

2 *A Decade of Organizational Change*

Tim Porter-O'Grady

SHARED GOVERNANCE: THE CALL FOR CHANGE

It has been more than a decade since the concept of shared governance began to be implemented in nursing organizations throughout the United States. The three originating hospitals, St. Joseph's in Atlanta, St. Michael in Milwaukee, and Rose Medical Center in Denver, have not only pioneered the shared governance model but have matured in it and remain as committed to it today as when they first implemented it 11 years ago (McDonagh, 1990).

The shared governance approach to organizing and empowering the nursing profession in the workplace continues to grow in the United States at a rapid rate. More than 1,000 hospitals and health care agencies are in some phase of shared governance implementation, and more than 300 hospitals have had it in place for 5 years or longer. Data are being generated from research studies that support the efficiency, efficacy, and satisfaction of the nursing staff and leadership with the approach (Ludemann and Brown, 1989). As more data become available, generalizations can be made about the effectiveness of nurse empowerment and the satisfaction with this approach by a broad host of beneficiaries (Jones and Ortiz, 1989).

As with any "new" approach to organizing professionals and their work, much activity and energy have propelled shared governance into an identifiable, meaningful form. Although the concept has been based on solid organizational principle and theory as well as emerging notions about the professional workplace, there were no models in place for implementers to use for guidance. Rather, the "script" was written as shared governance models were unfolding.

Shared governance represents the democratic and representative principles congruent with a democratic society, but there has been little support of such approaches to empowering and organizing the professional worker in the American workplace. Other than the typical third-party collective bargaining processes, which sometimes polarize worker and workplace, there were few other models of integration and empowerment that were mutually beneficial and agreeable.

The historical role of the nurse also influenced the kind of organizational approaches that have been used in the past to manage nurses and control their work

(Henry, 1990). There was little to suggest that the individual nurse had much control over her own work, and there is much to support the fact that the nurse's role was always subjugated to the role of the physician and administrator in the hospital environment (Ashley, 1976).

There have been many changes to this scenario. The relationship between the nurse and the workplace has recently undergone assessment for dramatic and even radical change as both the health care system and its broader community undergo adjustment.

Even the research data on which much of the management process has been based have been subject to much question and reinterpretation in the past 10 to 15 years (Mintzberg, 1990). Much of the application of management and human resource theories has been based on studies conducted in manufacturing plants and industrial settings. There has been little research that reflects the unique characteristics of professional employees and the working conditions that are unique to them (Porter-O'Grady, 1986).

Only within the last three decades has there been an emerging consciousness of gender equity in the American workplace. Because of legal changes and the burgeoning number of women in the work force, much has changed with regard to the legitimate role and relationship of women and men. Some discussion regarding and attempts to create a truly equitable workplace in which gender considerations do not affect role selection or performance considerations have been initiated (Gibbs and others, 1990).

Shared governance models anticipate this reality and have served to give form to the effort to create equity in the nursing workplace and to build a model that not only represents the beliefs of equity but also provides a form and forum for the expression of the related beliefs. Much of the original impetus for organizational structuring of shared governance has subsequently been determined to be unsubstantiated. However, it should come as no shock to the reader that much of what we come to accept as gospel in health care organizations is based on a great deal of myth. The nursing leader must sort through a wide variety of behaviors, cultural values, rules, relationships and other organizational variables in order to find the truth that undergirds the behaviors of those who work in health care (Helgesen, 1990).

Because nursing organizations have seldom been successful in attaining attendant organizational support, it has been challenging to achieve generalized commitment in making workplace changes. Nurses are not accustomed to "rocking the boat" and taking control of their sector of the health care system. It can even be said that nurses historically did little to change their work status. It is surprising how prevalent this sentiment still remains among practicing nurses (del Bueno, 1990).

It can easily be said that the very nurses that organizations have prepared to be this way are practicing today. They have been socialized to behave in the most acceptable way along a path of least resistance. The truly unique and creative nurses either burn out early, slip away, or are driven away. Some of them may even become nurse managers. Childish behavior and general anger frequently emerge in the staff as such nurses act out their impotence and frustration and the

organization soon can become petulant. At best, the staff become dependent, malleable, and passive, unable to act for themselves and unwilling to expend the requisite energy to change their condition. At worst, the staff become passive-aggressive, acting out their anger by sabotaging, undermining, complaining, and refusing to change their condition or circumstances.

