internal system evolves as a result of the interactions when a reciprocal response is expected. This theory also indicates that a synergistic group effect is more powerful than the efforts of each individual combined. Social systems theory is important in understanding collaboration; it describes the benefits of mutuality, reciprocity, and the synergy of the collective whole and is important in understanding the positive effects of a shared governance system.

CONCEPTS IMPORTANT TO PROFESSIONALIZING NURSING

Collaborative management is dependent on organizational cultures that espouse the belief that both management and staff must work as partners or colaborers to contribute to the success of the overall organization. A partnership arrangement would empower staff in certain areas and enhance their sense of autonomy. According to the theorists and researchers (Porter-O'Grady, 1987; Presholdt, Lane, and Mathews, 1987) the professionalization of the organization would be enhanced with the development of partnership relationships with the staff rather than the superior/subordinate relationships seen in hierarchical organizational structures. Professionalism, autonomy, and leadership style—all these concepts have been cited in business, organizational, and nursing literature as important to the professionalization of a discipline and essential to role satisfaction. It is important to explore the meaning of these concepts and their importance to nursing to understand how to incorporate them into practice.

Professionalism of Nursing

Early sociologists (Carr-Saunders and Wilson, 1933; Greenwood, 1987) who studied professional groups created a list of characteristics typical of the professional that included (1) provision of an essential service to society, (2) theoretical foundations for a specialized body of knowledge; (3) autonomy and authority over their practice, (4) a code of ethics, and (5) membership in professional organizations that socialize the participant to a specific professional culture and define standards of performance that specify desirable and predictable patterns of behavior of the professional. This list has been expanded by to others to include (6) education at institutions of higher learning, (7) scientific inquiry to expand the knowledge base, (8) emphasis on service rather than self-gain (Sims, Price, and Ervin, 1985), and (9) formal testing on competence or control of the admission to professional standing, rights, and privileges (Hall, 1968). Hall also highlighted the characteristic of "a calling" to the profession or a commitment to the work of the profession that motivates the work of the professional and is the source of satisfaction.

Management has a responsibility to nurture and defend the work and commitment of the professional in the organizational structure, which can create conflict for the manager. The professional often believes that his or her primary commitment is to the public with a secondary commitment to the organization, whereas the manager's primary commitment and responsibility is to meeting the goals of the organization. In hospital-based nursing, the hospital's goals also are to meet the needs of the community and public that it serves. However, the other organizational goals of profitability, expansion of services and facilities, and enhance-

ment of productivity may be perceived as conflicting by the professional and the manager (who is also a member of the professional group with the goals of the profession). Although it is critical for hospitals to remain financially strong to accomplish their goals of community service, cutbacks in staffing, tightened productivity goals, and other measures to improve the economic viability of the hospital may seem contrary to the goals of professional groups in the hospital.

Traditional bureaucratic structures emphasize order, structure, and clearly defined patterns of communication operationalized through an elaborate hierarchical system. This type of structured system is highly efficient, but it does not always allow for independent decision making or interdependent relationships that are necessary for professional practice. Excessive bureaucracy and the subsequent routinization of activities often encroach on the control of professional discretion that is needed for the work of the professional and necessary for intrinsic satisfaction. Benveniste (1987, p. 23) stated, "Professionalization . . . is the substitution of discretionary roles for routinized roles."

Managers are taught to have a global and organizational perspective of problems, whereas professionals are often more narrowly focused in areas where their specialized skills and knowledge are useful. Although discretion is necessary for professionalism, management is still required to exercise some control over the work and outcomes of the organization. Issues of professionalism, scope of responsibility, and lines of authority often become clouded and add to role confusion and conflict.

The subordinate status and dependent role of nursing has contributed to the discipline's failure to be recognized as a profession. Porter-O'Grady and Finnigan (1984) indicate that the very values of bureaucracy, with goals of order and control, may actually prevent the occurrence of professional behavior. Hospitals may espouse a belief and value of the professional role of the nurse, but the organizational design itself may prevent true professional development and create conflict and frustration. Organizations that are matrixed for multiple-level involvement in planning, networking, and communication enhance the professional development of the staff. Any organizational structure that places accountability and authority for practice issues at the level of the professional practitioner rather than with management will also promote professionalism.

Unfortunately, some nurses are unwilling to assume the responsibility for professional involvement and participation in decision making. Their commitment to the organization is limited with per diem affiliations and task orientation to their work assignment rather than a commitment to the "calling" of the profession. Porter-O'Grady (1987) purports that "true professionals exhibit an inherent ownership of the role manifested in the work of the profession" (p. 282). Professionalization of an organization requires management to relinquish some control of issues related to professional practice, but it also requires professionals to be willing to accept responsibility and accountability for their own practice.

Professionalization of the organization is the professionals' responsibility. It requires cooperation as new roles are defined and sensitive issues about authorities and accountabilities are clarified. Professionalism of the organization will lead to more collaborative relationships between staff and management, because commu-

nications are opened in the process, status differences are minimized when issues are resolved with input from both managers and highly skilled, motivated professionals, and commonalities in direction and goals become clear.

