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# *Preface*

The rate of change affecting the delivery of health services is almost overwhelming. Nursing leaders are struggling to keep up with the demands of a constraining and changing health care system. The direction of the future is uncertain and, in many ways, frightening.

In the past, the script was clearer and the players and their prescribed roles were more certain. With changes in the economic and social variables affecting health care, those certainties no longer exist. As the cost of health care continues to rise dramatically, providers and payers work out what and how services will be offered and how they will be paid for.

The agenda for the future is unwritten and wide open. There are no longer prescribed rules and relationships that are not subject to question or change in some way. What was once considered sacred is now history. What sense can be made of all this? What is nursing's role as we sort through the uncertainties of the future? If there is no established script, who will write a new script, and what part will nurses play in its unfolding?

All of these questions drive the nursing profession as it seeks to build a new identity and determine its place in a changing health care system. Whatever the answer to the above questions, nurses need to create a forum for discussion and establish mechanisms that will facilitate the profession's response to whatever demands emerge. Nurses will have to be able to direct their own responses, make critical decisions about their role, and assume newer responsibilities in a changing service framework. Indeed, nurses may have to play a major role in defining the framework within which nursing and health services will be offered in the future.

To be able to set the agenda and control their future, nurses of tomorrow will need to be prepared and skilled in providing leadership in a diffuse and multidisciplinary setting. They will find themselves in increasingly decentralized and non-institutional settings. They must be able to assertively articulate their roles and expectations, manage their own practice, give direction in the application of health care, and establish a truly professional relationship with colleagues both within and outside the profession.

Preparation for the leadership role in nursing cannot simply be a unilateral process. Nurses must, in good measure, join in a common effort to advance the profession keeping in mind the best interests of those they serve. In every place where nurses practice together, a framework for interaction, policy formation, clinical standards, and nursing initiatives must be established and operated effectively. Nurses must be able to present an image of collaborative and collective commitment to health care and join with other leaders in health care to write and live out a new script that can better serve those who come to the health professions for services. Also, nurses must join with other caregivers in a collaborative coal-

tion to deliver health care in new ways. The old hierarchies which prescribe roles and authority that are more exclusionary than inclusive will no longer work. Nurses in all arenas of practice want to play an increasing role in the decisions affecting what they do and how they do it. As the women's movement matures and influences workplace relationships, a demand for greater participation and ownership is unfolding.

Ten years ago the concept of shared governance took form in a very few institutions across the United States. Nursing service thinkers and leaders began the struggle to create a new organizational model that better fit the needs of a professional, knowledge-based worker. Also, the unique needs of nurses, most of whom are women, needed to be addressed in an organizational imperative that respected the history and unique character of nursing. Since that time, over 1000 hospitals initiated professional governance models, often called shared governance models, in an effort to create a truly professional nursing staff. The goal, at that time, was to get nurses more invested in their work and profession and to strengthen nursing in the workplace in ways that would empower it as a profession and retain the interest of its members. Shared governance activities soon became the outcome of the recommendations of the various commissions and study groups looking at nursing and assessing its needs. More data have been generated in the past few years to validate shared governance as an effective organizational model, and other disciplines in the health care field are interested in applying its concepts to their own interests and needs. Indeed, it has become a vehicle for building the collaborative interdisciplinary relationships that will be models for the future of health care delivery.

During the years that I have been associated with shared governance, people from a wide variety of settings and from different countries have asked if there are certain principles of implementation that can be applied, regardless of the specific models that may be developed. Since all who have implemented shared governance in one form or another have been creating and learning the process at each step along the way, the underlying principles for implementation have been slow in emerging and are just now being clarified.

This book is designed to articulate the principles and processes associated with the implementation of shared governance, regardless of the setting or the model chosen. It focuses not on the step-by-step processes but on the underlying characteristics of implementation that will affect all who seek to develop shared governance, regardless of their approach. In this way, the book provides a useful reference to validate the process of shared governance and to assist in the evaluation of progress. It alerts the planner and implementer to problems, concerns, and developmental issues that invariably will emerge.

While this book provides insight and advice regarding the entire process of shared governance implementation, the planner and implementer of shared governance may need additional references to successfully unfold a professional practice and governance model. The *Shared Governance Implementation Manual* which was developed as a companion to this book, provides practical, step-by-step guidance regarding the implementation of shared governance. Together the books offer a complete resource to facilitate implementation of a shared governance model.