Although these characterizations may appear extreme and unflattering, they are nonetheless true. When there is no legitimate outlet for the nursing staff to express anger and frustration, they must find alternate ways to deal with sentiments. When the organization finds the staff's feelings upsetting and challenging and cannot accept their expression and disapproves of the associated behaviors, the energy must be vented elsewhere. Thus it is directed in the only tolerated manner, which is on the self and immediate others. The ways are often violent, demeaning, and self-deprecating. This scenario creates a neurotic and codependent organization (Kets de Vries and Miller, 1984).

If classic family systems were used to assess this scenario, the dysfunctional elements would be evident. Issues of control, mental anguish, hostage holding, parent-child role behaviors, and family violence, all would be present and extreme therapeutic measures would be recommended. The nursing "family" in the nursing organization would require much dialogue and communication and a solid reformatting of relationships to determine a healthier way for the parties to interrelate and interact.

This backdrop provides the impetus to study organizational models that would change the relationship between staff and management. The dependency characteristics benefit none in the profession and therefore have no real or legitimate social value. Both the organization and the profession must mature with regard to their relationship and neither can remain unchanged. Both parties need each other, but not in ways that represent an unhealthy continuation of their past dependencies and dysfunctional behaviors. A newer model of interaction representative of an adult relationship is necessary to create a positive framework for interaction. It is in this context that shared governance takes its form and provides its meaning.

Leaders involved with shared governance have reflected on this historic conditioning and sought appropriate strategies to define a newer, healthier, and stronger relationship between the profession and the workplace (Pinkerton and Schroeder, 1988). When the concept of shared governance was being considered, it was thought that it did not have the seeds of any substantive changes in the health care system or the social system. In addition, the staff was not prepared for such a radical role and structural change and could never accomplish significant decisional process without substantial support from the appropriate manager(s).

The issue in operation relates to readiness for change. Change never can be fully anticipated or planned for; it evolves. The key to handling change is to be open to it and to find ways to work in concert with it. Participants should let its energy pull them into newer and more desirable realities. This is not always easy.

Shared governance as a concept applied to nursing developed from the above realities and circumstances. It seemed to address directly those operant behaviors in most hospitals that exemplified the nurses' greatest frustrations with the system. The concept appeared to confront the organizational beliefs that nurses often found

themselves confronting. The concept of shared governance forced almost everyone to look at what they were doing, how they were doing it, and at what cost (Porter-O'Grady and Finnigan, 1984).

To ensure that the shared governance approach addressed the problem appropriately, or at least was not a retread of past models, its form was squarely centered in professional accountabilities and nonadministrative-driven values. Most management principles in the United States were the fruits of research done in industry and manufacturing plants (Witte, 1980) and are not particularly relevant to the values inherent in nursing. Nursing, on the other hand, is a knowledge profession with an emphasis on professional value formation that often puts it at odds with a workplace, the hospital, determined to shape its workers in values of its own making. When nursing education was centered in hospitals, the task was relatively easy. As nursing education moved into independent schools, the task became harder and nurses were less predisposed to manipulation of their values. Dissatisfaction and other negative responses about the relationship between nurses and their practice settings have accelerated over the past three decades.

More recent research in work settings similar to nursing's has shown that an entirely different approach is necessary for successful relationships between the work setting and the worker (Peters, 1987). Control, influence, partnership, and recognition are all terms emerging in studies of the last two great commissions studying nurses and their needs. The orientation of the hospital and other clinical centers toward the nurse has been in great need of retooling. High turnover rates and increasing demand for nursing services have created pressure for different approaches to organizing and managing the workplace that are more compatible with the character of the nursing profession and the needs of its members.

Of equal impact on the practice of nursing is change in the health care system. It is widely known that the United States is in the midst of tough economic times (Beatty, 1990). When the magnitude of the economic shortfalls is considered, they may be overwhelming. It is obvious that the health care system cannot remain exempt from the realities of constraining economics without undergoing some adjustment in its service provision (Brown and McCool, 1990). Demand for health care service has not changed; indeed it is increasing. Cost of service has not declined, even though the hospital-based portion of care has declined as a percent of the whole, and thus the needs of the consumer have not justified reductions in dollars available for health care services. Yet, reductions in hospital-directed dollars have totaled more than \$10 billion in the past 4 years. Clearly, whether desired or not, reduced funding forces service changes, and nursing cannot help but be directly affected. A need to be cognizant of the economic realities affecting nursing practice has driven nursing leaders to consider how the health care dollar is apportioned, the impact on nursing, and how best to respond to any resultant changes. The important point is that nurses want to respond to their own issues and make space for themselves at the policy-making tables and no longer let others decide their economic and service fates (Haddon, 1989).

