing Association, (2000). Nursing is a political act- the bigger picture. Nursing Now, Issues and trends in Canadian nursing, 5(8), 1-4.
[9] Carney M, (2009). Enhancing the nurses' role in healthcare delivery through strategic management: recognizing its importance or not. Journal of Nursing Management. 17(6), 707-717.
[10] Conger CO, Johnson P, (2000). Integrating political involvement and nursing education. Nurse Educator, 25(2), 99-103.
[11] Dowswell T, Wilkin D, Banks-Smith J, (2002). Nurses and English primary care groups: their experiences and perceived influence on policy development. Journal of Advanced Nursing, 37(2), 35-42.
[12] Elo S, Kyngas H, (2007). The qualitative content analysis process. Journal of Advanced Nursing, 62(1)107-115.
[13] Esmaeili M, Dehghan-Nayeri N, Negarandeh R, (2013). Factors impacting membership and non-membership in nursing associations: A qualitative study. Nursing & Health Sciences, 15(3), 265-272.
[14] Ferguson LS, (2001). An activist looks at nursing's role in health policy development. JOGNN, 30(5), 546-551.
[15] Fyffe T, (2009). Nursing shaping and influencing health and social care policy. Journal of Nursing Management; 17, (6), 698-706.
[16] Graneheim UH, Lundman B, (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Education Today, 24(2), 105-112.
[17] Hewison A, (2008). Evidence-Based policy, Implications for nursing and policy involvement. Policy, Politics, & Nursing Practice, 9(4), 288-298.
[18] Hsieh HF, Shannon SE, (2005). Three approaches to content analysis. Qualitative Health Research, 15(2), 1277-1288.
[19] Hughes F, (2005). Policy- a practical tool for nurses and nursing. Guest editorial. Journal of Advanced Nursing. 49(4), 331.
[20] Irajpour A, Alavi M, Abdoli S, Saberizafarghandi MB, (2012). Challenges of interprofessional collaboration in Iranian mental health services: A qualitative investigation. Iran J Nurs Midwifery Res, 17(2), 171–177.
[21] Iranian Nursing Organization Informational site. (2014). [online] available at :< http://ino.ir/>.[Accessed 4 Jan 2014]. (persian).
[22] Kowalik SA, Yoder L H, (2010). A concept analysis of decisional involvement. Nurs Admin Q, 34(3), 259-267.
[23] Mason D J, Leavitt JK, Chaffee MW, (2011). Policy and politics in nursing and health care, 6th ed. Elsevier
[24] Milstead, JA, (2008). Health policy and politics, a nurse's guide 3rd ed. Jones and Bartlett.
[25] Oxford dictionaries. (2006). Concise Oxford English Dictionary 11th revised ed. Oxford University Press, Oxford.
[26] Rafferty AM, Traynor M, (2004). Context, convergence and contingency: Political leadership for nursing. Journal of Nursing Management, 12(4), 248-265.
[27] Reed J, Ground I, Dunlop M, (1997). Philosophy for Nursing. London, Arnold.
[28] Salsali M, Cheraghi MA, Ahmadi F, (2009). Organizational factors affecting knowledge transfer into practice in Iranian nursing context. International Journal of Nursing Practice, 15(5), 426-436.
[29] Streubert HJ, Carpenter DR,(2007). Qualitative Research in Nursing: advancing humanistic imperative.4th edition. Lippincott Company.
[30] Sullivan EJ, Garland G, (2010). Understanding power, policy and politics, In: Practical Leadership and Management in Nursing. Pearson.
[31] Taft SH, Nanna KM, (2008). What are the sources of health policy that influence nursing practice? Policy, Politics, & Nursing Practice, 9(4), 274-287.
[32] Thuent LF, Friedrich BV, (2008). Interdisciplinary collaboration for health care professionals. Nurse Administration *Q*, 32(1), 40-48.
[33] Villeneuve MJ, (2008). Yes we can! Eliminating health disparities as part of the core business of nursing on a global level. Policy, Politics, & Nursing Practice, 9(4), 334-341.
[34] Zarea K, Negarandeh R, Dehghan-Nayery N, Rezaei- Adaryani M, (2012) Nursing staff shortages and job satisfaction in Iran: Issues and challenges. Nursing and Health Sciences, 19(4), 464–478.