

models of care delivery and professional relationships will continually unfold, creating entirely new ways of serving patients. Openness to inviting others who are not nurses into a stronger relationship with nursing will be a clear characteristic of the health care enterprise. In many ways, nurses are leading the way into these newer models by creating them as a response to a demand for more effective and cost-efficient service models.

Health care will continue to move toward a community-based approach to the delivery of health care services. Driven by cost considerations and the continuing changes in the demographics of health care, much of what is offered will not be centrally institutionally based. The question raised by this reality is: How will nurses stay integrated and professionally connected in increasingly diverse service settings and nursing roles?

Newer kinds of service and organizational structures must be formatted to address the changing frame of reference for nursing practice. The wide diversity of practice and disparity of practice settings and roles will drive nursing to organize and structure itself in ways not previously considered appropriate or legitimate. Economics will continue to influence the types of service structures and the business relationships that exist in health care. Regardless of whether a universal payment structure emerges in the American health care system, one thing can be assured: there will be fewer dollars available for intervention at the high-tech and terminal end of care services, and more dollars will be moved to address both prevention and chronic health needs as the population ages.

To ensure the necessary service integration and continuity and to build on those structures already present in the system, hospitals and health centers will continue to play a key role. The relationships, control, and services in these centers will adjust considerably over the years, but their role will still be central to effective delivery of health services.

In these "health service centers" a high level of control and coordination will be exercised, even though much of the services provided will be offered outside the institutions. Through complex computer networks, hospitals will control everything from patient data, service characteristics, pricing, and charging. Human resource use will be monitored just as patient care reporting, providing both care and cost information to every provider regardless of service location. Payment for services will be more directly related to the service provided; therefore salary or fee rates can be more accurately documented and matched to the services provided by the professional and the cost/benefit relationship can be clearly described for both institution and provider. Thus both the cost and income obtained in nursing services can be more clearly calculated and tied with other important data to determine the value and contribution of both the service and the nurse to the viability of the enterprise. This information can help nurses maintain data with regard to the cost of providing services, their value in the situation, their contribution to the organization, and its contribution to them.

These information networks will become more user friendly and more valuable over time. As they become better-operating and can provide some direct support to the nurse, they will be more successful not only as tools for reporting but also as mechanisms for better managing care and integrating the workplace.

These mechanisms will not be sufficient to provide the kind of integration and identity that members of a profession indicate they need. The connectedness of each to the other is one of the requisites of professional relationship. The ability of the profession to ensure it is meeting the demands placed on it by society is just as important as anything else nursing might do. To do this, however, nurses must be able to connect with each other and study the work of the profession beyond simply the level of individual work. As a profession, nurses have some collective obligation for the broader issues affecting not only what nurses do but also the effect of what they do on the whole health care system.

The work of shared governance is to increase the act of partnership between the profession and the organization in the provision of health care services. In the initial stages, however, this partnership has more to do with creating the structure and behaviors in the nursing organization essential to partnership than actually creating real partnership within the work context. The initial effort of the nursing organization in shared governance is attempting to create organizational models that emphasize mature adult-adult relationships in the workplace. Because of the tradition of ascendant behaviors on the part of the medical staff and administration with regard to the roles of any other practitioners in health care, the real contribution of others was never fully evidenced or acknowledged in the health system. Often, as in the case of nursing, its own internal and external behaviors did not reflect well or equitably on itself or with either of the "power groups" in health care. This was a reinforcement of the perception in the system that nursing and other groups were and should be subordinated to the physician and administrator, whether legitimate or not. Because it has been so much a *circumstance* of the relationship between the groups in health care, time and history have made it now a *condition* of the relationship.

As health care evolves toward new models that reflect a different paradigm, relationships and the prevailing assumptions about them are subject to question. As emphasis in the care and treatment in a health care model, when contrasted to an illness care model, changes dramatically, so too do all the relationships previously entered into or perceived in the "old" model. It is within this circumstance that many of the future roles, structures, and relationships of nursing will unfold (Kinzer, 1990).

The reasons for and conditions supportive of inequity in health care are quickly changing. Improvements in education and opportunity for women and thus nurses have accelerated at an unparalleled rate during the past three decades. As more information becomes more broadly generated and as specific kinds of information become more valuable, the nature and character of relationships change. As health becomes more important than illness and health care is refocused and restructured to value this reality, nurses will assume roles and relationships that will require a different self-perception and relationship with others in the health care system.