The intent of a shared governance system in a hospital is to enhance the professionalism of nursing (Peterson and Allen, 1986). Similar to the writings of Benveniste (1987), authors supporting a shared governance system for nursing suggest that a restructuring of the organization is essential for nursing to develop as a profession and that it is necessary because nursing is a profession.

Autonomy

One essential component of a professional discipline is the establishment of mechanisms for self-regulation and governance. The concept of autonomy is important in understanding the necessity for collaborative management structures in professionalizing nursing and promoting role satisfaction and retention. Simply stated, autonomy is the freedom to make choices or to choose a course of action without external controls. The word autonomy is derived from the Greek words, "autos" (self) and "nomos" (rule) and implies control over one's self and destiny (Dempster, 1990). Historically, the term has been used to denote self-functioning and self-directedness. In developmental theories, autonomy is used to describe a stage of development in which the child begins to exercise a sense of personal choice (Erickson, 1963).

Professional behavior is predominantly intellectual and based on a theoretical foundation unique to the science. The right to participate in decisions affecting one's professional practice is central to the concept of autonomy and has been a source of both interprofessional and intraprofessional conflict in nursing. Nurse-physician and nurse-management conflict has stemmed from disagreement over the right of the nurse to participate as a partner and/or colleague in decisions affecting the care of assigned patients and in decisions affecting the professional practice of nursing within the organizational context.

The history of American nursing has been steeped in bureaucratic structure. Although major strides have been accomplished in the professionalism of nursing, concern continues regarding the lack of autonomy in professional practice and true participation in decision making. Traditional bureaucratic organizational structures have limited the staff nurse's participation in decisions affecting professional practice and have delegated that authority solely to administrative nurses or to a few advanced clinicians. Policies and procedures developed by nursing for patient care are often written by administrative nurses and ratified by the medical staff structure. Care delivery systems are designed by nonpractitioners to meet the financial goals of the organization and may be unrealistic or negatively impair the quality of patient care. Orders are given by other professionals to be followed by nurses, rather than an interdisciplinary team planning care (which would consider the perspective and input from each professional group caring for the patient). Consequently, nursing as a profession is known for its lack of autonomy and is considered by some to have semiprofessional status because of this lack of control and discretion in decision making.

To function autonomously within organizations, nurses must be granted the authority to define the scope of practice, the goals and subsequent responsibilities, and the specific role functions and domains of practice. The professional group must also have the power to influence the organization in matters related to its professional practice. According to Aydelotte (1983) ". . . the degree of professional autonomy . . . depends on the effectiveness of the group's efforts at governance. Without governance, there is no autonomy. Without autonomy, full professional status is unattainable" (p. 632).

Other scholars suggest the concept of autonomy incorporates the sense of competence (Flathman, 1987; Haworth, 1986), self-mastery (Lindley, 1986), and individualism and independence (Christman, 1989). Autonomy in professional practice cannot be realized without competence, nor the ability to exercise discretion without the proficiency to anticipate the consequence of one's decisions. Other dimensions of autonomy have been described as cooperation, interdependence, self-determination, sanctioning or vesting, and mature participation (Curtin, 1982; 1987). The roles that nurses fulfill are independent, dependent, and interdependent. Autonomy is an important concept to be realized for professionalism to develop, although complete autonomy may not be completely achieved (McKay, 1983; Stichler, 1989).

The professionals' desire for autonomy, self-organization, and increased discretion in their work has been studied and discussed critically in the last decade. The quality of life movement (Meltzer and Nord, 1981; Toch and Grant, 1984), participative management (Scanlon, 1948; Toch and Grant, 1984), and shared governance proponents all discuss the enhancement of autonomy of the professional practitioner as benefits to management. The positive effects of participation in decision making by the professional in practice issues have also been studied and reported extensively (Kanter, 1977; Loveridge, 1988; Mann and Jefferson, 1988; Metzger, 1989; Prescott, Dennis, and Jacox, 1987). Although the literature has abundant references to the importance of autonomy in professional practice, operationalization of this concept in the hospital and other organizations has been difficult.

The concepts of power, autonomy, and discretion are closely related. Power has been correlated with independent actions, involvement in decision making, and assumption of accountability for actions (Kalisch and Kalisch, 1982). Although there are many definitions of power, it is often defined as the ability to accomplish one's intended goals. Power is viewed as a characteristic of individuals (Beck, 1982). One is perceived as powerful when able to control important organizational resources, have possession of certain information, or is influential because of relationships with other powerful people. Power is the ability to choose and make those choices happen (French and Raven, 1959; Raz, 1986), which results in a perception of freedom and autonomy.

Issues of autonomy and authority are also interrelated. The professional desire for autonomy inevitably alters traditional managerial roles, challenges vested lines of authority, and creates potential conflicts between management and staff. Authority relates to the legitimate use of power. Benveniste (1987) suggested that or-

ganizational authority differs from professional authority and that moving more authority to the professional does not necessarily minimize the authority, responsibility, or accountability of the manager. In fact, he suggests, authority and power are increased as a result of shared tasks and responsibilities. In this sense, the benefits of shared power and authority are similar to the social systems theory discussed earlier that espouses that the synergistic group effect is more powerful than the combined efforts of individuals. The fear of losing one's power in a shared effort is a common fear and often prevents collaborative management styles from developing and evolving to full maturity.