One caveat must be mentioned at the outset and will again appear throughout this book. Shared governance is a vehicle for change, growth, and empowerment for the profession and the professional; it is not an end in itself. It serves as a vehicle for creating and managing change and preparing a desired future. It is not *the* future. When shared governance has moved the profession of nursing along the way toward a preferred future, it will have done its work. Newer and more appropriate organizational and professional configurations will undoubtedly evolve. This is as it should be. Shared governance is, however, an essential passage along the road to the future maturing of the nursing profession. All nursing organizations will, in one form or another, need to experience its impact. To the extent that this book facilitates that passage, it will have accomplished the goal of its authors.

**Tim Porter-O'Grady**

*It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, that to take the lead in the introduction of a new order of things. Because the innovator has for opposition all those who have done well under the old conditions, and lukewarm defenders among those who may do well under the new.*

Machiavelli

The Prince

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# 1 *A Conceptual Basis for Shared Governance*

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Jaynelle F. Stichler

A new age has dawned in the management of the professional worker. The superstructure of the bureaucratic organization is undergoing a tremendous metamorphosis with new norms for managerial and employee behavior. Contemporary management scholars indicate that companies demonstrating excellence are replacing traditional bureaucratic structures with governance structures that emphasize employee participation and involvement (Naisbitt, 1982; Naisbitt and Aburdene, 1985; 1990). Organizations are recognizing the positive significance of systems that grant professional employees the responsibility and accountability for governing issues directly related to their professional practice. Organizational charts are flattening with the elimination of multiple layers of bureaucratic structures. Emphasis is placed on direct interaction between the manager and the worker who delivers the service to the customer or who makes the product manufactured by the company. Successful and progressive organizations have shifted to a collaborative style of management in which management and employees work as teams or in partnership to realize the mission and values of the organization and the goals of production or service.

## **NEW CHALLENGES IN HEALTH CARE AFFECTING NURSING**

Hospitals have exemplified the traditional bureaucratic superstructure for centuries, but current demands in health care have challenged core bureaucratic beliefs. Health care costs have continued to spiral upward despite federal mandates for their control or reduction. Hospitals that have not responded to competitive pricing in a managed care market have been closed or acquired by other, more financially successful health care systems. "Quality" health care often remains undefined, elusive, and even unaffordable.

The retention and recruitment of professional nurses and the importance of their satisfaction with their role have never been so critical. Health care employees, and specifically nurses, have become a valuable yet scarce commodity as the nursing shortage continues to escalate. American Hospital Association survey data indicate that the registered nurse vacancy rate for hospital nurses rose to 12.66% in 1989; this represented a 2% increase over the December 1988 rate of 10.6% (American

Organization of Nurse Executives, 1990). Increased acuity in hospitalized patients and increased technologic interventions require continuous and sophisticated monitoring and assessment by professional nurses. Shorter lengths of stay involving intensive plans of care and extended services after hospitalization also increase the demand for nurses. Nurses are the health care professionals best prepared to provide the coordination of patient care from home to hospital and back to home. At a time when the health care system most needs the expertise of nurses, many are leaving the profession. The shortage of nurses is evidenced by vacancies in nursing positions, job dissatisfaction in the work force, lack of organizational commitment, high turnover rates, and a diminished number of applicants to colleges of nursing. With fewer nurses to employ, some hospitals resort to using more expensive "registry nurses" when available, resulting in higher salary rates per patient visit, increased difficulty in competing for managed care contracts, and decreased profits. When replacement registry nurses are not available, hospital administrators have occasionally been forced to restrict or discontinue services, creating financial disaster for some health care organizations.

Several explanations for the nursing shortage have been offered. Career opportunities outside nursing are available to contemporary women, whereas in the past, women's career options were often limited to nursing or education. Lack of prestige and status in the nursing profession, poor remuneration for the level of education required, scope of responsibility and workload, and unsatisfactory working conditions deter young women and men from selecting a nursing career and create professional dissatisfaction and turnover among experienced nurses. Lack of autonomy and control in decisions affecting the professional practice of nursing; poor interpersonal relationships with management and other health care providers; and lack of recognition and reward for professional expertise have also been cited as reasons for disillusion with the nursing role (Bream and Shapiro, 1989; Nursing Shortage Poll Report, 1988; Office of the Inspector General, 1989).

Currently, managing personnel costs is critical to an organization's overall financial viability, but hospitals are expending major financial resources to obtain staffing through registries, to finance expensive recruitment campaigns, and to provide costly orientation programs. Nursing managers and administrators additionally are consumed by the need to retain the personnel they have and to assure their commitment to their organization.

