

# 10 *Shared Governance: Looking Toward the Future*

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This book has outlined the characteristics and elements influencing the development of shared governance. The focus has been on the current strategies that have emerged over the past 10 years that facilitate the successful unfolding of a nursing shared governance model. If the considerations and discussions ventured by the authors are faithfully applied in the implementation process, success should be ensured regardless of where this approach might be implemented.

In addition to the growing data base regarding successful implementation processes, there is mounting evidence of the successful outcomes of the shared governance process. From objective data supporting the reduction in turnover and increase in retention to the qualitative data that show higher levels of nursing satisfaction and investment in the work and the workplace, shared governance as a professional model is benefiting those who struggle to make it work (Ludemann and Brown, 1989).

The status and role of nursing change in this model from the inside out. First, the nursing organization begins to feel better about itself and to relate differently both within and outside the service. Soon others note that there is something different in their relationship with the nursing organization and begin to assess their response and react to the changes in operation and relationship. This reaction is sometimes positive and at other times this change in nursing generates some concern. The behaviors and self-perception of a profession as pivotal to the provision of health services as nursing cannot avoid having an impact on those who relate directly to it. Some will be thrilled with the enthusiasm and growing sense of self that nurses project; others will be uncertain about what such a change means to their relationship with nurses and the adjustments the system will have to undergo to accommodate these changes. Some may be obstreperous about the changes in the behavior and role of nurses and may not wish to accommodate such changes into their relationship, thereby creating a period of transitional stress between themselves and their nurse colleagues. Such situational occurrences must be expected in a challenging and politically intensive environment such as health care. These are the conditions and risks of change, maturation, and reaching a point where others must accept the new and those who see and act as though they deserve consideration and equity. This is what shared governance demands and produces.

## **SHARED GOVERNANCE AS A TRANSITIONAL MODEL**

The world is in constant change. What was appropriate yesterday is passé today. The values of yesterday yield to the challenges of tomorrow. What was appropriate for one time is inadequate for another.

Although shared governance is a highly successful vehicle for building a truly professional nursing organization and strengthening the profession and the role of nursing in the health care system, it too must undergo change as time and conditions warrant. The times and conditions of the health care environment will demand newer considerations and approaches that will more adequately advance nursing to the forefront of health care, calling for newer arrangements and structures to do so (Haddon, 1989).

If shared governance becomes an end in itself or a point of arrival, it will have failed to serve its intended purpose. Shared governance has always been a transitional model—a means to reaching a new point as a profession and as a vital health service. It is better characterized as a journey than a point of arrival. Its value diminishes as defined goals are achieved. Retaining the structure as though it were the place to stay is to fail to continue the work of maturation and transformation that is always the work of a profession in the fulfillment of the public trust for which it is empowered and licensed.

The concept of describing the structures and work of nursing more as a vehicle than an event is sometimes difficult for the profession. Gains in political, social, role, relational, and equitable outcomes have been long awaited, challenging in process, and uncertain in benefit. In these circumstances the temptation to retain what is gained in the form in which nurses receive it is strong and tantalizing. Unfortunately, to do so is to hold tight to an illusion that soon dissipates into another set of circumstances and conditions that change the experience, defy the perception, and call us all to a new reality (Peters, 1987).

## **CHANGING TIMES**

Life conditions and world circumstances are changing at a quantum rate. Reality seems to be continually adjusted, even before there is time to get accustomed to that new state of being. Although more sensitive to the changes around us, they are so life changing we are not certain we know how to respond to them. From fundamental moral values to political relationships, the world seems to daily reflect an entirely new set of variables demanding response. Those things we have come to count on and trust as constants in our lives change before our eyes and, unfortunately, leave us few tools to cope with what replaces them (Morris, 1990).

The emerging changes in our world are not simply transitional events. They are transformation processes that are changing the very fabric of human existence and calling us to a future radically different from anything we know. As Figure 10-1 illustrates, we are indeed moving from one age to another age—out of the industrial age into a social technocracy whose character and circumstances are still unclear and our picture of it is opaque at best. It is approaching with such speed that we truly do not know how to understand it, or to cope with it (Toffler, 1990).

