ways externally generated, must always be assigned, and does not customarily transfer to other roles or situations.

Conversely, accountability operates in a different manner. In a professional context, there are expectations associated with the role of the professional. There are educational and social preconditions that are necessary for the profession's work. It is assumed that when a worker completes the obligations of the profession and has been incorporated into the professional body, there are essential characteristics that will attend to the exercise of that role. Those characteristics are so vital to the role that they are considered a part of the essence of that role; the role cannot unfold without them nor can it be defined without conceiving it in the context of those characteristics. They are inherent to the role and emanate from it— not to have them is not to live the role. They can be defined as the accountabilities of the role. These characteristics are attributed to it from within the role, can never be assigned, nor can they be given away. They arrive and leave with the person, even when the person leaves the function of that role for another setting or role.

The reason accountability is discussed with such intensity relates to the fact that most long-term shared governance models are based on accountability delineations. As work accelerates to create a newer model for organizing and delivering nursing care services, a solid premise for these newer models must be provided. This is especially true for governance models, which presuppose a different belief about both the worker and the work. The traditional industrial model structures represent a way of believing and working that is an outgrowth of concepts and research ensuing from manufacturing organizations and productivity models in the industrial sector, as discussed earlier in this chapter. Most of the research on which hospital organizational and management systems are based reflects similar thinking as that directed toward assembly line and production-oriented settings. Only in the last decade have concepts and research that represent professional nursing values and work begun to unfold (Hersey and Blanchard, 1989). It must be emphasized that whatever professional approaches emerge, they must not only be empowering but also be solidly based on a set of professional values that can bear the weight of organizational integrity, and incorporate the checks and balances necessary to ensure that work is both appropriately identified and performed at the level of satisfaction identified by both the worker (nurse) and the consumer (patient).

Models Should Be Based on a Clinical, Rather than Administrative, Organization

Another principle of shared governance must be considered—all designs and models should reflect a clinical base of organization rather than an administrative structure. Historically, the nursing organization has reflected administrative lines and mechanisms of authority and function in the prevailing hospital structure. This setting allowed good integration and control of nursing within both the dominant medical system and the hospital's own complementary medical service system. Because the hospital's originating purposes were strongly medically driven, most of the service structures developed in the system reflect the predominant service requirements of the medical staff. All service providers in this model were developed to accommodate this relationship, and the organizational characteristics of

the hospital reflect this relationship for the most part. This structure does not assume equity of roles and reflects both the ascendant role of the doctor and the hierarchical structure of the hospital that supports it. The nurse has heretofore been a subset of both.

If nurses are to create equity in the hospital or health system, they must temper the current structure, refuting the fundamental underpinnings of the current modus operandi and much of its operating characteristics. It is not wise, however, to legislate against an inadequate structure unless it is known both why it is inadequate and what will replace it. A previous work provided a thorough discussion of why the structure is inadequate and how shared governance is an appropriate structural alternative (Porter-O'Grady, 1984). It is essential, however, that the nurse remember that the structure cannot simply be changed by noting its inadequacy and not moving toward substantive change. One of the major problems in current nursing self-governance efforts is the fact that nurse leaders, in many cases, have created the operating structure without the essential behavioral and organizational shifts, which delivers a different message to the various members of the system about the position and role of nursing in corporate as well as practice decision making.

The base of this shift and the basic principle promulgated is that nursing is primarily and wholly a clinical system. If it is to reach full tenure in the organizational system and reflect the desired equity, it must be centered squarely on what the profession is and what it does. All roles not directly involved in its work then become supportive to the work; in essence, servants to the practitioner to whom the nursing organization and its support must be directed. Anyone who does not do the direct work of the profession is therefore a servant to those who do.

This has not been the prevailing consciousness of the profession in the current health care system with its traditional management structures. Management has evolved into the caretaker and agency role, ensuring that the staff members do what they are supposed to, in the right numbers and kind, at the right time, and to the right degree of proficiency and productivity. In most current structures the manager, regardless of position within the system, acts more as the agent of the institution than as the profession's link to the necessary support and resources of the organization directed to the provision of nursing care.