A premise of shared governance and other collaborative management styles is that the professional makes decisions about professional matters and the work of the profession. Professional discretion is necessary to actualize this principle. Professional and managerial authorities overlap whenever managerial decisions must consider professional knowledge or when professionals must use managerial principles and authorities to perform the professional work. Benveniste (1987) suggests that managing professionals requires not only giving professionals sufficient discretion to accomplish professional tasks, but also sharing managerial tasks where professional values, knowledge, and skills are relevant. In essence, managing the professional worker requires the development of an organizational structure that not only supports and sanctions professional discretion and autonomy, but also shares decision making with management on issues affecting the practice.

Accountability is also a concept related to autonomy. The self-determination, discretion, and independent decision making inherent in autonomy also entail the accountability for one's decisions and actions. Some suggest that the degree of autonomy attained by nurses is measured in the degree of accountability of practitioners held in the public court system (Marks, 1987; Murphy, 1987).

Although these concepts have been defined, analyzed, and demonstrated as important to the job satisfaction of professional nurses, professionalization of nursing has not been actualized in many hospital settings. It appears that a new style of manager is necessary to change the cultures of organizations to embrace collaborative styles of management.

LEADERSHIP STYLES AND MANAGING PROFESSIONALS

Bureaucratic organizational structures have been the frame of reference for hospitals for centuries, and the traditional roles of management from the industrial model have been well established. Participative management, shared governance, or other models that enhance professional practice demand a new style of manager different from those characterized in more bureaucratic structures. Contemporary management scholars indicate that this new style of management is necessary to motivate professional employees who are paid for their knowledge, skill, and expertise, and not "just to get the job done."

Kotter (1990) suggests that managers in organizations may be "overeducated in management and undereducated in leadership" (p. 105), which results in their inability to move people with diverse opinions, skills, and interpersonal relationships in a similar direction to accomplish the goals of the organization. Kotter

contends that interdependence is the central feature of contemporary organizations in which no one has complete autonomy, but rather employees interface because of technology, management systems, the work itself, and matrix-style management structures. These linkages and interdependencies require a leadership style that assists others to change and cope with change in an environment that is highly volatile, competitive, and fast-paced. With less emphasis on management and more on leadership skills, Kotter contends that managers must spend time aligning individuals and developing networks within the organization to help implement the vision and strategies of the organization. This process includes helping individuals to focus more globally on a new approach to an issue rather than attempting to solve a series of short-term problems. Such an approach empowers employees to think in new ways and allows discretion in solving both the short- and long-term problem.

Naisbitt and Aburdene (1990) suggest that the dominant principle of organizations has shifted from operations control to leadership that motivates people to respond quickly to change and enhances individual potential. They suggest that leaders will "inspire commitment and empower people by sharing authority" (p. 219). Successful organizations will treat employees as partners and team members in which the personal goals of the professional worker are met while accomplishing the mission of the organization.

New descriptors have been developed to represent the contemporary manager of professional organizations. Teacher, coach, facilitator, coordinator, and integrator are terms often used in current literature (Naisbitt and Aburdene, 1990; Porter-O'Grady and Finnigan, 1984). The new leadership style develops a "winning" commitment and attitude from the professional employee, and the leader is both coach and cheerleader assisting the professional to be self-managed, empowered, and better educated. Because of diminishing labor forces, the leader will need to hire employees who are highly educated and motivated to completing the job in times of uncertainty and fluctuation. Today's management emphasis is less focused on control, because uncertainty is uncontrollable, and is directed more to managing the constant and rapid change characteristic of modern organizations. Leadership requires vision and the interpersonal skills to articulate the vision. It is essential that leaders be capable of inspiring the professional rather than moving the group toward the accomplishment of the organization's goals.

Bennis and Nanus (1985) advise that organizations that manage professionals or work that is scientific and highly technical should emphasize decision making that is participative and should encourage communication of ideas from "the bottom up." All those who affect or are affected by the decision should have a voice in making the decision. Power, influence, and status should be based on participant involvement, face-to-face communication, and information sharing rather than on hierarchical position. Peer recognition should be determined by competence levels, interpersonal skills, and involvement. These themes, which Bennis and Nanus refer to as "collegial architecture," are founded on the following belief that people will do a good job if: (1) they are provided with the correct information, equipment and facilities, and procedures; (2) the vision and need have been well articulated to them; (3) the blame is not attached to failure; (4) there is shared

responsibility and accountability for outcomes; and (5) managers will "lead" rather than manage and allow the employee flexibility to use individual discretion.

Kotter (1988; 1990) suggests that the new leadership does not push or pull people in the "right" direction, but rather motivates and inspires employees to achieve the vision of the organization by satisfying the basic human needs for achievement, belonging, recognition, autonomy, and self-esteem. True leaders involve people in achieving the organization's vision and work, which gives the employee a sense of control. Creating an environment in which leadership skills can be role modeled and developed in younger employees who also demonstrate leadership potential is the ultimate act of leadership and will provide the most powerful source of competitive advantage today.