In the midst of these changes nurses are working to unfold a shared governance

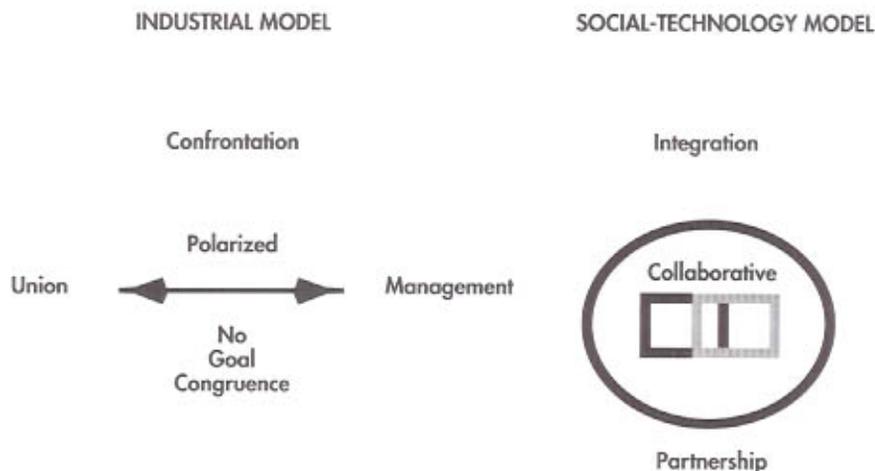


FIGURE 10-1. The industrial model versus the social-technocracy model.

model. Ostensibly, the model prepares the profession and individual nurse for essential new roles and behaviors. Nurses will need to be proactive in efforts to write the emerging script in ways that are beneficial for those whom nurses serve and for the continuing effectiveness and viability of the nursing profession in meeting health care needs in a system in transition. Shared governance serves as a baseline or foundation on which further adaptive structures will be designed and constructed for the future. It is the appropriate redesign and restructuring of the health care system and nurses' responses to it that will be increasingly important as a key task of nursing and nurses. Although shared governance acts as a formal bridge to a new sense of self and a stronger set of relationships and power within the profession, this context provides a foundation for even further change and providing some form and focus in order to have a meaningful impact on the delivery of health care in the future. It is for this purpose that the next steps beyond shared governance must be directed. As those steps are taken, they must allow nurses to design new forms and forums to govern those newer circumstances and contexts within which nurses will work and make their contribution to those they serve.

The health care system of tomorrow will be as different as the world that reflects it. There will be entirely new approaches to provision of health care services. Nursing resources will be used in many new ways and provide nursing services in ways not yet conceived. These roles are not yet altogether clear, nor can they be. The delivery system will undergo much transition before its form and nurses' roles are clear. However, this concern is the crux of the current issue of change with regard to the nursing profession. Just what will the role of nursing be in writing a new script for the future of health care and nursing's role in it? If nurses are not involved in writing this new script, what roles will they be destined (or assigned) to carry out, if any?

Clearly, during transitional times, whoever writes the scenario for tomorrow will no doubt dictate the roles. If nurses are not at the policy table where the de-

liberations and determinations of how health care will be provided, there may be a good chance that the value nursing can bring to the discussions and the pivotal role that nurses play in the process can be underrated, skewed, or forgotten. The outcomes could thereby be severely compromised because a key player in the health care process is either missing or underrepresented.

Expectations born of a strong shared governance system should lead the nursing profession to expect a role in shared decision making, especially regarding issues that affect what nurses do. Assertive skill building and a clear agenda facilitate the contribution nurses make to deliberations affecting the future of health care delivery. A structure that supports and expects a nursing role to be included in policy and strategic processes that decide the direction and fate of the health care entity or enterprise is vital. The level of maturity contributes to the effectiveness of the health care system and allows a broad range of considerations to emerge and be supported as an important part of the nurse's responsibility for defining and living the future. The overriding sense of contributing to that future provides nurses a stronger sense of ownership related to the solutions and to the work necessary to implement them.

## **AN ORGANIZATIONAL PARADIGM SHIFT**

It is surprising that employee involvement and ownership processes have been so late in the United States. Here, where democracy is the standard bearer for the free world, the rigidity and authoritarianism of the workplace challenge the American ideal. However, the realities of a changing global economic stage and competitive marketplace are driving American companies to redesign. Included in the redesign is the effort to create a more involved and invested workplace that incorporates the worker into the decision-making process.

The effort to accomplish this redesign is new and initially appears clumsy and overwrought. There is an awkward overindulgence and even paternalism in the effort that is a part of moving toward creating truly involved relationships. It is the relationship that ultimately will make all the difference in making the "new" workplace successful.