The American Hospital Association in conjunction with other commissions, associations, and foundations has reviewed the status and image of nursing for the past three decades (National Commission on Nursing, 1981). From the myriad published public testimonials of nurses and the study findings of the commissions, several recurrent themes have been cited as critical factors leading to role dissatisfaction. These factors include (1) lack of participation in decisions affecting patient care and the practice of nursing, (2) inadequacy in the systems for delivery of care, and (3) negative interprofessional relationships, specifically with physicians and hospital administration.

Publications from numerous groups commissioned to study nursing have recommended a spirit of collaboration and collegiality among health care providers

and involvement of nurses in decisions affecting nursing practice and patient care to support the vital role of nurses as members of the health care team (Department of Health and Human Services, 1988; Lysaught, 1970; National Commission on Nursing, 1982). Magnet hospitals and other organizations that have been most successful in recruitment and retention efforts have facilitated development of organizational cultures and climates that foster autonomy, accountability, and educational growth in professional practice (Department of Health and Human Services, 1988). In a professional atmosphere of mutual trust and collegiality, nurses are active on multidisciplinary committees, governance and planning councils, and career advancement programs. Many of these hospitals encourage joint practice models as recommended by the American Nurses Association and the American Medical Association as a method of enhancing nurse-physician relationships and improving the coordination of patient care (National Joint Practice Commission, 1981). Terms such as professional networks, partnerships, interdisciplinary teams and committees, and shared governance are the hallmarks of many health care organizational mission and value statements that encourage the development of a culture that recognizes the unique and necessary contribution of each of its employees and professional groups. Although nearly three decades have passed and some progress has been made in meeting these goals, realization of collaborative practice in health care organizations still is not the norm.

What is necessary to build commitment, job satisfaction, and professionalism among nurses? What changes are needed to attract bright, articulate college students to the profession? Health care organizations are struggling with such questions without realizing that the solution may require the same metamorphosis identified by other businesses and industries. Decades of empirical studies of other industries and disciplines have demonstrated the positive effect that participation in decision making has on the professional worker's job satisfaction, but this finding has yet to be implemented in many health care organizations.

Successful health care executives are beginning to realize that cost-effective, quality service is delivered by a team of professionals who have internalized the zeal for quality patient care, who are committed to the organization, and who are empowered to practice their profession without unnecessary restraint. Nurses empowered to practice their profession must participate in any decision that affects the professional practice or the delivery of care to patients. Shared governance as described and defined by Porter-O'Grady and Finnigan (1984), Pinkerton and Schroeder (1988), and others is founded on this premise.

The implementation and operationalization of shared governance requires establishment of a partnership between the nurse and the manager to work together to meet the goals of the organization. Traditional hierarchies that place position and power between the employee and the manager are replaced by a collaborative relationship in which both parties share in fulfillment of the common goal of providing cost-effective, quality patient care. By valuing and operationalizing the concept of collaborative management in health care organizations, organizational frameworks such as shared governance can be developed that encourage management and staff partnerships, enhance the professionalism of the organization, and promote role satisfaction among the professionals.

## MANAGEMENT AND STAFF RELATIONS

Traditional managerial functions placed emphasis on planning, organizing, staffing, directing, and controlling (Rowland and Rowland, 1980). Contemporary authors describe the necessity for a new style of management. Naisbitt and Aburdene (1990) state that more successful organizations are replacing authoritarian organizational structures with new cultures that espouse belief in the cultivation and nurturance of employees interested in the right to participate in the organization. Hierarchical organizational charts are replaced with networking systems delineating more lateral and collaborative relationships. Naisbitt and Aburdene (1985) indicate that employees not only want to participate in the planning, decision making, entrepreunering, and quality assurance efforts, but they also want to share in the profit of the company. Quality performance, productivity, and creativity are rewarded with new compensation systems, incentive programs, and employee stock-option plans. These authors believe that the quality of work-life is critical to today's employee, and the astute manager realizes that the more satisfied worker is more productive, needs less supervision, and provides a higher quality of service. Naisbitt and Aburdene (1990) indicate that most employees want to make a "difference" and want to be recognized as important to the overall success of the organization.

Similarly, other contemporary authors writing about the pursuit of excellence in organizations espouse the importance of building commitment to the organization and excitement about the service to the customer. An emphasis on the professionalism of the organization can be best obtained by a management and corporate culture that emphasizes human interaction and participation (Deal and Kennedy, 1982; Hickman and Silva, 1984). Peters and Waterman (1982) indicate that more successful corporations have a "loose-tight" structure—although there is control and discipline, the organization and culture support autonomy in the worker, which enhances creativity and innovativeness. Discipline is a set of shared values that provide the framework upon which autonomy can be developed.