The need for partnership relationships has also emerged in the nursing value system. Understandably, nurses want to play a major role in making the decisions that affect what they do, how they do it, and the impact of their work on patients and on the health care arena. Nurses have realized that they are stakeholders in the

health care enterprise and therefore should play both a policy and an implementation role in service selection and how it is provided. If the health care organization does not manage its services well and thereby suffers losses, nurses and patients suffer, too. The institution's gains and losses do not occur independently of those who provide them. Nurse providers are aware of the impact of mission, direction, and position statements that set a course for the institution for better or for worse. At best, nurses will have to work to achieve, and at worst, accept and live with the impact of these policies. As stakeholders, nurses have found that a passive stance did not ensure that service provision considerations were an integral part of decisions made that influenced patient care. As the ostensible advocate for the needs of the consumer, nurses believe it is imperative that they play a more direct and integral role in decisions that impact patient care (Burda, 1990).

It is clear that the above may be true and desirable, but nurses and nursing practice are not positioned or skilled in the processes essential to accomplish the desired roles associated with power and policy decisions. This reality is irrelevant to whether nurses can effectively make such decisions. It has more to do with the internal structures and dispositions of nursing. Can nurses legitimately be expected to both play out decisive roles and then actually do the work?

The internal dynamics of most nursing organizations do not permit a sufficiently broad base of professional involvement and investment from the professional staff to either permit staff to assume these roles, or even modify the structures and skills that would make it possible for staff to have some locus of control in these arenas. As indicated in previous texts on shared governance, history and gender have had a restrictive influence on nursing staff roles that involve influence and control. Managers, even nurse managers, have maintained this status quo. What has resulted is a passive-aggressive, dependent, clinical staff with neither interest or insight into the issues that most affect what they do (Porter-O'Grady, 1986).

This situation creates a direct conflict, and it is difficult for the nursing staff to emerge a winner. When nurse managers attempt to persuade their staffs to expand interest in their own accountability, the rewards of passive dependency moderate against nurses affirming both the energy necessary to make changes and the very value of the change itself. This, combined with the lack of insight and skill, assures that there will be limited, almost isolated, response to critical political, policy, and economic issues that directly affect what nurses do and the resources available to them.

SHARED GOVERNANCE: THE PRINCIPLES OF RESPONSE

From this context the concept of shared governance takes form. Connecting the words *shared* and *governance* is both purposeful and meaningful. Shared, because no one will get to tomorrow alone. People are inherently interdependent. Hardly anyone can do anything without impacting someone else. Shared governance recognizes this reality and, as a result, integrates unilateral action with collateral values or purposes and, through negotiation and consensus, seeks an agreeable outcome. These operational realities impact decision making and roles. There are no unilateral decisions in health care (Bocchino, 1990).

The second word, *governance*, ties the activities of the nursing profession in a given setting into the governing, ruling, decision-making processes of the entity of which nursing is a part. It indicates that as a professional discipline, nursing has a governance character with regard to its own affairs and a governance connection to the policy and directional decisions of the governing body of the entity. Such characterization is synonymous with corporate partnerships wherein each of the partners has a negotiated but defined role in both policy and the work of the enterprise. Each partner knows the extent and nature of their individual contribution and is required to exercise it because each is committed to it. Rather than being mutually exclusive processes, governance and function are correlates of each other. The essential variable in this connection, however, is that each party knows what the other party has to offer, offers it, and is thereafter accountable for what is achieved or accomplished as a result of the action. In a professional model of shared governance, the accountable professional stakeholders define their mutual and distinct relationships and contributions and collectively agree to unfold them for a purpose that is mutually beneficial and consistent with both the mission of the enterprise and the charge of the profession.

ACCOUNTABILITY

The key to the work of the parties in the work relationship is a clear understanding of the accountabilities of each of the partners. The concept of accountability is essential to the definitiveness of any productive relationship in the work context. A fuller understanding of accountability and its meaning lies at the heart of the effectiveness of any equity-based collateral work relationship. When nursing is trying to evolve into an equity-based relationship from a subordinated relationship, with all that movement implies, understanding the character of accountability becomes central to shared role definition and shared decision making.