The "noise" and stress of the transition will serve a valuable purpose. First, the superficial and trendy programs that teach total quality management and environments of excellence (and other such "packages") must be experimented with and then, in typical American fashion, discarded because they cannot produce what they promise. The idea that personal and professional values can, by mere act of will or organizational process, be melded mindlessly into an amorphous multidisciplinary team committed to an abstract ideation such as quality is not only silly, it is untenable. Such processes violate the essentials and hard work associated with professional investment and ownership, relational integrity, collaborative agreements, and role and functional parameters driven by the emergence of a "knowledge worker" class in American society (Toffler, 1990).

Rather than give up professional obligation and identity, such character needs to be maximized for a meaningful investment in the outcomes of work to be achieved. The professional worker has a maturing sense of self and commitment

to what she or he is doing, bred into the role through years of preparation and application. In today's fragmented work, it is one of the values that can be identified with as contiguous and consistent and maintained. In essence, this knowledge and professional identity is the one thing the professional worker takes home and carries wherever she or he may go. With an increasingly fragmented, decentralized workplace, the individual's professional identity and knowledge base is one of the few life constituents to link with others and create any sense of human and professional connection.

In many of the emerging service-based programs that focus on the service receiver—the product or quality—the perspective of the individual worker is sometimes either lost or relegated to some other level of consciousness. For any quality connection to be made, there must be equated investment in both the worker as provider and the patient as receiver. They enter into a relational exchange in the health care frame of reference, and the exchange will require the efforts of both parties if a desirable outcome is to be achieved. The connection is therefore a living experience that incorporates the life processes, skills, and openness of each to the other in order to work or to move to a "higher" or more esteemed level of either interaction or healing. No value can be meaningfully expressed if the relationship of both is not balanced and attended to, regardless of the power of the drive for a quality outcome or product or cost effectiveness.

None of this suggests that a renewed focus on the product, customer, or patient is not desirable. It is. Nothing can serve the health care field better than a concerted, informed, and legitimate emphasis on the patient, consumer, and/or outcome by all those who provide service. It is suggested that this objective is not achievable over the long term if both the needs of the worker and the needs of the consumer are not equally addressed and attended to. The assumption that the professions, and thus professional workers, are not interested in the best shortchanges the commitment of the worker and fails to create the requisite partnership between the organization and its professions to a process whose outcome is mutually beneficial.

Equally important is the need to teach the process of achieving measurable outcomes that can provide a level of confidence with regard to the quality of one's work and the quality of the work of the enterprise as a whole. When professional skills and values are incorporated into this process and individual investment is nurtured, the organization will surely benefit as evidenced by its own measurement related to the achievement of its goals or quality standards. The partnership, in this case between nurses and the organization, cannot exclude the equitable infusion into the effort of the values, commitment, and concerted action of the professional group in the exercise of its role.

The professions, including nursing, must recognize the need to validate the effect of their work on both the consumer and system. Professional groups have too long escaped reasonable scrutiny to determine the real value and benefit of the services they provide. It has almost appeared that they were afraid to focus on their value because such an emphasis may reveal the group's shortcomings and that the supposed contribution did not match the real outcomes. In other words, there is an unspoken fear that the profession and its work are truly not worth the price paid

for its services and thereby subject to inevitable judgment and possible decline in both value and numbers.

The chances are good that this scenario is simply not true and that nursing will find that its value has historically been underrated and that the full value of the profession in the healing process has not been thoroughly explored (Passau-Buck, 1988). Adopting models that focus on the consumers of health care and on service outcomes should provide a stronger base for validating nursing contribution. Therefore nursing should not be reticent to explore opportunities to assess its role and value and to attach the determinations from that assessment to the management of the nursing resource. The issue is the willingness of the profession to do the work necessary to determine its place and legitimate role and function in the delivery of health care services. Because it is likely that the role is broad-based and is the foundation of the contribution nursing makes to health care delivery, the profession should move with confidence in concert with activities to facilitate the determination of its value and contribution. Nursing leadership should be willing to:

1. Evaluate objectively the process of value determination as fully as possible. This process includes the development and familiarity with statistical processes such as those associated with standard data analysis: flow charts, histograms, data diagrams, variance analysis, cause-and-effect data tools. Algorithmic processes that help objectify specific processes must also be incorporated into measurement of services provided. All levels of the nursing service must be comfortable with these processes.
2. Better define quality. Nurses must refrain from use of generalized descriptors of their work and focus more fully on units of service, patient care elements that relate to the payment methodology, and establish a stronger relationship between outcome and the process that achieved it.
3. Better describe and directly identify the relationship with the client or patient. Nurses must move beyond the "second step" service role (agent of the doctor or hospital) to a primary identification with the patient directly and establish roles and relationships within the context of nursing's own paradigm, not the reflection of someone else's role.