Leadership for Collaborative Management Styles

The manager in a collaborative management structure such as shared governance must focus on new roles that Porter-O'Grady and Finnigan (1984) summarize as facilitating, coordinating, and integrating. Although the manager/administrator may lose some centralized decision making authority, accountability for the outcomes of the professional staff's decision making is still maintained. Because the collaborative process is the underlying framework for shared governance, the administrative team must develop collaborative group process skills to develop and consult with the nursing staff. Unequal status and power must be balanced, professional knowledge integrated, and participants valued for their contribution in order for collaborative relationships to develop and flourish. Obviously inherent in such a culture is the belief and trust that the staff will be able to complete the work necessary to accomplish the mission and goals of the organization. Consultation for critical decisions is accomplished with the chairpersons of strategic councils as well as the management team, which equalizes the power base of both groups.

Shared governance systems also affect the traditional managerial roles in hiring, promoting, disciplining, and controlling. Many organizations espousing shared governance use peer review and credentialing committees to perform the work of evaluating and controlling professional performance and privileging professional practice. Such actions provide the professional body with the authority and accountability to examine members of their profession and certify their competence, which is a hallmark of professional practice.

Interdisciplinary collaboration is essential in shared governance models as the administrative staff and council chairpersons work closely with other professionals to articulate and negotiate the needs of nursing. An essential management role is to promote interdisciplinary collaboration by planning and implementing forums for assessing and assuring quality, discussing bioethical issues, and promoting interdisciplinary communication in practice and education.

Most importantly, administrative nurses in a shared governance system should understand the domain of nursing and how the governance or management of nursing can complement and support the professional practice of nursing. By developing collaborative partnerships between the administrative and clinical nursing staff, the professionalism of nursing can be enhanced.

NEW ORGANIZATIONAL STRUCTURES IN NURSING

Bureaucracies are considered the antithesis of values related to professional functioning. Emphasis on control, order, standardization, and routinization may help measure outcomes and promote a false sense of organizational effectiveness, but it does nothing to promote the innovative thinking essential to the creation of successful organizations. To achieve full professional status, the members of the discipline must function autonomously in the governance of their own practice.

Shared Governance Models

According to Porter-O'Grady and Finnigan (1984), the professional worker needs an organizational structure that emphasizes lateral rather than hierarchical communication and relationship patterns. Such models would be more collaborative, using the expert knowledge of the professional in all issues related to professional practice. The professional's work and goals are interdependent with the management and mission of the organization. Without provision for interdependence and autonomy, the professional's practice is reduced to that of a technician who is subordinate to others and to the system. These authors relate the need for a system that delegates decision-making authority related to professional practice to the professionals within the organization. This delegated responsibility is actualized in collective forums and in independent discretionary judgments. Such action places the accountability for professional activities with the professional employees and promotes collegiality and equality in peer relationships between interdependent parties (clinical nurses and the management staff).

Recognizing that the hospital organization is an interdependent system of units whose success is dependent on the success of the whole, Porter-O'Grady and Finnigan's model of shared governance focuses on an organizational design that acknowledges this interdependence and facilitates the interaction among professionals at all levels within the organization. Shared governance reduces the emphasis on hierarchical relationships and highlights the professional's right to be involved in governance of the profession.

Shared governance is one example of a collaborative management structure and is characterized by the same dimensions seen in collaborative processes: balancing of power, reciprocating, and interpersonal valuing. Power is balanced equally between management and staff on issues related to the professional practice of nursing. Communication is facilitated by a matrix of councils or representative bodies empowered with the authority and accountability of decision making for the profession. Roles and responsibilities are clearly delineated in bylaws for the nursing divisions.

The essential structure of a shared governance system supports the work or practice of nursing and includes a network of five fundamental elements including governance or management, peer relations, professional development, practice, and quality assurance. Management assumes accountability for issues within its control, whereas the profession is accountable for the definition, delivery, and evaluation of its practice. In this sense, the dimension of reciprocating is operationalized as council, team, or committee members share information, expertise,

and talents to do the work of nursing. Consensus on these issues represents the beliefs of the nursing professional group for each specific organization. Most specifically, the talents of the professional practitioners are integrated and synthesized with those of the administrative professionals to create a stronger dimension of nursing than was realized by the simple representation of the profession by administrative nurses.

Shared governance also initiates the third dimension of a collaborative management framework by granting the authority necessary for true decision making to the practitioners of the profession. There is a valuing of the nursing staff, with the realization that the work of the organization cannot be accomplished without the practitioners of nursing. As in all collaboration, a commitment to the process must occur. A commitment to shared governance must also occur at all levels in the organization for the organizational process to be successful.

In shared governance there are distinct areas in which the employee and manager have rights of final authority in decision making. The clinical nurses have authority over practice issues, and nurse managers have authority over management issues. Inherent in operationalizing shared governance is the belief and trust that employees, when given pertinent information and parameters, will make sound decisions. Because hierarchical organizational structures vest authority and control with the managerial staff, new roles emerge for the manager in a shared governance or collaborative management model.