Accountability differs from the responsibility-based processes we normally associate it with. Indeed, it has a definition that really operates in reverse of the nominal action of responsibility. Accountability within a professional context can be simply defined as the exercise of activities inherent to a role that cannot and are not legitimately controlled outside the role and for which the locus of control emanates from within the role. Conversely, responsibility is generated or delegated to the role, always has an external locus of control, is generally assigned by someone with the authority to do so, and depends on negotiation and acceptance of the delegation for fulfillment. In other words, accountability is fundamental to the role and can never be assigned away, whereas responsibility is delegated from outside the role and is, therefore, always assigned. Accountability reflects an attributed role, and responsibility reflects an assigned role. Responsibility falls within the context of the structure of the work; accountability falls within the context of the character of the work. This contrast will be rearticulated later in this chapter.

There are conditions to accountability that give form to its meaning. It is both a concept and a term that is not always characterized or used consistently. For professional accountability to operate it must meet three conditions: autonomy, authority, and control (Porter-O'Grady, 1989). The professional must have the right (autonomy) to undertake specified action, the power (authority) to implement ac-

tion, and the ability to enforce (control) the action in an ongoing and consistent manner. These conditions of accountability are essential characteristics of the professional role of the nurse. Without them, much of the definition of nursing's professional role and the underpinnings of shared governance are missing. It is often difficult to shift understanding of legitimate roles and accountability in an organizational system that is structured on the premise that there is only one locus of control in the organization that it is tied exclusively to the management role. When the conditions and circumstances of professional accountability are more clearly delineated and its differences and legitimacy recognized, it becomes easier to comprehend models that, by design, purposely structure other control points in the organization and build structure on the legitimate loci of accountability.

These issues have emerged over the past few years as important foundations for professional governance models (Porter-O'Grady, 1989). In the initial years, issues of organization and operation were secondary to reactionary strategies to change an undesirable structure that produced professional impotence in the practice arena. However, there is more to organizing work than simply objecting to the status quo. Whatever is to be substituted in place of the "old" must work better, fulfill what it purports to do, and effectively alter the conditions that drove nursing leaders to consider it in the first place. The change also must reflect a set of values that drive the move to shared governance, which give the change some meaning, and connect that meaning to some useful format. This change must empower the affected group (nursing) to make the requisite change in their best interests, but not at the expense of any others, and to the net overall benefit to those who receive nursing services.

In the formative stages of the first shared governance systems, much attention was given to empowerment structures. Although structure is important, it is not as important as a solid understanding of the principles that drive shared governance. Leaders in shared governance now understand that a variety of structures can be used to house the process of self-governing activities. Attention to structure provides a format for the concept, but no structure is adequate if it does not support the principles upon which the concept is based.

Clarifying the accountabilities attendant to the professional role of the nurse is a formative activity. Professions can generally express their accountability in the following areas.

Practice

The role of any profession is related to the work it does. Its "birthright" should be found from within its work activities. As such, those activities should result from the fundamental values and beliefs that drive the work. It is presumed that the nurse knows these and can actively apply them within the context of her role. However, often the nurse does *not* know what these premises and values are and cannot identify whether her practice is consonant with them or operates in opposition to them. If she does know them, the nurse may not always be confident that she is free to act on them and that, if conflict were to emerge from her actions, that her actions would be adequately supported by the delivery system. All of these elements must operate in consonance before they can be effectively applied.

Practice is that process whereby the professional does the primary work of the

profession. It is toward that work that all the activities of the organization and the profession are directed. It can be stated that both the purposes of the profession and its fundamental activity take their form in the work or practice of the individual practitioner. This accountability is fundamental and cannot be assigned or given away. It is directly attributed to the practitioner and cannot be legitimately located anywhere else in the organization. Included in this premise is all the attendant authority the practitioner needs to accomplish the requisites of the professional role and the expectations of those served by that role. In a governance model, this authority does not legitimately rest anywhere else in the organization. Included in this accountability is the right to control the following: position (job) descriptions, standards of care, performance expectations, career advancement, and interdisciplinary relationships.

Accountability for the above standards rests solely with the practicing nurse and cannot be legitimately exercised beyond that role in a shared governance system. The belief that the practitioner is ultimately accountable for defining practice is fundamental to the concept of shared governance. The challenge lies in the establishment of structures that support the practicing nurse's locus of control within this accountability.