## **MOVEMENT FROM HIERARCHICAL STRUCTURES**

Recognition of the transition to more collateral approaches to structuring the decisional process is emerging in health care (Naisbitt and Aburdene, 1985). This move is not without trauma. The hospital health care system has historically developed with a rigid hierarchy and a solidly structured decisional pyramid. The doctor has generally been assumed to be at the top of the medical pyramid because of the socially promulgated myth of informational and clinical ascendancy (Kalisch and Kalisch, 1988). It is difficult to change the structure that supports the physician. The medical model has been the generalized approach to the offering and payment of health care in America for this century.

Now it is more strongly recognized that there are a number of ways to offer

health care services outside of a medical model fixation. Increasing evidence supports the efficacy of such practices, raising questions about the viability of maintaining a high-cost, high-intervention system for the delivery of health care in America (Fagin, 1990). Policymakers and legislators in the public sector are beginning to alter the service and payment infrastructure to allow the provision and payment of a different array of services provided by a different kind of provider.

The traditional hospital structure is being threatened continually by increasing cost-control measures. The intent has been to move the patient through the hospital system quickly or to have the patient not enter the system at all, if it can be avoided. Such a strategy has worked admirably, reducing the annual rate of hospital cost significantly through the 1980s and early '90s (Evans, 1989).

Services normally provided by hospitals are now being provided in other settings. Those procedures performed in doctors' offices have increased at the same rate as hospital costs have declined. To counteract this effect, Congress has introduced cost caps to physician payments; the private sector is following with its own efforts to control doctors' payments (Grimaldi, 1990). In effect, the health care system is being forced by economics to change its service characteristics. Paying solely for sickness is quickly becoming outmoded and begs for a different service and payment arrangement in the future. Incentive payment structures will focus on emerging proposals that keep costs as low as possible or, ideally, do not ever generate those costs.

Efforts to produce health giving or maintaining services or to provide services at the lowest point of service cost will continue to develop. As the population ages and as chronic issues become the dominant health concerns of the population, nonacute and noninterventive strategies will ensue at an accelerated rate. The data that support the early intervention or prevention of the conditions or circumstances of illness have long-term benefits, not only on patients' health but also on the costs of providing health care over the long term. Recent data show that emphasis on early nutrition, adequate housing, education, and prevention all contribute to the reduction in health problems in later life. Failure to do this results in high-cost illness (Program, 1990).

The effects of this refocusing will soon emerge in the service delivery system and be reflected in the payment structures as the data increasingly support the transition. How services are provided also will change radically. The hospital as the traditional location of all intervention services of an acute nature will become less central to the delivery of many services provided in the system. Emerging models of service delivery will take precedence and newer, more cost-effective ways to treat patients will develop outside of the hospital. Connection to the hospital will be maintained as the community's link to a more intense diagnostic or therapeutic environment.

Many community or noninstitutional services will be provided by nurses in nontraditional settings. Their practice will reflect the requirements of the client and be offered where the client can more easily access them and remain as independent as possible for as long as possible. The nurse in such situations will often become a primary provider of health care, referring to the physician only when a medical plan of care needs to be incorporated in the patient's care. This change in

the structuring of health care will change the role and relationship of the nurse to others in the health care system (Hudson, 1990). Because the structure in the example above indicates a high degree of decentralization, the nurse will be less loosely tied to the institution than today. Nurses will also interact more often with other health professionals as an independent part of their work than they have in the past. The therapeutic relationship will include consultation and advice from a number of health professionals, based on the needs of the patient and what the health professional has to offer the patient.

Patient problems will become less acute and more chronic than in the past. Because of this reality and fueled by an increasingly aging population, the nurse may often be the case manager or key primary care provider. This will begin in the low-income, high-service need arena where the nurse's service and economic value will be well evidenced. As the data related to the efficacy of nursing expand into the policy and payment area, adjustments in the payment structure will accelerate and direct payment for services rendered will result. The nurse's viability in the "mainstream" also will be encouraged by successes in managing the underserved.