Unionization

Bureaucratization of professional work often results in the unionization of the professional workers, since it minimizes their professional discretion and autonomy. Mercadante (1983) identified that unionization of nurses is often the result of lack of control and participation in decision making in professional practice issues, performance appraisal and promotion, and policies and procedures. Although the professional desires more control and autonomy when initially seeking assistance from an organized union, unionization of an organization often results in less individual control over professional issues. Individuals also experience less personal power because power is shared among management, union, and the individual professional practitioner. Collaborative management is minimized in a unionized organization, since the relationship between the union and the profession with the organization is often viewed as conflictual rather than cooperative or collaborative.

Participative Management

Participative management is based on the premise that involving the professional in decision making is important for role satisfaction, but the term "participation" provides for many levels of involvement. Forms of participation can include seeking advice, obtaining support, voting on decisions, or simply notifying interested parties of actions previous to implementation. The amount of participation should be determined by how essential the professional knowledge is to management or organizational effectiveness, and how important professional participation is to motivate and potentiate the professional's effectiveness. In hospitals, it is apparent that the organization's effectiveness is dependent on the professional's

knowledge and expertise. It would seem apparent that a high level of participation by professional nurses would be essential.

Mercadante (1983) viewed participative management as a form of shared governance and indicated that a shared-authority model is a staff motivator and satisfier since it promotes communication between management and staff. The results of the study indicate, however, that the subjects perceived themselves as involved in decision making but that the final decisions were made by administration. In this sense, their involvement was more consultative than participatory. Mercadante offers a four-point plan to improve the perception of true participation that includes (1) goal planning with committee members, (2) recruiting committee members who wish to be actively involved, (3) eliciting suggestions and input from members and providing responsive feedback, and (4) developing joint problem-solving sessions with administration and staff nurses.

In contrast to Mercadante's belief that participatory management is a form of shared governance, Porter-O'Grady (1988) believes that the two types of management are distinctly different. Porter-O'Grady (1982) indicates that strategies to increase communication and interaction between staff and management are important but cannot replace the importance of true involvement and control over issues that govern the work activity of the employee. "Participative management by its very definition means allowing others to participate in decisions over which someone else has control" (Porter-O'Grady, 1987, p. 282).

MAKING COLLABORATIVE MANAGEMENT A REALITY IN THE WORKPLACE

Several studies (Blegen and Mueller, 1987; Hinshaw et al., 1987; McKay, 1983; Vanderslice, Rice, and Julian, 1987) have demonstrated a number of variables that affect job satisfaction, and the variables cited as predictors of job satisfaction are also essential variables for the professionalization of organizations. Because recruitment and retention resources are scarce, interventions having the greatest impact must be carefully identified and initiated. Enhancement of collaborative management styles and the development of organizational cultures that nurture professional autonomy and legitimate participation in decision making affecting professional practice are critical. Promoting collaborative management systems in a hospital is complex, and multiple strategies can be implemented.

The process of collaboration is characterized by interpersonal valuing, integration of ideas, opinions, and expertise, and a balancing of unequal power (Stichler, 1989). The collaborative manager should promote an environment or culture that demonstrates a valuing of the professional nurse and recognizes that the goals of the hospital/unit could not be realized without the professional nurse. It is recommended that the manager involve the clinical nurse in decisions that affect the professional practice of clinical nursing and in decisions that affect the delivery of patient care to enhance the development of collaborative behaviors. Implementing systems such as shared governance, participative management, joint practice models, or other similar programs enhances staff involvement and participation in decision making. These systems also provide for increased nurse-manager interac-

tion, planning, and coordination of patient care that integrates the expert opinions of administrative and clinical nurses. A balancing of power occurs in the council model of shared governance, which fosters nurse-manager collaborative behaviors. Nurse managers generally serve on the clinical councils as consultants without voting privileges, which helps to balance the power in patient care decision making between clinical and administrative nurses. In addition, the chairpersons of each council in the shared governance system meet with an administrative director to coordinate the activities of patient care and the professional practice of nursing.

It is also recommended that career advancement programs be developed that allow those who choose to practice clinical nursing at advanced levels to be rewarded financially and with recognition of their power by expertise. Open communication between management and nurses that allows freedom of expression of concerns, criticisms, creativity, and opinions is recommended to enhance nurse-manager collaboration. Encouraging clinical nurses to be active participants in strategic planning and program implementation, quality assurance activities, scheduling on-duty time, along with providing educational offerings will promote nurse-manager collaboration in domains traditionally recognized as management. It is recommended that nurse managers move from the more traditional leadership styles and roles of management to contemporary and collaborative roles that include facilitation of patient care, integration of ideas, opinions, and expertise, and the coordination of resources including manpower and finances.