Nurses in community settings—from home to community center, from clinic to hospital—will play primary roles in delivering health care services. Often it will be the nurse who is the identifier of needs and the gatekeeper of clinical services. It may be the nurse who refers the client/patient into and through the system and on whom the physician may depend for referral and access. It will be the

nurse who may connect the patient to the service network and will work with the social service professionals to determine how various service processes can be best used to the patient's benefit.

The nursing role will become more central to the delivery of services in non-institutional settings and will become increasingly involved in decentralized settings. As a result, the nurse's ability to identify with colleagues and to maintain the integrity of the nursing service and profession will be progressively more difficult. The current move to product line and service line structures and interdisciplinary care models is just a small sample of the kinds of new structures and relationships that will be necessary to provide services in a more efficient and cost-effective manner. In addition, the modification of total quality management principles from the industrial and manufacturing sectors of the economy will influence how people are used and related in providing services in the future (Minerva-Melum, 1990). The ability of the professions to do what they do best and to maintain their identity and their value in society will be directly related to their adroitness in establishing newer relationships within their ranks that can prevail in the existing atmosphere. The structures they create, however, must be powerful enough to participate in the design of new systems, yet flexible within the ever-adjusting models of providing services.

The real work of creating professions' internal structures will be important and at the same time delicate. The professions are not islands. The nature of their representative processes and political context heightens their public visibility. It will be imperative that they not be shortsighted or self-serving in their efforts to restructure their organizations. In this effort there is a fragile balance between the needs of the profession and its members and the needs of those it serves. It may initially appear that efforts to gain increasing control over the activities of the profession can operate at the expense of increased service availability and collaborative relations with other disciplines who see a major role for themselves in the delivery of health care services. Boundary development often appears to constrain others' work or even be self-serving. Over time it will also be more difficult for one profession to work independently without the participation of other involved or affected groups.

To reach the point where the relationships of other disciplines are affected by nursing boundary developments in any but a significant way, nursing as a profession must gain stronger control over the activities of its members. Nursing must control its relationship to both the work and the workplace. Nursing practice must have as much influence on the design and choice of service provision to which it has a significant role as any other group with a major role. Because this requires considerable retooling of the workplace and the nurse as worker, much internal rearrangement must occur. All activities that reflect nursing obligations and roles under a service structure that is led and operated by nurses are included.

To accomplish such a change is not easy. Not only must nursing leaders be concerned with how nonnursing leadership responds to this effort, they also must be concerned with nursing colleagues' fear of this undertaking. Many nurses have long sought to be individually or sectionally empowered at the expense of the empowerment of the profession as a whole. Nurses have cooperated with other ad-

ministrative leaders in fragmenting the nursing organization or profession in the work setting into a number of functional organizational components responsible to administrative leadership that is either not committed to the work of nursing or unprepared to understand the commitment of a profession in the accomplishment of its mission. These circumstances have resulted in the increasing vocationalization of nursing, the definition of nursing work in strictly functional terms, and the institutionalization of the perception and operation of the role of nurses and nursing in health care delivery. Often, individuals in nursing leadership in such situations have advanced their own personal power but at great expense to the profession and its power to make aggregate and integrative change for the organization and the patients nurses serve.

In its current form shared governance responds positively to this situation. It creates a desirable organizational model that operates at the benefit of both the organization and the profession. It builds on the beliefs associated with creating work partnerships between the profession and the institution. Shared governance strengthens the relationship between nurses and reactivates the desire for "connectedness" between all nurses in the enterprise regardless of where they may work and to whom they may "report." Benefit is seen by nurses in their collective relationship, not in a polarized sense as often occurs in union settings, but instead as a part of the policy-making structure, as a partner or investor in the enterprise. In this way influence is seen as a part of the collective effort with the organization rather than one that operates as fully independent of any obligation to the success of the enterprise. Success, in this frame of reference, causes the desire to be a part of it and extends success to other members of the success group wherever they may be located. This desire to be "a part of it" operates in opposition to the prevailing behavior in nursing not to be a part of the whole, evidenced in the breakup of the nursing service into a number of nonrelated, nonintegrated nursing groups.