Benveniste (1987) describes ways of "professionalizing the organization" and indicates that a management style that promotes consensus building rather than a bureaucratic structure is essential to organizational effectiveness and the motivation and satisfaction of the professional worker. He suggested several organizational models that will result in a more "professional" organization. Most of the models entail increasing the professional employee's involvement in decision making, planning, and other work of the organization. The dual governance system that Benveniste describes is similar to the shared governance system described by Porter-O'Grady and Finnigan (1984). In these models of dual or shared governance, specific decision-making responsibilities and authorities are delegated to a professional group(s) for issues relative to professional practice.

Unfortunately, some pitfalls of collaborative styles of management are often ignored by scholars. Although Benveniste indicates that collaborative management structures enhance professionalism within the organization, he warns that the scope of the delegated authority to professionals should remain narrow, well-defined, and task-oriented because some professionals do not possess strong managerial skills. He also cautions that dual governance structures may lead to dis-

agreements between management and staff regarding the right of professionals to be involved in all decisions, including those that often are irrelevant to professional practice. Benveniste describes the disadvantages of dual/shared governance as: (1) increased bureaucracy because of elaborate committee work, (2) increased costs associated with employee time expended in participation, and (3) turf battles regarding the propriety of decisions. Benveniste warns that once dual governance systems are implemented, the formally organized groups of staff could quickly convert to unions if true collaborative efforts fail or if the system is dismantled by management without staff consent.

## MANAGEMENT STYLES AND JOB SATISFACTION

Several possible frameworks for understanding and managing organizations are described by Bolman and Deal (1984), but the human resource framework seems most applicable to the discussion of employee involvement in organizational governance. The human resource approach emphasizes interpersonal relationships, individual involvement and participation, and organizational democracy. Hierarchical structures and traditional rules of communication are eliminated, thus leading to a matrix style of management dependent on networking, informal coalition building, and cooperative teamwork. Within this framework more employee involvement in planning, decision making, and governance is fostered. The authors indicate that this "people-oriented" style of management leads to increased creativity, involvement in day to day operations, and commitment to the organization.

Although not supported by empirical data, the thoughts of contemporary writers are built on the foundations of earlier works of organizational researchers and theorists. In early organizational research, employee satisfaction was linked to both individual and organizational variables (Taylor, 1911). Maslow (1954) theorized that self-actualization, the highest level of fulfillment, could not be realized until other more basic needs were satisfied in hierarchical order. This theory is important to nursing because it recognizes that the advancement of the profession is first dependent on the satisfaction of more basic needs such as the assurance of appropriate work loads (physiologic), provision of job security (safety), promotion of partnerships and team development (social), and demonstration of appreciation and recognition (esteem) for nursing's contribution to health care.

Herzberg's (1968) two-factor theory hypothesized that satisfaction was not the opposite of dissatisfaction on a single continuum but rather that satisfaction was the result of motivational factors including recognition, advancement, achievement, the work itself, increased responsibility, and other rewards. He further suggested that the absence of these factors did not cause dissatisfaction, but that dissatisfaction was caused by a different set of hygiene factors such as interpersonal relationships among organizational members, work conditions, pay, and security. Herzberg's two factors compare with the five hierarchical needs described by Maslow (1954). The motivators relate to Maslow's higher-order needs, and the hygiene factors relate to the lower-order needs. With this framework, a collaborative management style could be considered as a hygiene factor that would need to be met before job satisfaction could be realized.

Lawler and Porter (1971) described a similar theory of satisfaction suggesting that satisfaction was related to extrinsic and intrinsic rewards. Extrinsic rewards referred to those provided by the organization such as pay, promotions, job security, and status; intrinsic rewards were individual acknowledgments of worthwhile accomplishments (internal satisfaction). Building on this premise, Porter, Lawler, and Hackman (1975) suggested that a reciprocal relationship existed between the individual and the organization that affected the employee's level of satisfaction, behavior, and performance. Ultimately, the reciprocal relationship between the individual and the organization affected organizational effectiveness. Porter, Lawler, and Hackman (1975) summarized the reciprocal relationship between the organization and the individual by stating that "organizations tend to motivate the kind of behavior they reward" (p. 343).