This relationship is significantly altered in shared governance. The accountability of the manager is closely assessed and narrowly defined to focus on those roles and functions that directly relate to both resource provision and staff support. The manager's role, however, is not weakened in the delivery system. If anything, it is enhanced because for the first time, a clear, definitive expectation for the manager can be articulated and applied without confusion regarding roles and functions that are not properly or legitimately attendant to it.

Conversely, the staff role also becomes clearer and accountable in a much broader context. Ownership of the clinical processes becomes much more definitive as the definition of what that ownership means also becomes more distinct. Accountability becomes a solid basis on which to build the role of the nurse because all the organizational structures must reflect it. When the staff members know what their power base is and the arenas over which they have control, they develop highly effective checks and balances to ensure that the clinical values are adequately addressed.

Sorting the roles of management and staff and distinguishing the accountabilities distinct to each function is also beneficial to the manager. In the past, with industrial model beliefs and structures, the role of the manager was not so clearly distinguished from the role of the staff. Often the manager was expected to make certain that the staff fulfilled both work rules and practice requirements. Indeed, the manager has historically been the locus of control for most every function in the delivery of nursing services. In the shared governance approach, the nurse manager's role operates within a narrower frame of reference with a much clearer framework for management accountability.

Instead of an amorphous and expansive boundary to the role, a more clearly defined structure of accountability becomes essential and better defined. Focus on the fundamental role of the manager and the resource base of management emerges, freeing the manager to be more capable of investing in those activities that more directly relate to expectations for the role. The manager can then actually produce outcomes for which the role is directly accountable without the pressure of fulfilling accountabilities that can never be legitimately those of the manager. This also frees the nursing organization to better define and obtain those outcomes from the role of practitioner it could only partially obtain in the past. The staff members' accountability for their roles is directly related to the proximity of the accountability to the legitimate locus of control for its exercise. This principle also applies to the manager.

The principle of management accountability for the exercise of the role within the context of the work of the role is fundamental to shared governance success. The manager is accountable for the human, material, fiscal, support, and organizational resources of the service. In the past managers have been insulated from this expectation because it was highly ambiguous. When accountability for the role of management becomes clearer to all in the organization, the parameters that both define it and measure performance related to it become much clearer and straightforward. It remains less ambiguous to all parties that relate to it and depend on it. From this framework much clearer performance expectations can be defined and nurses can more clearly articulate their management role with other key managers, who can then act as moderators and evaluators. In a shared governance structure, it is important that each role be clearly described and understood by the individual and the staff. The management role is no exception.

SHARED GOVERNANCE STRUCTURES

There are a number of structural approaches to shared governance in the United States. In the early 1980s when the concept was first applied to hospitals, there were few principles to guide the introduction to the process. Although it was intended to empower the staff, it was not clear what that was and how the staff should be empowered. As the concept of accountability was clarified, it became the base for validating the approaches to shared governance as a part of ensuring that true empowerment was the outcome of the process. Many times, attempts to include staff in some form of participation never seemed to move them to the de-

gree of participation anticipated. The staff's "do I gotta wanna" response often surprised and disheartened nursing leaders to the point of asking whether efforts to motivate the staff were worthwhile.

The real transfer of accountability and the attendant power changes in the staff are noted in shared governance models. When there is no real net transfer of powers there is little commitment to the process. The shell of shared governance is in place but the core action of shared governance is missing.

Some organizations have implemented the format for shared governance but little of the substance. Participatory efforts are not characteristic of real shared governance. Participation always indicates that control and authority rest elsewhere. One shared governance principle when applied to professional practice indicates that accountability only truly exists where the authority for it does; if there is no authority, there is no accountability. If authority can be second-guessed or approval for it rests elsewhere, then true authority is located in the place of final approval. This is the principle most often missing or compromised in shared governance organizations that are not complete or do not yet work as intended or hoped.

Shared governance is a trust-based system. It purports that *all* members of the nursing staff are full participants in the profession's work. The prevailing belief is that all nurses are stakeholders in the work of health care and want to do all that is possible for them to render good health services. Although the system recognizes that there are a few in the profession who do not share these values, the entire professional system should not be built to protect the receivers of health care from the indiscriminate actions of a small minority, but instead, to validate the commitment and contribution of the majority of nurses who do the lion's share of the positive work of providing health care services.