Organizational Climate and Collaborative Management

The climate of the organization characterizes the generalized "feeling" of the organization and reflects the structure and processes of the organization. Although organizational climate is relatively stable over time, the manager can influence the climate by her or his style of management. To enhance a positive organizational climate, the manager should recognize the nurse's expertise as a clinician and empower her or him to participate in decisions, actions, and planning that affect patient care or the professional practice of nursing. Minimizing bureaucracy and traditional lines of communication facilitates the development of autonomy in the professional nurse and will minimize the formal structure of the organization. Position structure can inhibit the natural creativity of a nurse who wishes to risk individual participation in changes to unit functioning or patient care. Reward and recognition by the manager of the clinical nurse's contributions to quality patient care facilitates the perception of a positive organizational climate. Leaders who demonstrate warmth, concern, and consideration will effect increased job satisfaction among the work force. It is recommended that managers maximize positive changes in the organizational climate by facilitating nurses' participation in all aspects of operations and by empowering nurses to seek creative solutions to day-to-day problems. In developing a true partnership relationship with the nursing staff rather than the traditional bureaucratic relationship, the manager can positively affect the climate of the organization and ultimately the job satisfaction of the individual nurse.

Numerous studies (Godfrey, 1978; Jacobson, 1988; Nursing Shortage Poll Report, 1988; Stember et al., 1978) have validated that an unrealistic work load has a tremendous influence on the stress level of nurses and is directly related to burnout, job dissatisfaction, and anticipated or actual turnover. Because of the importance of this variable in job satisfaction and retention, it is strongly recommended that the nurse manager be particularly attentive to ensuring realistic work loads and preserving the same when hospitals face severe economic challenges and nursing shortages. Clinical nurses and administrative nurses must work together to redefine patient care delivery systems that realistically have professional nurses performing responsibilities that must be performed by the professional and delegating palliative, comfort, or general hygiene functions to other support personnel.

"Administrative or managerial support" is a little-understood construct and can be defined differently depending on each individual's perspective. It is recommended that the manager talk with staff to better understand their perspective of support. By so doing, the manager can be better equipped to meet the employees' expectation of supervisor support and minimize the stress incurred when expectations are not met.

SUMMARY

Professional partnerships between management and the professional staff can result in organizations that value collaborative management principles and structures rather than the superior-subordinate relationship in bureaucratic structures. An integrative network promotes both interprofessional and intraprofessional consultation and collaboration that not only fulfills the employees' need for participation and ownership in organizational processes and outcomes, but also fosters collective creativity and innovativeness. The theoretical framework and the operationalization of collaborative management styles support the work of earlier organizational researchers and theorists and most specifically support contemporary writers, who suggest that organizations rich in collaborative networking rather than bureaucratic hierarchies will be the most successful.

REFERENCES

American Organization of Nurse Executives. (1990). *Nurse Executive* 2(9), 1.

Argryis, C. (1962). *Interpersonal Competence and Organizational Effectiveness*, Homewood, Ill.: Irwin Dorsey Press.

Aydelotte, M.K. (1983). Professional Nursing: The Drive for Governance. In Chaska NL, editor: *The Nursing Profession: A Time to Speak*, New York: McGraw-Hill Book Co, pp 830-843.

Bechtold, S.E., Szilagyi, A.D. and Sims, H.P. (1980). Antecedents of Employee Satisfaction in a Hospital Environment, *Health Care Management Review*, 5(1), 77-78.

Beck, C. (1982). The Conceptualization of Power, *Advances in Nursing Science*, 4(2), 1-17.

Bennis, W. and Nanus, B. (1985). *Leaders*. New York: Harper & Row.

Benveniste, G. (1987). *Professionalizing the Organization*, San Francisco: Jossey-Bass.

Blake, R.R. and Mouton, J.S. (1964). *The Managerial Grid*, Houston: Gulf Publishing.

Blegen, M.A. and Mueller, C.W. (1987). Nurses' Job Satisfaction: A Longitudinal Analysis. *Research in Nursing Health*, 10, 227-237.

Bolman, L.G. and Deal, T.E. (1984). Modern Approaches to Understanding and Managing Organizations, San Francisco: Jossey-Bass.

Bream, T. and Schapiro, A. (1989). Nurse-Physician Networks: A Focus for Retention. *Nursing Management*, 20(5), 74-77.

Buccheri, R.C. Nursing Supervision: A New Look at an Old Role. *Nursing Administration Quarterly*, 11, 11-25.

Carr-Saunders, A.M. and Wilson, P.A. (1933). *The Professions*, Oxford: Oxford University Press.

Christman, J. editor: (1989). *The Inner Citadel: Essays on Individual Autonomy*. New York: Oxford University Press.

Curtin, L.L. (1982). Autonomy, Accountability, and Nursing Practice, *Advances in Nursing Science*, 4, 7-14.

Curtin, L.L. (1987). The "Employment" of Autonomy, *Nursing Management*, 18, 9-12.

Deal, T.E. and Kennedy, A.A. (1982). *Corporate Culture: The Rights and Rituals of Corporate Life*, Reading, Mass,: Addison-Wesley.

Dempster, J.S. (1990). Autonomy in Practice: Conceptualization, Construction, and Psychometric Evaluation of an Empirical Instrument, Unpublished manuscript, San Diego.