Studies linking satisfaction and dissatisfaction to performance and productivity have been neither consistent nor conclusive. In an analysis of early research on the subject, Vroom (1964) found only a few references to worker satisfaction and productivity. In a review of current literature, Tauskey (1978) purported that a stronger relationship is observed between dissatisfaction and absenteeism or turnover, which ultimately reduces organizational effectiveness, than the relationship between satisfaction and productivity. The inverse relationship between job satisfaction and turnover has also been reported extensively in nursing literature by several researchers. Hinshaw, Smeltzer, and Atwood (1987) reported that group cohesiveness, control over practice, and autonomy were predictive of job satisfaction in nursing. Job stress as measured by factors such as lack of autonomy and conflict with administration was also negatively related to job satisfaction and predicted turnover. In a similar study, Stichler (1990) reported the results of a path analytic model in which collaboration between the nurse and the physician and between the nurse and the manager predicted job satisfaction. Although both types of collaboration predicted job satisfaction, only nurse-manager collaboration predicted anticipated turnover. It appears that the absence of nurse-physician collaboration (conflict) is episodic and affects job satisfaction situationally, but not to the same degree as the chronic nature of nurse-manager conflict, which ultimately leads to thoughts of resignation. These findings suggest the importance of a collaborative style of management to enhance job satisfaction and to reduce the possibility of employee turnover.

In a correlational study, Tiffany, Cruise, and Cruise (1988) found that the degree of autonomy or discretion is positively correlated to the degree to which professionalism is perceived by the group. "As professionals practice their skills within the context of the larger society, not only must they have the knowledge specific to their practice, but they must be afforded the discretionary room necessary for the use of that knowledge" (p. 72A).

Bechtold, Szilagyi, and Sims (1980) stated that autonomy and participation in decision making affecting the work of the employee had a great influence on worker attitude and satisfaction. Similar to these findings, Stamps and others (1978) reported that nurses from three different samples rated autonomy as the most important aspect of job satisfaction. Duxbury, Henley, and Armstrong (1982) found that an organizational climate that supported professional autonomy

and participation in decision making was significantly related to job satisfaction in nurses working in a neonatal intensive care unit. Similarly, Donohue (1986) found that an organizational climate that was characteristic of open and interactive communication between the deans of schools of nursing and the faculty contributed to overall job satisfaction, high morale, and increased productivity. These studies indicate the significance of autonomy, participation in decision making, and an organizational climate that fosters interactive communication as important variables in job satisfaction among specific populations of nurses.

Argyris (1962) and Herzberg (1968) studied the effects of various leadership styles of managers on the satisfaction of workers and found that styles that promoted employee involvement in decision making contributed to increased satisfaction and productivity in employees. The findings of Vroom and Yetton (1973) and Stogdill (1974) also indicate a positive relationship between participation in decision making by subordinates and job satisfaction.

Similar findings are reported by nurse researchers (Prestholdt, Lane, and Mathews 1988; Taunton, Krampitz, and Woods, 1989). The results of these studies demonstrated that nurses who were employed in units with managers who exercised authoritative leadership styles were less satisfied and less committed to staying in their jobs. The nurses reported centralized decision making, less autonomy, less individual power, and less supervisor support than other units.

The nurse administrator can play a major role in determining the extent to which nurses participate in interdependent decision making. Several researchers have discussed the positive effect of employee participation in decision making on job satisfaction (Blegen and Mueller, 1987; Vanderslice, Rice, and Julian, 1987). Buccheri (1986) reported that nurse managers are often more satisfied than their staff because of their participation in decision making and the recognition that they receive for their involvement. This study indicated that sharing information that affects the staff, providing support for their needs for influence, recognition, and communication, and allowing participation in decision making is directly related to job satisfaction.

The works of these theorists and researchers provide the foundation for contemporary and collaborative styles of management including human resource management, participative management, organizational democracy, quality circles, self/dual/shared governance, and others promoting involvement of the workers in organizational planning, decision making, quality control, and gain sharing. Reflecting trends in the development of management science, recent nursing and health care literature also suggests, documents, and provides evidence of the positive effects of employee participation in decision making affecting professional practice.