Nurses are capable and effective caregivers worthy of trust and ownership of their practice and their work. This is the belief on which the whole process of shared governance is built. The structure and its characteristics should reflect this reality. Different from the more traditional participative management approaches, shared governance is based on trust and constructs a trust-based organizational model. There must be a sense in all the leaders in the nursing service, both administrative and clinical, that all are committed to the same purposes and seek the same outcomes.

Because shared governance reflects professional values, it moves the location or positioning of the practicing staff nurse from the bottom of the hierarchy to the middle of the organization. The hard lines of the organizational pyramid are softened and rounded and a more egalitarian approach is created. In the center of the circle is the professional nurse, who by both role and location connects the organization to the service it provides. As Deming concludes, this approach builds the organization around its service provider and creates a relationship between the service provider and the client (the nurse and the patient) (Deming, 1990). All other roles related to that one must support it. In other words, all roles not directly providing service to the consumer of the service are subservient to the service provider. This approach clearly changes the character of the organizational relationships and seriously redefines all the roles in the service setting.

Shared governance models that do not reflect this key value may fail to achieve the outcomes intended by the approach. Unless there is a sincere and true shift of accountability and authority to the staff for those things that are essential to their role, there will be serious problems in obtaining the staff commitment and care outcomes expected from this approach.

There are three prevailing model approaches to shared governance that reflect these characteristics to date: congressional, unit-based (sometimes called administrative), and councilor. These approaches comprise the majority of organizational avenues undertaken by health care settings around the country. Each has a unique organizational form yet supports the common underpinnings and principles of shared governance. These models are introduced here, but they will be explored in more detail in Chapter 5.

Congressional Approach

This approach to shared governance is perhaps the model with the strongest nursing-based structure currently in operation. Its internal integrity and highly rational democratic foundation make a vigorous framework for institutional use of shared governance. The congress, made up of the entire professional body (and designated others as institutionally determined), sets the infrastructure for the profession. The congress elects or appoints from among its membership representatives who will undertake the various accountabilities and functions of the nursing profession on behalf of the congress. Accountability for the work is invested in the committees of the congress that are responsible to the congress for what is done on its behalf. Committees such as practice, quality assurance, education, management, staffing, professional issues, research, etc. are assigned control of the various accountabilities determined by the congress as essential to the work of nursing. The chairs of these committees make up the cabinet of the congress or the nursing staff. The cabinet is the locus of authority for those things that relate to the profession as a whole and all of the professional interests of the nursing staff in the institution. It is the highest executive body in the nursing service and integrates the nursing activities, and functions and deals with major issues related to mission, purposes, finances, and objectives of the nursing service. It also serves as the forum for the chief nursing officer and acts as the liaison between the corporate system and the nursing professional system. It is efficient, tightly structured, and representative and it gives strong evidence of the partnership between the profession of nursing and the organizational system. This is its strength. Its greatest weakness is that it serves nursing well but does nothing to really integrate the health care organization as a whole. It creates a strong power base for nursing but can alienate the other services and create an elitism that can be threatening to others, sometimes undermining the organization. It is also a high-risk model to other professional leadership, notably physicians, within the organization. This approach sometimes make it difficult to start but serves as an excellent transitional model when inroads have been successfully created through an alternative approach. The other two models in the nursing organization can also provide transition toward this model because of its strong internal structure and its viable political statement in the organization.

Unit-Based Approaches to Shared Governance

This approach is perhaps one of the most popular processes. It has the most immediate impact on the staff, with rewards and payoffs coming early in its implementation. It is also the least risky approach because it does not invest the entire nursing service in its implementation. It is usually begun by staff at the unit of service level and often responds to a long-determined need for more staff involvement and ownership. It is a high-ownership model because all the unit staff members are involved to some degree in its implementation or operation.

No two approaches are exactly alike. One of this approach's strengths is the cultural specificity of its application. It most uniquely represents the values of the staff and can be manifested in a range of vehicles. From self-scheduling to standards setting, and from staffing systems to salary programs, many opportunities arise for the staff in the unit-based approach, limited only by the insight, desires, and creativity of the staff. Even clinical delivery approaches and budget design can be addressed in such approaches, which can lead to an abundance of exceptional processes for how nursing work is done and its costs along with the return on the investment of the nurse.