Although shared governance creates this opportunity to again "rejoin" nurses, it does not and has not created a forum that can be better self-described and self-controlled. Nursing is still conceived primarily as an employee group and remains within the delineation of employee status both legally and operationally. This delineation limits the ability of the profession to behave as a true partner in health care delivery with the credibility and obligation that accompany that designation.

This reality does not improve the broader sense of obligation to health care on the part of the practitioner of nursing. As long as nurses focus simply on their component of the work and not on the whole exercise of health care providing roles, their consciousness remains functionally or task focused. This pertains to the institution and its perception of the nurse as well. Thus, today in shared governance there is a more committed, satisfied nurse with a stronger sense of self and role in relationship to others and a stronger sense of power over those things that affect nursing. There remains only to develop the role of the nurse so that the nurse sees, both individually and collectively, the obligation to set direction for health care, produce a financially viable product, tie productivity to reward, and negotiate equitably accountability for specified health care services. To do this demands a move to the next step of shared governance: nursing corporate reorganization.

## TRANSITION TO THE CORPORATE VENTURE

The movement to a new organizational model for nursing that is not institution specific is clearly a radical change. It creates a new paradigm of thought with regard to the organization and operation of the nursing service. In fact, the conception of a strategy that leads the profession in the direction of self-determination and self-sustaining behaviors is, in some circles, not in the best interests of nursing nor of benefit to the health care system.

It can be conceived that another interdependent player in the health care system would only add to the confusion and sectionalism of the professions and create communication and relationship problems. The assumption in these remarks is that there are no problems present in the current set of relationships and interactions among the various players in the system. Perhaps had nursing been at the table when policy and direction were set for the American health care system, it would not have its current problems. Historical denial of nursing access to the process of setting policy has clearly impeded success in providing adequate health care to the American public. Therefore it should be relatively easy for nurses to suggest a new approach to formalizing their activities and their relationship to the other players in the health care system.

Most of the work, however, will have to be done by and with nurses. They will have the greatest number of arguments and fears with regard to forming a new kind of structure and relationship with the health system. To separate as an entity from the current models will require much courage and engender a high level of risk. Some might conclude that to form large-scale corporate entities in nursing may take revolutionary activity with very little support in the system. This may be true, but it is more probable that it will be less revolutionary and more evolutionary than first perceived.

Nursing is doing well in the public forum and at the national level. As nurses become better educated and more astute in the political process, they are competing better for the attention of those who make policy and generate dollars to the service sector. The data on nursing efficacy are overwhelming and thoroughly validate the contribution nurses make to health care in America at a fraction of the cost of other providers, notably physicians. That process will continue.

Whereas growing national prominence and success are vital to the future of the profession, real change must occur in the service setting—where nurses practice and where the consumers of their services touch their lives every day. If behaviors and expectations do not change there, all the public effort at the national level will do nothing to substantively change the experience and role of nurses. It is in this setting that most of the changes must occur. It is also here where such changes will be more difficult and transforming.

## CREATING STRUCTURE

Shared governance as currently configured does much to change the internal operating structure of the nursing organization. It does not do much to change the overall relationship of the profession with the institution and the health system as a whole. There is an experience of change in the organization with others' relation-

ship to nursing, but mostly within the context of affiliation and problem solving. These internal changes are more mechanical than substantive. Often in these settings other professionals want to have some of the same operating characteristics and liberties as nursing appears to have. Generalized interest in empowerment emerges in a number of professional services and a generic desire to exemplify the characteristics of shared governance ensues.

These efforts to expand the influence and organization of shared governance should not be discouraged. The process is not *owned* by any one discipline, and the behavioral characteristics are beneficial to all. Indeed, nurses should work diligently to promulgate the values of shared governance within the organization to improve relationships, facilitate problem solving, and generate organizational consistency among the various work groups. Exclusivity and unilateral ownership create discord and ascendant behaviors, and alienate various groups in the workplace. It is the nature of nursing's work to be facilitating and empowering. Anything in the organization that benefits that process should be supported and encouraged. Many hospitals are developing institutional models of shared governance to create organizational integrity and consistency. Nursing should be encouraging, indeed, leading the way to develop this effort in all shared governance organizations.