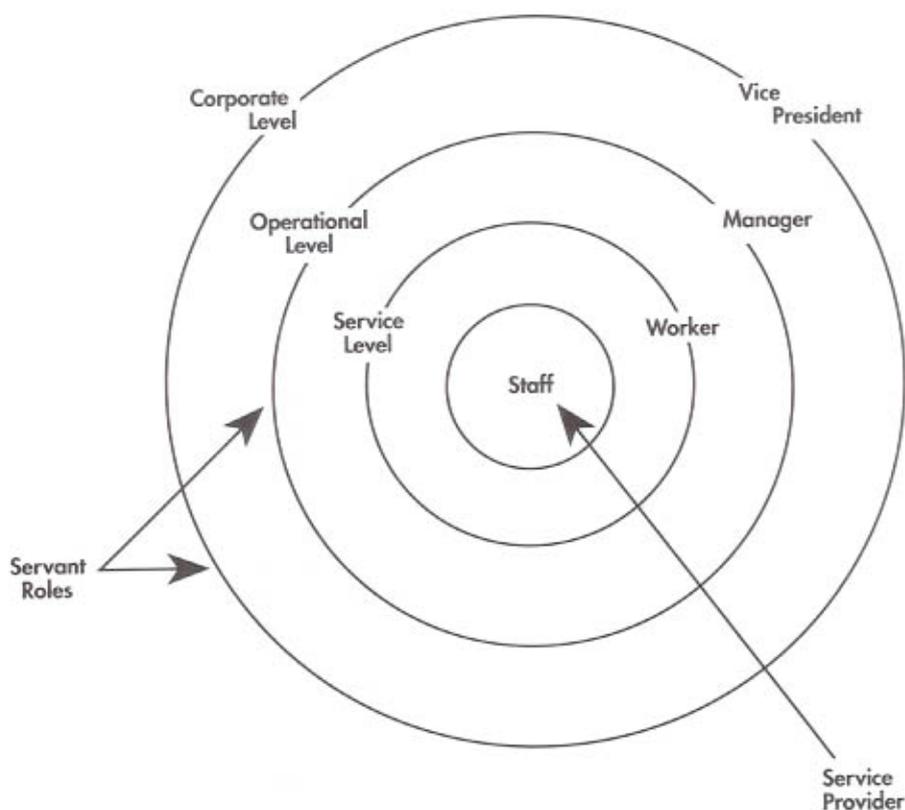
In the hospital, newer care structures and relationships will continue to emerge. Experimentation with a broad range of models and designs for care delivery will be undertaken. From case management to multidisciplinary teams and from unit-based designs to redesigning the patient care service, a transformation of service delivery approaches will occur. At the center of the new models will be the nurse, well prepared to manage the continuum of care. Regardless of the approaches created, nurses will most often emerge as the integrators and linkages in the care delivery process.

This shift will create a different relationship both within and outside of the profession. The organizational ties that bound the nursing organization in the past will be altered. Newer ways of connecting with the profession and maintaining a nursing frame of reference and support will be the major work of the profession over the next two decades.

Anticipating this change, nursing leaders in service and management will have to dialogue with each other to create organizational structures to support these newer relationships and service arrangements. The current organizational models, including shared governance, will have to adapt to these newer realities. Indeed, much of the structure of the nursing organization may assume a different look in the new health care system (see Figure 10-2).

Nurses will continue the need to be flexible and available to offer health care services in a variety of ways. Some exchange of value must result for the newer, direct health care provided by nurses. As the relative value of a nurse and the nurse's time are calculated within the system, newer ways to manage the nurse and connect with other nurses and the system will be developed.

Important in this consideration is the reality that the health care system is becoming increasingly decentralized and noninstitutional in its service framework. As the institutional services in health care become increasingly constrained, offering services in other ways and in other settings must increase. Home and community-based service structures will continue to emerge to address the need for services no



**FIGURE 10-2.** The organic model for the twenty-first century health care organization.

longer provided by hospitals. The opportunities for nurses to provide a growing array of services will be magnified almost yearly. Most new employment of nurses is not within the hospital structure but rather in other settings. How will nurses and nursing as a profession stay connected when its members are working in a variety of service arrangements in the communities and neighborhoods of America? How will nurses of tomorrow maintain their identity with the profession when they may spend more time working with other disciplines than with other nurses? Indeed, nurses may not see other nurses in their practice and may identify more strongly with their own work settings than with nursing colleagues.