The unit-based model's strength, however, is also its weakness. Although the unit may flourish in this context, the profession as a whole may languish. The diversity of approaches and values emanating from the unit structures may be so diverse and so culturally and unit-specific that a central theme or quality to define and characterize the nursing profession as a whole may never emerge. With this approach, often when the nursing organization attempts to gain a consensus from the various unit models, set a common agenda, or establish a common identity, their differences are so great that the various unit representatives cannot communicate effectively because their understanding of the issues and the shared governance approach may be fundamentally different. The nursing organization fails to become fully functional and ultimately serves merely as the sum of its parts rather than the parts reflecting the values of the whole.

This can best be avoided by developing a unit-based approach in conjunction with the professional model as a whole in the service setting. The service setting should determine the prevailing beliefs and values on which all shared governance activities unfold within the organization. Some attempt to control and moderate unit design should be located in an integrating authority in the service. Effort should be made not to cap the creativity and uniqueness of the unit approach. Rather, the professional authority should simply seek consistency of direction and integration of fundamental values in the process of implementation. Those issues that affect the profession as a whole in the setting should be reserved for the powers of the integrating authority so that units do not dictate practice and rules for the rest of the service or in contradiction to the intents and beliefs of the nursing organization. This approach maintains a healthy tension between the unit development and the organizational integration in a shared governance system.

Councilor Model

This model is perhaps the most frequently implemented method for shared governance. It is solidly based on the delineation of accountability and the principle of

appropriate locus of control. It is an institutional model and provides for both service structuring and unit-based differentiation. It is based on an organizational script that calls for centralization of professional control and decentralization of professional accountability. It is the model with the strongest potential for expansion beyond the nursing organization to include other health professionals and workers in the health care family. It is perhaps more challenging to implement because of its solid accountability base, but it clearly creates a strong basis for both the professionalization of nursing and the behavioral change necessary to a new script for health care.

Like the other models, it requires broad-based support from the executive to the staff centers in the organization. It depends greatly on the cooperative effort of both management and staff for its success. It does not devalue any of the roles in the organization; indeed, it builds on all of the roles that have an accountability base in the nursing service. It does, however, shift the locus of control for specified accountabilities, recognizing that many legitimate accountabilities may lie outside of the scope of the management role, contrary to the traditional delineators in organizations.

The councilor model divides the nursing organization into its five key arenas of accountability: practice, quality assurance, education (competence), research, and the management of resources. It builds an organizational system and the requisite structures on the established accountabilities and spreads authority for them throughout the staff and management. It attempts to sort the activities associated with the delineated accountabilities and build the authority for them within specified councils reflecting the accountabilities, themselves. Typically, therefore, there are four to five councils that have authority over the defined accountabilities. The necessary control mechanisms are invested within the councils to assure that the activities determined as appropriate for the council are performed and that all activities related to such functions are unfolded as expected.

In most cases there are three to four clinical councils and one management council. The clinical councils reflect a character of accountability designated as specifically clinical in scope and provide only for input from the management team. Usually this is provided for minority membership on the clinical council by a management representative from the management council. The prevailing membership of these clinical councils is composed of practicing staff members, and the leadership for the councils is also selected from the practicing staff.

The role of management on these clinical groups is to provide access to information and resources necessary to support decision making within the council. Each council needs to have essential data and supporting information to make decisions; access to some data may not be available. Much key information is provided to the manager to assist in the management and control of the service's resources. That information source and network should be made available to the councils to facilitate decision formation, and entry to it can only be provided by the management leadership. The locus of control for those accountabilities determined to be clinical shifts to the staff, and management support becomes central to the exercise of the clinical authority inherent in the council's activity. Until newer models of information generation and sharing emerge in professional organizations, the manager as moderator will continue to be vitally important.