Although it is important to fulfill the organizational obligation to create general stability, growth, and functional integrity, nursing must also recognize that its role in the health system demands that it continue to change into newer models. Because of the significance of the current economic and service shifts in the health care system, nurses must respond differently than they have in the past in order to participate in correcting both the excesses and inadequacies of the health system. This will require a different kind of relationship in the service setting and a different set of operating characteristics for nursing as identified above.

To achieve parity and partnership in the health system with policymakers, physicians, and administrators, nursing must have a different kind of relationship with them. This relationship must be one with both service and economic characteristics that directly affect the appropriate functioning of the health system. It must represent the economic and social characteristics of equity. The exchange between nursing and the health system must reflect a character of equivalence that includes the risk of both opportunity and failure. In addition, nursing must be able to articulate its service value in real economic terms so that the economic value can be both described and operated in a manner understandable to the payer. Simply, nursing must be able to define its service and have it compensated.

To accomplish this goal, however, a different process will be needed. Nursing is generally a service that has an aggregate of providers who furnish a multiple range of services in a collective venture. In hospitals, for example, units are staffed by several nurses who provide services to a group of patients. This model of service extends a different set of variables from the one patient-one provider fee for service model. All costs associated with nurses must reflect a more corporate undertaking than current unilateral provider-based fee for service arrangements could adequately address.

There are concurrent changes in the system that will create a growing number of venues within which highly decentralized services will be provided. These

nursing services must also be addressed by some entity that would be accountable for the delineation and management of the nursing resources that provide them. The organizations using nursing services must also be assured that the funds they are spending on these services are achieving the outcomes agreed upon at the outset of the relationship. Contracting this relationship will become increasingly more important in highly decentralized environments. If only to maintain continuity and standards of care, individual entities will require some way of ensuring that staff members who provide nursing services are capable and are meeting agreed upon standards for the delivery of nursing originated services.

How can the nursing profession prepare for the future by using models that not only assure nursing autonomy but insure nursing contribution to the service characteristics of the health system and also the outcomes promised in the original contracted relationship? Tying the service to agreed-upon outcomes and matching nursing performance to the achievement of those outcomes builds a different approach to the access and use of the nursing resource (Porter-O'Grady, 1990).

Shared governance models provide a solid underpinning for movement into newer organizational configurations. The accountability base of shared governance as identified in Chapter 2 provides the underpinnings of an organization that more clearly defines what it offers and evaluates what it accomplishes. The standards-based, quality-moderated approaches of most shared governance organizations built on the five professional accountabilities of practice, quality assurance, education, research, and resource management provide a strong framework for corporate formation. In those settings the process of nursing activities, when correlated with the outcomes achieved, builds bridges among work done, outcomes achieved, and the cost of the service. Charging and contracting nursing services thereby becomes a relatively straightforward proposition. The agency contracting for the service simply asks what it will receive for the funds expended and the nursing organization simply explains what it will do to fulfill the obligation, and a negotiated agreement with regard to service and payment is reached. Although not quite as simple as an agreed negotiation between independent parties, it does bear many of the characteristics of such a setup. Moderating the relationship are the payers, other providers, the agencies providing services, and other options in the delivery system. Also affecting the move to corporate formation are the following issues:

1. Review of political and legislative initiatives regarding the payment for nursing services in different ways than currently defined
2. Adjustment of payment formulas that fail to treat nursing as an individuated service (not a part of the "hotel" services) to reflect a more adequate application of dollars for nursing services
3. The option that non-nurse providers may emerge to offer services in a more cost-effective manner in areas once thought the exclusive province of nurses
4. The need to consider replacing high-cost providers like physicians for some services once offered exclusively by them but which could be offered by nurses with the same or improved outcomes at considerably less cost
5. A change in the employment and practice of nurses in a corporate model.

Nurses would seek privileges with the corporate entity instead of the service setting. The corporation would then sell individual or collective services to service entities as contracted.

6. Determination of the cost saving advantage of this approach to nursing organization and service. It can be reasonably assumed that since negotiated roles would reflect dollars available in the system, such nursing cost would not increase any higher than the current rate; indeed, it could be conceivably less.
7. The effect of newer configurations of corporate nursing services on the "master-servant" relationship as currently described in the American legal system. Also affected would be the traditional employee base, influencing the collective bargaining process as applied to the traditional workplace arrangement. Newer models of relationship in a professional corporation would ultimately emerge.