Current organizational models do not accommodate this newer (older?) kind of nursing practice. The values of the profession and the unique contribution of nursing to the health of the community may become lost if there is not a mechanism to conform to the new framework for nursing practice.

The shift in nursing practice will require a new look at an old issue. What is the appropriate base of education for nurses who must manage their own practice and who will be devoid of the extensive supervision and policy control in the decentralized setting? Indeed, the system will not be able to provide enough managers

to supervise all the new arenas of practice even if it so desired. The overhead and duplication necessary for such supervision would overwhelm the system and could not easily be economically justified.

To provide both the practice expertise and credibility with other disciplines, an advanced level of nursing education will be needed to ensure viability in a different competition for services. As other professions are increasing their educational expectations for their practitioners, nursing is still reacting to the entry into practice issue at the functional level of practice. Still a more than adequate supply of cheaply prepared highly technical registered nurses is being prepared in the United States. As the numbers of less educated nurses increase and become the majority of the nursing profession in the United States, the vocationalization of the profession will proceed over time. This may occur as the demand increases for nurses prepared at higher levels of expertise to assume direction and control of the complex array of health-based activities consumers will need if costs are to be reduced.

The demands of interdependent practice are based on the need to effectively communicate with physicians and to relate with other well-educated health professionals. This relationship demands that nurses be capable of meaningful professional relationships, able to articulate their role with reason, and prepared for patient- and self-advocacy. It is difficult to imagine that nurses with associate degrees may progress to the dialogue stage with other disciplines. The inequity of their information base and their inability to articulate, in comparable terms, their value and relationship within the same context that other disciplines have come to expect can cripple the achievement of professional equity. This is especially true when the other profession's minimum provision for professional practice is comparable to graduate preparation. If nurses expect equity in role and treatment, they must manifest the accoutrements of equity and exhibit comparable evidence of equivalence before the relationship can develop. In preparing for the future, nursing leaders must be cognizant of the need to change the educational focus from basic preparation to advanced education in those service areas that will be in greatest demand: community health, psychosocial, gerontology, women's health, midwifery, nurse practitioner, family practice, etc.

The new paradigm for health care is emerging in ways not previously imagined. The "old script" is not adequate to the needs and the current valuation of a non-illness-based health care system (Lamm, 1990). The traditional players are subject to the vagaries of a radically changing time. Physicians have long escaped the controlling characteristics of a limiting dollar and are now facing that reality with ever-increasing trepidation. Nurses have been directly insulated but no less affected by the changes and will have to soon directly account for their value in the delivery system. This entails translating their work value and economic value into concrete data to support the health system's continued investment in their services. Nurses must not expect responses to their demands for compensation, benefits, and other perks that are not somehow related to the result of nursing activity. A changed understanding and relationship between health care leadership and nurses is a certainty, but there will also be a changed character in the relationship between nurses and others. Expectation on demand is not sufficient.

The collective bargaining process so valued by organized nursing will also be subject to a change in role and character in the near future. As the challenges of the workplace change, the very nature of work relationships and the processes associated with collective bargaining cannot remain unaffected. At a time when polarization in the workplace serves no purpose, logistics that depend on polarized positions can only be failure strategies (Porter-O'Grady, 1990). When the opportunity to seek increasing shares of the economic pie is no longer viable because there is no increasing size to that "pie," efforts to maximize one's advantage at the expense of the other cannot succeed. All who share work in the enterprise are stakeholders in the work and the workplace. Seeking unilateral advantage without consideration of the outcome is simply an example of organized suicide. Neither management nor labor can "win" in a time of constraint if both parties cannot compromise, use the same language, mutually invest in the well-being of the workplace, and consider the impact of each party's decision on the viability of the other. Neither will survive with this flexibility. When the enterprise fails, there is no one to pick up the pieces and all the players are losers. The issues of rights, prerogative, due process, etc. pale when there is nothing to negotiate and no one is left to do the work because the place is no longer in business (Maraldo, 1990).