In the councilor model the manager focuses more specifically on her role in the organization. As staff members become increasingly competent in their accountabilities, the role of the manager in a broader but more specific definition of her role becomes vital to the success of the process. Newer delineators of coordination, integration, and facilitation of the work of the organization become central to the view of the work of the manager. From a narrow departmental focus with a strong operational component to a more systems-related orientation to the role of manager, newer ways of expressing and experiencing the role emerge. The concept of linkage in the organization increases in value and meaning as its application expands from the first-line manager to the executive in the nursing service. The nature of the linkage depends on the role's location in the system and demands a different set of skills and application of the role. The expectation, however, is that wherever the linkage is demanded, the manager must be clear about the role expectation and be skilled in fulfilling the role as effectively as possible. No longer are role understanding and exercise amorphous and ambiguous. Both the requisites and skills necessary to the role must be clear, readily apparent to all, and exercised with the greatest of skill. In all shared governance models, clarity of design, structure, function, and role are essential to the success of the model.

This model does not clearly define unit level activity or structure. It does not intend to prescribe those activities that should unfold at the unit level. Instead, this model seeks to provide a framework within which unit approaches can be designed to reflect both the service and culture of the unit. The only caveat that operates in this model is a constraint on those activities or approaches that may not be in concert with both the design and structure of the prevailing shared governance model. This model, therefore, provides an approach that attracts both unit level approaches with the need to integrate at the divisional or departmental level.

FORMALIZING THE STRUCTURE

There is limited reason to move toward a staff accountability-based shared governance prototype if it does not empower the staff and alter the way in which they are involved in decision making. Shared governance should change the very character of the organization and the relationships essential to its work.

Formalizing the shared governance structure and creating firm parameters for its successful operation are necessary for the system to function effectively. Both the culture and the operating system must reflect the character of the model in the way in which the organization does its work. Included must be the roles and relationships that emerge in a shared governance structure. There would be little value in implementing a shared governance approach and simply having it parallel or report to the existing reporting structure, with no substantive changes in the organization's operations. Empowerment would become merely an empty idea.

Giving empowerment substance requires a supporting structure that indicates respect for and involvement of those who have been empowered in the real decisional process. Value for this approach must be reflected in all the arenas where shared governance can have a legitimate impact. From administration and board to the other service providers, the shared governance approach should change the na-

ture and content of the relationships entered into between nursing and the rest of the organization.

In the first instance, the nurse executive is key to this transition. She must first believe that the shared governance model has legitimacy and can function effectively to empower the profession to do what it needs to do in delivering health care services. She must be committed to the nursing role in the organization and the right of nurses to play key roles in decisions that affect patient care. This is a vital consideration in implementing shared governance.

There are some (mostly those in clinical practice) who believe that the nurse executive soon forgets her fundamental foundation in nursing when she becomes an administrator and thereby becomes an opponent. Implied in that accusation is that she is no longer sensitive to the issues that emerge from the practitioner's perspective and work experience. Generally this is not true; indeed, most nurse administrators are as sensitive to the needs of patients and nurses as anyone else. Sometimes, however, the nurse administrator's perspective related to the practitioner shifts because of differences in role and the traditional power obligations and relationships in the job.

As an administrator, the nurse executive has an obligation for the appropriate use of institutional resources and the production of sufficient revenues to maintain the viability of the health care facility. The problem, however, is that in that role, the nurse administrator owes the predominant obligation for her position and its continuance not to the nurse's exclusive support but to her colleagues in administration and members of the board of trustees. Of course, the nurse executive could not survive without the long-term support of her peers in practice, but this is really a secondary consideration. This difference in perception and expectation may create tension in her role, but it can be easily managed through the control of information and through use of traditional participatory strategies.

In the "darker" character of her role, the nurse executive has the ability to manage and control both participation and resources, including the decision-making process. If she desires, she can manage and manipulate relationships and resources for her personal viability and advantage. She can, if she wants, manage the political framework and power equation for some time without truly empowering her colleagues and peers. In some cases, she can even create a powerful dependency (or codependency) relationship within the nursing organization to both maintain her power and to accelerate her personal value. For a few more controlling personalities, in this scenario, to share power is to lose it. For others, usually more insecure administrators, getting power and keeping it is difficult enough; to share it risks too much in both personal investment and organizational change.