Quality Assurance

Quality assurance is the second major element for which the nurse is ultimately accountable. The adequacy of practice cannot be assured without a clear delineation of whether that practice has actually achieved the outcomes to which it was directed. Because quality assurance is dependent on both the definition of practice and its exercise, it is a subset of the clinical role that takes its precedence in nursing practice. Again, the legitimate locus of control rests with the practitioner because it is a measure of the nursing role and is necessarily invested in the action of nursing practice for which only the practitioner can be accountable. For quality assurance to be appropriately carried out, it must be located with and in the practice context. Therefore, in shared governance, quality assurance is viewed as a clinical accountability and becomes a function of clinical work. The locus of control both for undertaking quality assurance and for assuring compliance with its requirements is a clinical function for which some structure must be attached.

It is necessary when thinking about the quality assurance function to recall that assurance of the quality of care cannot exist as a function outside the process that assures the quality of the caregiver. Both processes are quality assurance functions. Historically, however, the performance evaluation function that focuses on the practitioner has always been considered a management function. It has been assumed that the manager is the appropriate locus of control for this function. Because quality of care and quality of the caregiver are necessarily connected and essential if quality of care is to be provided, it can be asked, "How could one aspect be so distinctly clinical in focus and not the other?" Simply, it cannot. If the locus of control is in the practitioner for the quality of care delivered (and must necessarily be there if quality is to be obtained), then it is reasonable that determining the processes associated with measuring the quality of the caregiver must also be controlled by the practitioner. One is synonymous with the other; indeed,

they are inseparable. Historically, they have been arbitrarily separated as a matter of institutional control, not as a legitimate expression of staff accountability. They must be rejoined if they are to be fully realized and valued in the discipline. Shared governance accomplishes this. The accountabilities that normally fall within the context of the quality assurance function are: quality of care, performance evaluation, career advancement measurement, measurement criteria development, credentialing process, and privileging mechanism. The identified accountabilities form the basis of the work of quality assurance. Mechanisms for the undertaking of quality assurance without removing it from the practice setting and the practicing nurse are essential in the shared governance accountability format.

Competence

Competence is one of the vital concerns of a profession and its members. Issues related to the ability of the members of a profession and their ability to perform the activities of the profession within the standards of the profession for those activities are often identified by those outside the profession. The definition of competence and the standards that measure it are fundamental characteristics of the nursing profession and also exist as an accountability of every member of the professional group. The ability to assure the public that those who provide nursing services are and remain competent is a central activity of the professional group. However, traditionally in nursing, responsibility for competence has often been viewed as the role of the institution's management. Again, this comprises an illegitimate exercise of accountability because if the organization really wants to obtain it, it has to be placed in the hands of those who can give it, and historically, it has been placed in the wrong hands. Because accountability can only emerge from within the practitioner's role who performs the work of the profession, accountability for that work must rest with the service provider and the authority for that must emerge from the same place.

Unfortunately, both the beliefs and behaviors necessary to support staff accountability, how they perform their role, and what they need to do it often did not include the involvement of the staff affected by the rule making. As a result staff members saw those accountabilities as though they rested outside their role, in essence belonging to someone else, and their own individual ownership for them was moderated and muted. Conversely, in shared governance it is recognized that the accountability for competence rests within the role and cannot be legitimately transferred from the nurse's role. Ownership of competency accountability, therefore, must emerge in the appropriate ways in the professional organization and structures that support it in the staff role must be created and affirmed.

There is a dual obligation in the shared governance organization in relation to competence. In a profession the obligation for competence does not solely rest with the individual practitioner. There is also a corporate obligation for the competence of the whole profession, that is manifested in the individual nurse's obligation to others in the profession to ensure that each is competent to practice the profession. There is a corporate obligation of each for the other. This accountability is manifested in the obligation to both teaching and learning processes directed to obtaining and ensuring competence. Professionals are clearly liable to maintain

learning sufficient to the performance requirements of their work and necessary to the advancement of the work of the profession. At the same time they have the obligation to teach each other and to extend their collegueship to the role of mutuality in learning by agreeing to share knowledge as well as obtain it.