Some may argue that this scenario is simply an overdramatic representation of the current situation in health care. It must be noted that in the United States hospitals and health care facilities are closing at an average annual rate of more than 100 a year. It might be wise to ask nurse leaders in rural communities what it felt like when their hospital could no longer remain open and their roles were no longer available to them. Whether nurses are regarded as "labor" or "management," it behooves all nurses to consider how they can move from the periphery of the relationship with each other to the center, where the best interests of the profession and the enterprise are a mutual concern to nurses regardless of role and where the nurse can undertake consensus building processes. Nursing's collective future will depend on it.

Just as the relationship among nurses will be affected in the future, regardless of role, the role of management will change as well. Perhaps the most-changed role in nursing will be that of the nurse manager.

Management has undergone significant role redefinition in this century, but the fundamental expectations of the manager in the organization have not substantively changed for generations. Much of the manager's traditional role is based on a set of beliefs about the worker and the workplace that has remained unchanged. Many characteristics of the hierarchical structure in most workplaces reflect an almost primordial mistrust of the worker and a fundamental belief that the worker has little place in policy formation and direction setting for the organization. The worker has been viewed primarily as the person assigned to *do*, not to think, strategize, plan, or make decisions about work and how it is done. In fact, much of the research reflecting the modern view of the worker (the so-called scientific view) is based on work done in manufacturing settings and assembly line work environments (Hersey and Blanchard, 1989).

As indicated earlier in this chapter, the emergence of the knowledge worker has greatly changed the workplace and the attitude about the role of the worker in pol-

icy formation and direction setting. As Toffler and others have indicated, the success of the organization may chiefly depend on its ability to incorporate all of its participants to varying degrees in formulating and implementing the organization's strategic plan (Toffler, 1990).

The emergence in nursing of a professional consciousness will change the way nurses view their role and participation in the organization. In an age of equity, it is not surprising that the woman of today who is also a nurse is less accepting of arbitrary or third-party determinants of what she does and how much control she will be allowed to exercise in her role. Having reached a certain level of maturity (the average nurse's age is 41 years), she is more balanced and aware of both her own contribution and expectations. At the same time, the nurse entering practice today is much less accepting of predetermined parameters and is more willing to set her own. What is frustrating and also liberating about these "new nurses" is that the parameters are constantly shifting and they are willing to shift their circumstances to suit the changing condition of their lives. For nurses in the baby-boom generation who now seek some stability in the environment, these new nurses can be discomforting and destabilizing and appear noncommitted and selfish. Having been raised with plenty and few restrictions on their possibilities, the new nurses represent an entirely different view of their world. Although this may appear, in the short term, as a cultural clash, it is really a complementary process. After all, it is the mature nurse whose children are now entering the profession. She inculcated the higher levels of expectation and demand now exemplified by the new nurse. Although the new nurse may yet be naive about her place in the world, her levels of expectation regarding her life and its direction represent a new mode of thinking and behaving that will invariably have to be accommodated (Muff, 1988).

For the foreseeable future, nurses will seek a greater role in influencing what they do and exercising control over their lives. It is widely known that the shortage of nurses is not a temporary condition. Nurses know their value and will increasingly wish to see that value expressed in substantive ways. Nurses recognize how difficult it would be to operate a health care venture without their presence in the system.

There is also an increasing demand for nurses in other health care settings. The hospital is no longer the most viable option for planning a future in nursing. Indeed, the greatest new demand for nurses is outside the hospital: community-based programs, HMOs, insurance companies, private sector companies, private practice, per diem services, etc. These demands will increase as hospitals compete with these attractive options.

As a result of these changes, the best-educated and brightest nurses will abandon the hospital, leaving behind a majority of highly skilled but technically focused staff whose frame of reference for practice will be primarily intervention. These functionally focused nurses will have a narrow range of practice and will operate specific to the hospital environment. In the nonhospital setting as well, these same nurses will provide primarily functional, task-based, and supportive roles to the more broadly prepared nurse. The move to creating a technical/professional framework for the continuing transition of nursing education in America

will, therefore, have to be accelerated. Indeed, this differentiation is already a concerted need. Anticipatory changes in the education and use of nurses will be required to adequately address the real need for them in the near future.

Many nurses currently prepared and in practice at a wide variety of levels see their future role as a threat to the current paralleling of all nurses regardless of basic preparation or real ability. Differentiation by skill base will create a significant reality-based alignment of nurses that appears on the surface to disadvantage those prepared primarily for technical roles while it advantages those with baccalaureate and advanced degrees. Although this differentiation is a common mechanism for distinguishing roles in the professions, the cultural and behavioral shift in nursing is rife with political conflict and organizational transformation beyond the willingness of the profession to assume it in a significant or meaningful way.