Shared governance has provided a solid base for moving to more independent corporate structures. This can be accomplished over time by degrees: from internal operating structure to collateral corporate entity (a part of a health care holding company arrangement), to independent, freestanding corporate venture comprised of professional nurses.

Bylaws formats provide the first step in the transition. The professional nursing staff that emerges in a shared governance system requires, at some stage of the transition, the formulation and approval of bylaws for the nursing organization (Porter-O'Grady, 1985). Eventually, these bylaws must be approved as the operating characteristics of the professional nursing staff within the context of specific hospitals or health care agencies. The boards of trustees of those organizations must approve them before they have support necessary for them to be credible and a recognition of the professional independence of the nursing staff.

In the bylaws, format (see Chapter 8) and content are the basis for beginning identification of nursing as a corporate and independent entity within an organizational context. The seeds of its own corporate identity are born within the bylaws structure. This may raise concerns for some of the hospital leadership. To some, the idea of an emerging nursing corporate entity not strictly within the exclusive authority base of the institution is a threat to operational control and organizational integrity. This opinion reflects a strong attachment to the unilateral control structures of the industrial age. It is not consistent with the multilateral designs for organizations that reflect the partnership between the organizational system and its knowledge workers.

Most of the effort that will effectively move nurses to corporate arrangements will unfold in newer delivery arenas. As health care moves into the community and nurses assume a greater role in creating, managing, and providing services in these settings, opportunity will abound for new corporate arrangements. Joint ventures, collaborative practice models, community nursing centers, birthing clinics and centers, and gerontologic service centers are just a small sample of the opportunities for nursing-driven service arrangements. As preventive measures assume greater significance in the health system as an effort to reduce cost, there will be

even greater opportunity to expand the role of the nurse and extend organizational relationship.

Contracting relationships will create an arrangement that reflects a payment for services provided based on outcomes achieved. The satisfaction with outcomes will have to provide the relational base for nurses in the future. Nurses will need to recognize that there is a direct relationship between what gets accomplished and what people are willing to pay for. Individual nursing income will reflect the nurse's relationship to that reality.

In these settings productivity will also have its own reward. Increased opportunity for investment, income enhancement, and ownership for nurses will be afforded by their agreement to enter more fully into the activities that produce more revenue or income or reduce costs, thus enhancing nursing corporate margins.

Differing models of corporate arrangement will also be reflected in the newer health service arrangements in the future. Professional stock ownership models may materialize that make every member of the corporation a stockholder, investing the worker in the enterprise and its success. Program bonuses relate the nurse to the provision of additional income based on delivery of services that either enhance revenue or reduce costs in the organization. Whatever approach is taken, it will demand a different relationship between the individual nurse and the corporate entity.

There will also be demands on the organization that offers health services to enter into a different kind of relationship to the nursing service. On both sides of the issue, there are some significant concerns and issues affecting the future of the nursing relationship. Of benefit to the health care entity is the ability to contract within the parameters of the relationship clear to them. Outcomes can be identified and some measurement of the relationship between process and outcome can be included in the evaluative processes. Dollars spent can be accounted for and budgets can be reasonably definitive. Nursing benefits by a relative independence regarding how best to use dollars, some freedom regarding use of funding, and movement of funds when necessary to facilitate appropriate outcomes. Service delivery frameworks can be better controlled and adjusted based on their achievements for both the patient and the organization. This mutuality creates a more equitable and thus satisfying relationship for both parties. In such a setting much better outcomes for each patient should result.

Nursing is changed in this relationship in a significant way. The many arguments for status quo and for dependency values fade in an accountability-based relationship. The argument that the profession has a diversity of participants and therefore a justifiable diversity of commitments and outcomes will not be valid after shared governance systems are implemented. If a profession is to have any measure of influence or impact on its constituencies, it must have some measure of certainty with regard to what it can expect from its practitioners. Certain levels of performance, commitment, and expectation must be in place. If the profession cannot rely on the commitment of its members to achieve its agreed-upon outcomes, it should expect that it is seen as nonviable and therefore should be eclipsed by those who are viable.