Department of Health and Human Services. (1988). *Secretary's Commission on Nursing*, vol 1, Washington, D.C.: US Government Printing Office.

Deutsch, M. (1973). *The Resolution of Conflict*, New Haven, Conn.: Yale University Press.

Donohue, J.D. (1986). Faculty Perceptions of Organizational Climate and Expressed Job Satisfaction in Selected Baccalaureate Schools of Nursing, *Journal of the Professional Nurse*, 2, 373-379.

Duxbury, M.L., Henley, G.A. and Armstrong, G.D. (1982). Measurement of the Nurse Organizational Climate of Neonatal Intensive Care Units, *Nursing Research*, 31, 83-88.

Erickson, E. (1963). *Childhood and Society*, ed 2, New York: WW Norton.

Fawcett, J. (1984). *Analysis and Evaluation of Conceptual Models of Nursing*, Philadelphia: F.A. Davis Co.

Flathman, R.E. (1987). *The Philosophy and Politics of Freedom*, Chicago: University of Chicago Press.

French, J. and Raven, B. (1959). The Bases of Social Power. In Cartwright D, editor: *Studies in Social Power*, Ann Arbor, Mich.: Institute for Social Research, pp 259-269.

Godfrey, M.A. (1978). Job Satisfaction: or Should That Be Dissatisfaction? How Nurses Feel about Nursing. Part two, *Nursing 78*, 8(5), 105-120.

Greenwood, E. (1987). Attributes of a Profession, *Social Work* 2, 45-55.

Hall, R.H. (1968). Professionalization and Bureaucratization, *American Sociological Review*, 33, 92-104.

Haworth, L. (1986). *Autonomy: An Essay in Philosophical Psychology and Ethics*, New Haven, Conn.: Yale University Press.

Herzberg, F. (1968). One More Time: How Do You Motivate Employees? *Harvard Business Review*, 46 (Jan-Feb), 53-62.

Hickman, C.R. and Silva, M.A. (1984). *Creating Excellence*, New York: New American Library.

Hinshaw, A.S. Smeltzer, C.H. and Atwood, J.R. (1987). Innovative Retention Strategies for Nursing Staff, *Journal of Nursing Administration*, 17(6), 8-16.

Homans, G.C. (1950). *The Human Group*, New York: Harcourt, Brace & Co.

Jacobson, S.F. (1988). *Nurse Retention on High Stress Clinical Specialty Units. Nursing Resources and the Delivery of Patient Care*. Washington D.C.: U.S. Department of Health and Human Services.

Kalisch, B.J. and Kalisch, P.A. (1982). An Analysis of the Sources of Physician-Nurse Conflict. In Muff J, editor: *Socialization, Sexism, and Stereotyping*, St. Louis, Mo.: CV Mosby, pp. 221-233.

Kanter, R.M. (1977). *Men and Women of the Corporation*, New York: Basic Books.

Kotter, J.P. (1988). *The Leadership Factor*, New York: The Free Press.

Kotter, J.P. (1990). What leaders really do, *Harvard Business Review*, 90(3), 103-111.

Lawler, E.E. and Porter, L.W. (1971). The Effect of Performance in Job Satisfaction. In Connelly, J.H. Jr, Gibson, J.L. and Ivanevick, J.M. editors: *Fundamentals of Management: Selected Readings*, Austin, Texas: Business Publications, pp 110-150.

Lindley, R. (1986). *Autonomy*, Atlantic Highlands, NJ: Humanities Press International, Inc.

Loveridge, C. (1988). Contingency Theory: Explaining Staff Nurse Retention. *Journal of Nursing Administration*, 18(6), 22-25.

Lysaught, J.P. (1970). *An Abstract for Action*, New York: McGraw-Hill Book Co.

Mann, E.E. and Jefferson, K.J. (1988). Retaining Staff: Using Turnover Indices and Surveys, *Journal of Nursing Admininstration*, 18(7,8), 17-23.

Marks, D.T. (1987). Legal Implications of Increased Autonomy, *Journal of Gerontological Nursing*, 13, 26-31.

Maslow, A. (1954). *Motivation and Personality*, New York: Harper & Row.

McKay, P.S. (1983). Interdependent Decision Making: Professional Autonomy, *Nursing Administration Quarterly*, Summer, 21-30.

Meltzer, H. and Nord, W. editors: (1981), *Making Organizations Humane and Productive: A Handbook for Practitioners*, New York: Wiley.

Mercadante, L.T. (1983). A Study of Nurses' Perceptions of Participative Management. In Chaska N.L., editor: *The Nursing Profession: A Time to Speak*, New York: McGraw-Hill Book Co, pp 696-707.

Metzger, N. (1989). Making Employees Feel that They Make a Difference, *Health Care Supervision*, 7(3), 1-7.

Murphy, E.K. (1987). The Professional Status of Nursing: A View from the Courts, *Nursing Outlook*, 35, 12-15.

Naisbitt, J. (1982). *Megatrends*, New York: Warner Books, Inc.

Naisbitt, J. and Aburdene, P. (1985). *Re-inventing the Corporation*, New York: Warner Books, Inc.