Although there are certainly other factors in this scenario, it is interesting that many times the largest single provider of health care services is afraid to make substantive changes in the work structures and relationships that can both benefit the profession and, therefore, patient care. Unilateral and paralyzing fear of what others would think, or how they would respond, how the medical staff feels, what other departments think, whether it would be permitted, etc., in some cases indicates the relative dependent relationship of nursing and nurses to the prevailing structures. This is true in many organizations even at a time when it is claimed

nursing has the strongest and best-educated leadership available in the health care system.

Moving to shared governance is a risky enterprise. It is an effort to create a new organizational model that better serves the needs of nurses and their patients. To empower means to shift the power arrangements and to create new sources of power. The belief is that there is a net enhancement to both the nurse and the organization. Such a critical shift represents a transformation of everyone's roles and relationships, including those of the traditional manager and administrator as previously indicated in this chapter.

CREATION OF STAFF LEADERSHIP

One of the most dramatic and difficult undertakings in the development of shared governance is the culturing of leadership skills in the staff. Because shared governance is a staff-driven model, exercise of leadership skills in the various forums of decision making is not optional for the staff leadership.

Although the need for leadership is unquestionable, the availability of it in a staff that never expected to assume it in a formal way is uncertain. At times, there are those, who by predisposition or previous exposure, are strong leaders. Usually these people do not readily or freely emerge in the nursing organization. Not only do they not emerge, but staff members are often reticent to undertake the leadership role. The degree of risk and the uncertainty of the role sometimes predicate against assuming these roles.

Operating to moderate the emergence of staff leadership is the uncertainty of the shared governance process itself. Often staff members are unable to conceive an organization that would be willing to allow the staff to govern themselves. They may feel that there is a "catch" somewhere, or that some manager is waiting, ready to second-guess the exercise of staff authority and decisions. Genuine feelings of inadequacy are often present during the initial stages of shared governance implementation. It is not surprising, therefore, that many staff members are both unprepared and uncertain about assuming leadership or becoming active on shared governance forums.

A slow transition to the role of leadership with the staff combined with liberal support are essential at the outset. The staff members must trust that they are, first, respected in the role and then have a base of support available to them when needed. An orientation to the expectation of the role as either a member of a key governance group or the group's leader is often needed. Depending on the degree of authority and commitment, a training program that provides the essentials of the leadership role covering such topics as group process, group dynamics, problem solving, priority setting, consensus seeking, and agenda writing is an appropriate way to indicate solid support for the effectiveness of the leader. Time invested in the staff leader early in the developmental process will be beneficial in effective work in the governance bodies later in the process.

Lack of preparation for the role and the requisite supports are often the greatest barrier to the success of the staff leadership role in shared governance. Although some of those expenditures may appear like major commitments at the outset, they

are returned to the organization in positive group output and the value of the leader to the organization.

The successful application of the leadership role in the staff is central to effective expression of power in the governance bodies. Because most decisions will be made there and the successful operation of the nursing organization depends on the work of the governance groups, both the quality of the process and outcomes of the group are critical to their viability. To facilitate this requires some sophisticated insights with regard to the culture and character of the group, its definitive work, and those processes that enable the group in its work rather than inhibit it.

Staff participation is also critical to the success of any staff model. At the outset, however, staff members will not participate in overwhelming numbers. Some have even indicated that the staff purposely stays away. This is acceptable behavior, which reflects the staff's current values and limited job-based investment in their profession and work. Most see what they do as job-directed and are dedicated exclusively to doing the work that is required, when it is required, and then returning home to the nonwork aspects of their lives, often forgetting they were ever involved in it.

Many nurses would object to this characterization of them, indicating that there are many who feel strongly about their role and are very committed to the work of the profession. This is undoubtedly true and the sentiments are valid. The focus of the above statements is related less to the dedication of the nurse and more to the structure that fails to give that dedication direction and form. If the practicing nurse sincerely wants to express professional values in a legitimate forum, she often has to leave her patient care work and move into other more significant decisional and power roles in the organization to do so. Even this scenario creates frustration and confusion, simply because as she moves further away from the work of nursing, she is both perceived to be and is actually less in touch with the practice setting.