## **COLLABORATIVE MANAGEMENT STYLES**

Fawcett (1984) indicated that a theoretical framework can provide substantive direction to the understanding of certain concepts by identification of other related concepts and potential linkages, and implication of philosophic assumptions about the concept. Shared governance is one example of a collaborative management

structure. To understand the theoretical relevance of the concept of collaboration to shared governance, it is important to first define the terms and describe the attributes, antecedents, and consequences of the concept of collaboration. Collaboration and the recognition of its importance in business, education, health care, and other behavioral sciences is not new. The term *collaboration* is often used to refer to the process of working together as a team, but such a simple definition seems to minimize the significance of the process that occurs in a collaborative effort. *Collaboration* refers to a cooperative process that synthesizes and integrates the talents, resources, information, and expertise of two or more persons to accomplish a common goal (Stichler, 1989). Although some authors (Blake and Mouton, 1964) consider collaboration a method of conflict resolution, it is also considered an essential process in situations of goal interdependence (Tjosvold, 1984). Organizations are units of individuals who work interdependently for the accomplishment of the organization's missions and goals; therefore collaborative relationships between management and staff become critical for worker satisfaction and the effectiveness of the organization.

The process of collaboration is interactive and dynamic and is characterized by a balancing of power when participants have unequal status. Elements involved in collaboration include establishing parity; defining roles, responsibilities, and accountabilities of each party; resolving conflicts by negotiation and assertive behaviors; communicating horizontally rather than vertically; and participating in decision making. In a collaborative management framework, the power between management and staff is balanced or equalized by developing a matrix of communication and authority lines rather than a hierarchical authority pattern. Roles and responsibilities are defined, negotiated, and redefined according to projects, assignments, committees, and/or functions rather than vested positions. Subordinates are delegated the authority for decision making as it relates to their specific area of interest and/or professional practice. In this sense, the power inequity between management and staff is balanced for professional practice interests.

Sharing of information, cooperating and working as a team, synthesizing talents, expertise, and input, and establishing a consensus are also characteristic of the reciprocal nature of collaborative relationships. In a collaborative management framework, the organizational structure and culture would include collective bodies in which the work of the organization would be done. The talents of individuals would be integrated and synthesized in teams, councils, or committees to create outcomes that might not be realized if only the individual efforts of managers or staff were encouraged.

The process of collaboration leads to a sense of interpersonal value and a reinforcement of interdependency to accomplish the mission or goal. In collaborative relationships, the parties develop trust and respect one another and commit to work together on specific issues. Participants are selected to work on particular issues because of their skill and expertise in a certain area rather than their position in the management structure. In a collaborative management framework, management empowers the staff by granting them the privilege of making decisions in specific areas that may include specific projects, assignments, or professional practice issues. This premise is founded on the belief that given the correct

information and direction, individuals will make appropriate decisions in a defined situation.

The concept of shared governance has not been explicitly defined in the literature, but the name would imply the allocation of control, power, or authority (governance) among mutually (shared) interested and vested parties. The vested parties in nursing are those who practice nursing by providing direct patient care and those who practice nursing by managing or administrating settings (hospitals or other health care environments) where clinical nursing care is provided. Both parties share a common goal—to provide quality nursing care to patients. In this sense, those who practice nursing by providing direct patient care and those who manage or administer patient care are interdependent in their goals and in their relationships.

The concept of collaboration is one of the underlying principles of shared governance and provides a conceptual framework for management styles that promote employee participation in decision making, involvement of employees in governance issues, autonomy in professional practice, and ultimately the attainment of professionalism. Two important theories, cooperation theory and social systems theory, provide insight into the concept of collaborative management styles and their importance in organizations.

### **Cooperation and Goal Interdependence Theory**

Deutsch (1973) stated that perceived interdependence of goals significantly affects the dynamics and outcomes of social interaction. In cooperative processes, participants perceive that their goals are positively related. Recognizing that others' progress helps their own success, persons in cooperative relationships expect to give and receive assistance from others, trust others in the relationship, disclose information, feelings, and intentions, and define role expectations of one another.

In competitive relationships, people perceive their goals as negatively related. Realizing that the success of others threatens their own success, feelings of doubt, fear, frustration, and anger often lead to offerings of misleading information, acts of hostility, and minimal productivity on joint tasks.

Deutsch (1973) also postulated that independence has its own dynamics and outcomes. Persons working in an independent state see little need to establish a trusting relationship or to communicate information, since they are essentially isolated. Because collaboration is defined as a cooperative team effort to achieve interdependent goals, Deutsch's theory is important in understanding collaboration. This theory is also significant in understanding collaborative relationships in nursing because the discipline fulfills both independent and interdependent roles in its duty to society.

Deutsch's theory of cooperation (1973) can readily be applied in understanding the collaborative relationship between nurses and management, and becomes an important theory in understanding the dynamics of shared governance.

### **Social Systems Theory**

Homans (1950) described human social behavior as a social system characterized by interactions with and without expectation of a reciprocal response. A new