There is one certainty in the next decade. The need for advanced practice in the health care marketplace will continue at an accelerating rate. If the nursing profession cannot respond proactively to the need, the system will respond in other ways and the nursing role will continually become more functional, vocational, and managed outside of the constructs of a professional frame of reference. Nurses with advanced preparation may simply move into another social descriptor for themselves and nursing will lose whatever equitable professional delineation it currently has or will have obtained in the future.

## THE NEED FOR A STRUCTURAL MODEL

No major change or social transformation can occur without a structure to provide form and direction. At a time when historical structures are continually being questioned with regard to their efficacy and effectiveness, newer models are being proposed almost monthly. The question raised during this time of transition is: What is the most appropriate kind of structure needed by nursing organizations or organized nursing to assist it in bringing form to the changes nurses must undergo to prepare themselves for an ever-changing health care system?

Regardless of the structures designed or selected by nurses, they must be internally integrating, capable of presenting an image of solidarity, involve all those who practice nursing in decision making, and respond to the increasing demands on nurses to lead change in reformatting the American health care system. The model for change should reflect the need for change and be service based, reflecting the cultural circumstances of each of the organizations from which they will emerge. Increasingly, these models will have to reflect involvement of smaller units of nursing activity to include nurses at all levels of activity in the organization. This process will have to invest all nurses directly by affecting nurses where they live their lives and make changes in the way in which they relate, problem solve, and work. Failure to adjust circumstances and relationships at the work level of the organization means failure to make any substantive change in important areas in the practice places where most nurses spend the majority of their nursing experience (Porter-O'Grady, 1988).

Perhaps the most significant issue affecting shared governance today is the fact that many organizations that *claim* to have shared governance do not. One of the

issues that often develops in nursing service circles is reflected in the wide disparity between what nurses say they are or do and what actually exists. Unfortunately, in such situations, people believe only what they see. Health care leaders outside of nursing often chide nurses for talking grander than they live. To them, such talk often appears more dream than truth. Credibility is directly affected by such situations. This same circumstance affects the perceptions of others with regard to the development of nursing shared governance (Porter-O'Grady, 1989).

Shared governance creates a significant shift in both the structuring and empowerment of the nursing organization. It makes some fundamental changes in the way the professional workplace is conceived and operated. It is not an old message in new clothes. It is not a new way to be nice to workers. As the preceding chapters clearly illustrate, shared governance is a major undertaking that does not occur overnight and cannot be undertaken by either management control or fiat. It creates an organizational and operational system that reflects the values of professional accountability and builds structures to ensure that such accountability is obtained and maintained. Shared governance creates the form and process that leads to a level of equity behavior in the nursing organization such that it relates to itself and to other disciplines in a manner reflecting its value, commitment, role, relationship, and leadership in the provision of health care services.

Shared governance is not an end in itself. It is a means to an end. It demands that those who undertake it have a notion of where they are going and are willing to undertake a concerted and collective effort to attain their goals. It is, therefore, ever-shifting and changing in both form and structure. One does not arrive at shared governance. One travels along the road of shared governance to move to newer places and roles as the health care system and the American public demand.

Nursing must be able to confront the changes that affect it in ways that are at once both challenging and responsive: challenging, insofar as an appropriate proactive response must be constructed; responsive, insofar as the needs of those who seek response are addressed. The structures within which nursing's work unfolds must permit the broadest possible investment and dialogue but also an accountability that ensures adequate response that leads directly to effective action. This cannot be accomplished successfully without much transformation and work in the nursing service.

The structural models addressed in Chapter 4 serve as a framework for discussion of current approaches to formatting shared governance in those organizations initiating such approaches to create a professional organization (McDonagh, 1991). Most of this book is devoted to issues of implementing shared governance in a variety of settings. The issue for future consideration is: What about tomorrow? Will this model as described herein serve the profession well as it moves into the twenty-first century? The answer is a resounding *no!* No model of organization is fixed in time. The social and relational realities are always changing. Organizations of professional workers, especially, must always be free and ready to meet the needs of a changing society and service framework. Included are the responses undertaken by a profession to the changing demands on the profession itself.

Newer delivery models will emerge that reflect a different sense of community in the delivery of health services. Integrated, multidisciplinary, joint-ventured