Learning in the service setting has always been an expectation of every practitioner, but attention to the role of teacher for every practitioner has been less emphasized. The role of teacher has been considered more a function of skill and choice than a generalized expectation of each nurse. Indeed, functional roles have been created in nursing services for just such purposes, further deemphasizing the individual obligation to teach and creating a functional service framework (in-service educator) for the role of teacher. Rather than creating structures that accommodate the education accountability in every staff member, service leaders have created a functional framework for education that actually removes individual obligation for teaching and places it in a departmentalized function. Recent movement to competency-based unit education models is a current redirection of this process back to the clinical environment and thus into the hands of nursing staff.

The three accountability areas are fundamental to any service-based delivery of nursing care. Because they represent accountabilities common to the practice of any profession, they are often considered generic to professional work. They should, therefore, be incorporated into any clinical authority structure in the organized nursing service.

Often activities that relate to the validation of current knowledge and the production of new knowledge (as identified in the research function) are not considered part of the operations of a professional service. Previous work on shared governance (Porter-O'Grady, 1984) has not devoted much space to the issue of professional research even though it is a fundamental accountability of a service profession.

Research

Research is essential to the activities of any profession. If a service profession is to remain current and to advance the work of the profession and the service it provides to society, time must be spent in research activities. The reality, however, is somewhat removed from the principle. Research activity requires time and money. In nursing, both these resources are at a premium. Although this is true, it is also important to raise the issues of competence, growth, new knowledge, and professional equity as they relate to the public and to other disciplines. It becomes an issue of distribution of resources from a number of sources for the purpose of making clinical improvements that may change the way health care is provided and the cost associated with nursing services.

Initially, in the process of providing resources for the research function, the use of operational dollars may not be advisable or even available. However, strategies used to obtain grant funding, and foundation, corporate, or private donation programs are all appropriate to initiate a nursing research function. Because the function has not frequently been incorporated into a practice framework in most community hospital settings in the United States, it is a challenging experience to initiate. Leaders can expect that both staff and management may find it difficult to

either understand or support the introduction of research activities without a period of transitional stress. Although it is likely that there may be a variety of funding opportunities in the community to subsidize nursing research, activities that support it and energize the staff with regard to its benefit should accompany any initiation effort. As more nursing organizations expand on the accountability of research in their settings, additional information regarding how to be successful in these efforts will become available. The principle of research accountability for the profession, however, is fundamental and needs to expand in the service setting if the professionalization of nursing practice is to be complete.

Management of Resources

The final arena of accountability is the management process in the governance organization and relates specifically to the management of resources. The work of nursing cannot be accomplished without the requisite resources. The organization must be equipped to deliver what it commits to—without the appropriate resources and the ongoing management of them, it is difficult to assume that anything will be accomplished. Because the above accountabilities are essential to the practice of nursing, resources directed to their fulfillment serve essentially as the context within which nursing practice takes form. Recent research has indicated that attention to the issue of resources is equal to the exercise of the work of the entity (Mintzberg, 1990). In fact, resource management is so important to the enterprise that shared governance continues to recognize it as a defined role and supports the belief that someone must fulfill the obligation of this role.

This approach differs from some recent efforts to eliminate the specific role of manager in some self-governing enterprises and to allow the staff essentially to be self-directed. In these situations, however, the role has still somehow emerged in these systems because the accountability for resources must still be attended to. Often one of the staff members assumes certain aspects of the role, becomes proficient, and is assigned that role as a functional component of his or her job. Others may take on the other resource activities, thus dividing the role among workers. What has been noted in the recent research is that it is often ineffective and poorly attended to in such arrangements and staff is often unhappy with the obligation (Dumaine, 1990).

The legitimate role of the manager then becomes highlighted. Instead of eliminating this much needed role, it would be more appropriate for the organization to clearly isolate the functional accountabilities of the role and then ensure that it fulfills the defined expectations clearly within the parameters provided for it. It should operate in relation to its accountabilities in the same way that any of the other accountabilities function in the nursing organization. Historically, the manager's role in nursing has been expanded in a way that parallels industrial structures and behaviors. The professional character of nursing "got lost" in the experience and a whole era of employee- and job-based systems and expectations arose. In effect, nursing became a vocation with all the attendant behaviors that a job orientation naturally creates. Driving this system was the ever-expanding role of the manager. The role of the staff was diminished to the same degree as the manager's role increased. The resultant problem was a highly professionalized

nursing management staff and an equally highly vocationalized clinical nursing staff.