As the profession enters the mainstream as a corporate partner in health care, it

will find that the competition is tough and the expectations on performance are high. Stakeholders in the health system fight hard for their territory, their stake. If they think that it is threatened or compromised, they respond with passion. That is how the game is played in a free and open economy, and indeed, how it should be played. No one will acquiesce to the nursing venture based solely on demand. Evidence of nursing viability, maturity, and performance ability will be the primary factors influencing choice of nursing as a preferred service.

Political savvy will be essential in negotiating a place for nursing and competing with those whose perspective is different but who are just as interested in their viability (Rogers, 1990). Some in the health system have difficulty with this perspective. This is especially true in the age of total quality management in which the difference in work groups is somehow supposed to blend into homogeneous work groups whose sole interest is in the benefit of those they serve. Although collaborative strategies are essential in the emerging workplace, they will not be successful unless they represent the needs of the professional. Service is not a unilateral or unidirectional activity; exchange is involved in the relationship. This exchange demands some level of mutuality and all parties must obtain some value that is both rewarding and meaningful. Professional values will not disappear but must be moderated by the need for relationship and the mutuality that is invariably associated with success.

## **INFORMATION STRUCTURES**

Regardless of the form that nursing service corporations take in the future, they will invariably be linked by computerized data systems. It is inconceivable that nursing leadership will be able to operate multilocational activities in the same way that single institutional services were managed. These entities will have neither the resources nor the time to manage in models that worked in the traditional hospital. The need for informational support also will increase dramatically in the future.

The ability to document clinical activity has already been eclipsed by the activity itself. Nurses can no longer expect that they can even approach the level of documentation necessary today and in the future by using manual methods. Changes in the system and in the patient now occur at a rate demanding immediate response. The tools of information necessary to respond to these circumstances are already needed today and are essential in a distributive delivery system like that envisioned in the corporate framework.

Clinical nurses must be self-managing in ways not previously expected. Because they may never enter the corporate center, they will have to be connected in ways that provide access to both information and direction with regard to clinical and corporate activities. Nurses must be computer literate and be able not only to access appropriate information but to analyze and evaluate it as well.

The system will need the nurses' expertise with computerized systems because both the quantity and quality of their work will affect the nursing corporate venture. Nursing performance and productivity will also be measured by the kind of data that appear in the system relating what has been done with the expectations

for the service. Previously redefined quality indices will be built into the system and performance measures will be evaluated against the expectations. Clinical, service, performance, and financial demonstration will be readily accessible to the corporate leadership as well as the involved nursing staff.

Sophistication with the generation, collection, and interpretation of data will be an ongoing expectation of the practicing professional. This will be especially true of nurse leaders in the various service settings. They must be able to make quick judgments and respond appropriately. Because it is the primary tool of communication in highly decentralized settings, nurses must have facility in computer use.

The data produced in a corporate setting by clinical nurses will include operating and finance data related to the service provided. No longer will clinical providers be insulated from the information that affects performance. The computer provides information about the efficacy and viability of nurses' service. The availability of greater amounts of data will enable nurses to respond to changes in situations and how they respond. Nurses can be held accountable for the data and it becomes a management tool without substantial on-site supervision.

The preparation of practitioners clearly reflects the need for more highly prepared nurses. There will be an increasing need for master degree preparation in these decentralized service settings. Educational institutions must be cognizant of the need to accelerate preparation of highly trained specialists for these roles. This will entail continuing emphasis on retooling education to prepare fewer nurses with associate degrees for an environment with a decreasing need for these practitioners and encourage the preparation of nurses with advanced degrees in an era of increasing demand. This will not occur without "noise" both within and outside of the nursing profession. There are as many vested interests within the profession that do not operate in its best interests as there are on the outside. Because of personal value or need, there are many who perceive changes in the status quo as a significant threat. It is noteworthy that nurses who decry patients' or the health system's lack of insight with regard to health-giving behaviors often exhibit those same attitudes and behaviors when changes must be undertaken by the profession to better respond to a new set of demands and retool nursing for a new role in the future. This is further enhanced by these same nurses who are appalled when someone outside the profession suggests changes that respond to a current or future need in a way that threatens the nursing profession but could have been anticipated if nursing had previously addressed the issues.

## CONCLUSION

These are exciting times for nursing. The challenges and opportunities are almost overwhelming in their number and intensity. The paradigms for the health care system are shifting even as they are being conceived. There is no real model remaining that can be considered adequate for the future—the rules are changing before the health care system has time to adequately respond. The system costs more every day and provides less meaningful service. There are cracks in the health care system, just as in American society at large, that are indicative of far more serious concerns.