Naisbitt, J. and Aburdene, P. (1990). *Megatrends 2000*, New York: William Morrow & Co.

National Commission on Nursing. (1981). *Summary of Public Hearings*, Chicago: American Hospital Association.

National Commission on Nursing. (1982). *Nursing in Transition: Models for Successful Organizational Change*, Chicago: The Hospital Research and Education Trust.

National Joint Practice Commission. (1981). *Guidelines for Establishing Joint or Collaborative Practice in Hospitals*, Chicago: National Joint Practice Commission.

Nursing Shortage Poll Report. (1988). *Nursing 88*, 18(2), 33-41.

Office of the Inspector General. (1989). Hospital Best Practices in Nurse Recruitment and Retention, *Nursing Economics*, 7(2), 98-106.

Peters, T.J. and Waterman, R.H. (1982). *In Search of Excellence*, New York: Harper & Row.

Peterson, M.E. and Allen, D.G. (1986). Shared Governance: A Strategy for Transforming Organizations, *Journal of Nursing Administration*, 16(1), 9-12.

Pinkerton, S.E. and Schroeder, P. (1988). *Commitment to Excellence*, Rockville, Md.: Aspen Publications.

Porter, L.W., Lawler, E.E., and Hackman, J.R. (1975). *Behavior in Organizations*, New York: McGraw-Hill.

Porter-O'Grady, T. (1982). What Motivation Isn't, *Nursing Management*, 13(2), 27-29.

Porter-O'Grady, T. (1987). Shared Governance and New Organization Models, *Nursing Economics*, 5(6), 281-286.

Porter-O'Grady, T. (1988). Personal communication, Aug 1, 1988.

Porter-O'Grady, T. and Finnigan, S. (1984). *Shared Governance for Nursing*, Rockville, Md.: Aspen Publications.

Prescott, P., Dennis, K., and Jacox, A. (1985). Power and Powerlessness in Hospital Nursing Departments, *Journal of Professional Nursing*, 1(6), 348-355.

Prestholdt, P.H., Lane, I.M., and Mathews, R.C. (1987). Nurse Turnover Reasoned Action: Development of a Process Model, *Journal of Applied Psychology*, 72(2), 221-227.

Prestholdt, P.H., Lane, I.M., and Mathews, R.C. (1988). Predicting Nurse Turnover, *Nursing Outlook*, 36(3), 145-147.

Raz, J. (1986). *The Morality of Freedom*, Oxford: Clarendon Press.

Rowland, H.S. and Rowland, B.L. (1980). *Nursing Administration Handbook*, Rockville, Md.: Aspen Publications.

Scanlon, J.N. (1948). Profit Sharing Under Collective Bargaining: Three Case Studies, *Industrial and Labor Relations Review*, 2, 58-75.

Sims, L.M., Price, S.A., and Ervin, N.E. (1985). *Professional Nursing Practice, The Professional Practice of Nursing Administration*, New York: Wiley.

Stamps, P.L., and others. (1978). Measurement of Work Satisfaction Among Health Professionals, *Medical Care*, 16(4), 337-352.

Stember, M.L., Ferguson, J., Conway, K., and Yingling, M. (1978). Job Satisfaction Research—An Aid in Decision Making, *Nursing Administration Quarterly*, 2, 95-105.

Stogdill, R.M. (1974). *Handbook of Leadership*, New York: The Free Press.

Stichler, J.F. (1989). Development and Psychometric Testing of a Collaborative Behavior Scale, Unpublished dissertation.

Stichler, J.F. (1990). The Effects of Collaboration, Organizational Climate, and Job Stress on Job Satisfaction and Anticipated Turnover in Nursing, Unpublished manuscript.

Stogdill, R.M. (1974). *Handbook of Leadership*, New York: The Free Press.

Taunton, R.L., Krampitz, S.D., and Woods, C.Q. (1989). Manager's Impact on Retention of Hospital Staff, Part 2, *Journal of Nursing Administration*, 19(4), 15-19.

Tauskey, C. (1978). *Work Organization: Major Theoretical Perspectus*, ed 2, Itasca, Ill.: Peacock Press.

Taylor, F.W. (1911). *Principles of Management*, New York: Harper & Brothers.

Tiffany, C., Cruise, P., and Cruise, R.J. (1988). Discretion and Professionalization: A Correlational Study, *Nursing Management*, 19(2), 71D-72P.

Tjosvold, D. (1984). Cooperation Theory and Organizations, *Human Relations*, 37, 743-767.

Toch, H. and Grant, D.J. (1984). *Reforming Human Services: Change Through Participation*, Beverly Hills, Calif.: Sage.

Vanderslice, V.J., Rice, R.W., and Julian, J.W. (1987). The Effects of Participation in Decision-Making on Worker Satisfaction and Productivity, *Journal of Applied Psychology*, 17(2), 158-170.

Vroom, V.H. (1964). *Work and Motivation*, New York: John Wiley & Sons.

Vroom, B.H. and Yetton, P.W. (1973). *Leadership and Decision-Making*, Pittsburgh: University of Pittsburgh Press.