Shared governance models reconsider this equation and attempt to address it by "reprofessionalizing" the clinical staff and more clearly isolating areas for which the staff is fully accountable and areas for which the management staff is accountable. Separating these functions and distinguishing them from each other serves to clarify and assert the appropriate roles and to ensure that each party (practitioners and management) is fully invested with both the right and the opportunity to exercise its legitimate roles.

PRINCIPLES COMMON TO SHARED GOVERNANCE STRUCTURES

As shared governance has expanded across the country in recent years, principles that guide both the concept and the development of the structure have emerged. First attempts at initiating shared governance were uncertain and risky, but later activities have been clearer in both concept and design. Previous experience and good structures as well as an emerging body of knowledge have been helpful in unfolding newer approaches. The rigid adherence to existing knowledge about organizations and implementation has yielded to more flexible approaches that consider resources and culture in their design. It is becoming clearer that many of the principles that have driven industrial model organizations do not transfer adequately to an emerging parallel and collateral work system. Indeed, many of the traditional rules for organizations no longer apply (Farnham, 1989).

In such a scenario, the implementor writes the script for implementation as the structure unfolds. Satisfaction is derived from the validation of the structure, which comes from its success, and the new demands that evolve from a new structure and its impact on creating new relationships. That is not to say that there are not principles of shared governance that apply and guide the implementor in forming a model. Some basic rules of shared governance that have emerged over the years that guide both thinking and development of an effective approach to governance are listed below.

It Is Not a Form of Participatory Management

First and most important to the concept of shared governance is the recognition that shared governance is *not* a new brand of participatory management. In fact, the concept and workings of shared governance do not reflect the characteristics of participatory management at all. The shared governance process is an accountability-based approach that may change the locus of control and spread it across the roles in the discipline depending on the accountability and the legitimate location of authority for it. It assumes that there are a number of people who have fundamental accountability for defined functions in arenas of both practice and management. As explained previously, shared governance specifically recognizes five professional accountability areas: practice, quality assurance, competence, research, and management of resources, and defines the appropriate functions that attend to these accountabilities and then structures the organization to support their exercise.

It Is Not Management Driven

A second principle of shared governance is that it is not management driven. Because nursing is primarily and purposefully a practice profession, it is reasonable that the work of nursing must be at the heart of the nursing delivery system. It is also reasonable to assume that all activities that are neither direct caregiving nor related to that process are in support of it. To both logically and systematically tie the organization together, it is essential that the priorities be properly ordered. In a professional governance model, priority for authority designation must be addressed to the practitioner for those issues that directly affect what she does. This reality empowers her and provides the basis for some definitive allocation of staff-based authority and control. The staff members, therefore, are empowered to do whatever is directly necessary to them, affecting both what they do and how they do it. For the staff nurse, it is the first and final locus of control for those issues that most directly relate to her and what she does: practice, ensure quality, remain competent, and participate in the creation of new knowledge.

There Is No Single Locus of Control

A third principle relates to the shift in the locus of control. Traditional organizational principles indicated that there must be a focused locus of control for the work of the organization that takes form in the role of the manager. The manager, in both business and industry, became the central point on which the organization organized its work and obtained accountability. This role ensured that the work of the organization was accomplished and the goals of the service or section were met. The manager integrated not only outcome but also function and ensured that all was done within the context appropriate to the work.

In shared governance it is recognized that the work of a knowledge-based practice profession has no single locus of control. Indeed, in this model, a single locus of control both is alien to the processes associated with the accountability of the nurse and is not a condition conducive to the work obligations of the profession. A single locus of control can legislate against the principle of accountability identified above. If the nurse manager is identified as the sole locus of control, then it can be assured that the accountabilities identified in the practitioner's role are never addressed and thus are not appropriately fulfilled.

Differentiation of accountabilities and the appropriate designation of those accountabilities throughout the organization is necessary to the successful exercise of accountability. To clarify this, some basic distinctions must be made between responsibility and accountability. The nurse often finds that these two concepts are used interchangeably and that they are essentially assumed to basically mean the same thing. In fact, as pointed out at the beginning of this chapter, they are very different concepts.

By definition responsibility is fluid and must always be identified by someone in a preeminent role, assigned to someone in a subordinated role, accepted by the person in that role as a condition of functioning in that role, and then completed as agreed to. The person in the role must fulfill that obligation for as long as she agrees to serve the functions the role demands. It is accepted that as the person changes roles, so will the responsibilities associated with the new role change and that responsibility does not automatically transfer. Responsibility, therefore, is al-