The world is shifting to a new reality (Morris, 1990). There is no conception of what that reality will look like. There is no single script that will clearly define the preferred route to the future. Many scripts continue to be suggested and just as quickly are questioned or replaced by new options and suggestions. The players in the health care system are experiencing the pain of a disseminated system and are afraid of what it portends.

As with all major social change, there are opportunity and danger. Both appear to be couched in the same context. Perhaps both are the same thing viewed from a different perspective. Those who envision a response and are willing to assume the burden of not only creating a meaningful future but also living it will be well positioned to make it reality.

For nursing this time is either constraint or opportunity for arriving at a level of full maturity and partnership in the health care system. Shared governance provides every latitude necessary to develop and live the maturity and creativity necessary to make the health care system effective and meaningful. It provides a framework for nursing and nurses to become equal members of the health care team and to define more clearly their role and contribution.

Shared governance is really a model of professional maturity because it demands a professional, proud of the profession, desirous of being in control of professional life and of making a difference in job performance and quality. Such nurses want to play their role as full partners in decisions that affect their practice and are willing to make the necessary commitment to do so. Nurses in a shared governance model no longer worry about whether their services are valuable to the system. Instead they recognize that they are even more valuable than previously conceived and are anxious to provide form to that value by translating it into an economic and policy reality. Shared governance creates the milieu that ensures a nursing partnership in the health system. The nurse expects to both act and be treated as a partner in decisions that affect the future of nursing and the future of the health care system.

Shared governance creates a framework for even greater transition of both nursing and the health care system. Nurses recognize their unique contributions in relationship to the contributions made by others. They recognize the need to change how nursing relates to others and offers its services. The changing times call nurses to form new kinds of arrangements for doing their work. Corporate arrangements that create parity and newer opportunities to offer nursing services in different ways are the next major step in creating an equitable and viable nursing profession and service in the future.

This book has focused on the characteristics of implementing a shared governance system in nursing or any other discipline. It has emphasized the developmental characteristics necessary to create a successful model. It has not prescribed any specific approach. The authors have recognized that many approaches can work provided the principles guiding belief in shared governance are maintained.

There is no risk-free way to implement shared governance. If readers have implemented shared governance without significant "noise" in the system, then they may need to review whether shared governance is truly in place. To introduce this model into existing systems is inherently threatening to the operation. It changes relationships and the role of nursing and the nurse in the operation of the system.

It matures the nurse and creates an adult-to-adult frame of reference. It raises the expectations for communication and interaction, and sometimes raises questions that are uncomfortable, direct, or difficult to answer. Administration and management must change the way in which they relate and interact with the staff. Secrets are much harder to keep and adult-to-child communication strategies between management and staff are highly unsuccessful over the long term.

Benefits to the organization are extraordinary. Higher levels of satisfaction among the nursing staff and with the nursing organization are normal outcomes of shared governance. Higher levels of involvement by nurses in the organization are reasonable expectations. The maturing of the physician-nurse relationship is also strengthened by the shared governance model.

As with all systems, however, shared governance is not the end of a transition, rather it is simply a beginning. If the model is complete in itself, it has not served its true purpose. As previously indicated, shared governance is a vehicle—no more, no less. It provides an organizational framework for behavioral and systems changes. If it does not transform itself to the next stage of change, it can become an agent of stagnation and decline. Shared governance should provide a forum for safe risking of efforts to change and itself changes as the demand for movement indicates.

It is a time of great hope, great pain, anticipation, and uncertainty. It is a time to seek vision and leadership. The visionaries and leaders must come from different backgrounds and be able to join their visions and energies to create a new reality for the world. Today's nurses are transformational people, neither here nor there but rather perennially on the journey. The future will arrive soon enough. Its appearance depends primarily on what is done with today. Shared governance creates a way to make the future real and provides a vehicle which the nursing profession can use to join with others in taking the health care system where it needs to go. Health care needs what nurses have to offer; nursing needs a way to offer it. Shared governance provides the format for involvement, investment, leadership, and change for nurses and others. What is needed is the simple encouragement of leadership to emerge and join in writing a new script for health care wherever it is offered. That is what nursing was and is and upon which its future will be built.

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