To change this paradigm requires much work and time. Of course, the whole foundation for shared governance reflects the attempt to address this problem within the context of the organization without creating either threat or revolution. As some of nursing's more devout feminists would advocate, revolution may be exactly what is needed in the health care system (Maraldo, 1990). It is important to reflect that all parties to the venture must arrive at the future together and the continuing attempt to create ascendant responses will, over the long run, be futile.

Shared governance must use all of the available resources to create an effective delivery and governance response to the changing role and demand for the nurse. This is characteristic in the attempt to empower all the nursing roles affecting patient care. Each member of the nursing team has a primary right and obligation to participate in all the activities that focus on the delivery of nursing care services. Connecting this person in the current clinical setting to important decision making is the central theme of an effective shared governance system. It is in this effort that true staff leadership will emerge.

CLUSTERING AND UNIT TO DIVISION RELATIONSHIPS

Connecting the nurse to effective decision making is only half of the connection necessary to ensure that shared governance succeeds. Organizational and systematic connections are necessary if it is to operate effectively throughout the system. As indicated earlier in this chapter, formatting shared governance for only part of the nursing system and not integrating it with the whole can create disconnections and inadequacies in the organization. One of the main purposes of shared governance is to link members of the profession in a way in which they can have a collective role in affecting nursing decisions and activities. On the other hand, it would be inappropriate and ineffective to have large numbers of nurses in groups trying to make quick and effective decisions for the professional body as a whole. It is for this reason that group size is a major consideration in shared governance models. Because the key decisional groups must be kept small, their linkage to the organization and its components becomes increasingly important. Clustering services or units of like size and service often assists in reducing the tension of too broadly based representation on the one hand, and focuses decisions within the appropriate groups on the other. Selecting the decisional leaders from these cluster groups helps link the service clusters and entities, allowing them to feel properly represented to the key decisional forums in the organization without overwhelming them with members. Often the representative to the nursing service governance group can link that group to the cluster more directly by being selected as the chair of the cluster group and as that cluster's representative to the governance group. This approach is especially beneficial in larger hospital models (more than 300 beds) since it maintains effectiveness in the model without overwhelming its membership and drawing nursing resources away from the workplace in great numbers. In these constraining times, it is wise to select approaches that support the judicious use of nurses' time and keep them as close to their service as possible. Clustering works well to link the unit/service setting and the departments/division for effective decision making in both arenas.

SUMMARY

Much activity has unfolded over the past 10 years that has given nursing opportunity to grow in ways not previously possible. Shared governance has enabled nursing professionals to exercise great control over their practice and decisions that affect them. It has expanded the individual and corporate sense of self and contribution to the delivery of health care systems. It has done much to create in organizations the equity and parity in role, relationship, and responsibility between nurses (notably women) and hospital and health care leadership. Through it much freedom to risk, undertake creative change, alter service structures and patterns, and take control of the delivery of nursing has emerged with the resultant improvements in productivity and outcomes.

Shared governance is only the first step in a series of moves that will be necessary if the profession of nursing is to provide the leadership and set the direction necessary to retool the health care delivery system. It is simply the vehicle for

starting the journey that will move nurses in that direction by establishing an organizational format that invests all its members, creates a mechanism for equity and power sharing, establishes a structure for retooling the work of nursing, and positions the nursing profession to restructure the way in which health care is delivered.

Although shared governance represents a significant step toward creating the future, it is just a first step. Newer models and arrangements must emerge that join the nursing professional with other services and professions to address broad-ranging service issues in a transformed health care system. Ownership of nursing and nursing practice must continue to move into nursing hands and then be repartnered with other services and service providers in equitable and meaningful ways. Empowering nursing to simply have unilateral or ascendant power becomes parochial and self-serving, and provides nothing to positively affect either those nursing serves or the profession itself.

These are exciting times for nursing. The old rules and ways are quickly passing. The future is radically different from the past. Innovative and creative efforts are necessary to change the health care system in ways that are more health giving and responsive to the health rather than the illness needs of the American society. All nurses must be involved in the effort to respond to this change. Shared governance provides the opportunity to those who seek it to fully participate as partners in creating a better, more meaningful health care system. Shared governance provides a forum to look beyond what is currently in place and to secure nursing's place in the future of health care delivery.

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