accountability-based system. The concept is founded on individual accountability as opposed to individual participation in management. The basic belief system supports the concepts previously discussed in this chapter as well as in Chapters 1 and 2. The actual structure used to facilitate shared governance beliefs varies from organization to organization. Whether a system chooses the councilor or the congressional model of shared governance or others (see Chapter 4) is not as fundamentally critical as ensuring that the structure is sound, complete, and truly integrative of the critical elements arising from the belief system.

## PROBLEMS ENCOUNTERED WITH REFORMATTING NURSING WORK GROUPS

Nursing work groups are a significant part of the hospital environment. The grouping of nursing professionals varies from unit to unit, but in most systems, nurses are organized around a particular patient population base. They integrate into their group the full-time unit-based care support staff members and consider the nurse manager the group's leader. This structure is pervasive in most health care settings. Traditionally, the nurses and the support staff report directly to the nurse manager. The professional staff have some degree of autonomy with their practice environment on a one-to-one basis; however, overall the nurse manager is seen as the group leader. In addition, any support staff member who does not report directly to the unit's nurse manager may be viewed as not being within the control of the nursing unit's power base. Such members may be recognized as a necessary part of the team effort, but because of the lack of the direct hierarchical control over them by the group's leader (the nurse manager), they are not recognized as having full membership rights. This is the culture of most units in traditional hospital systems.

For professional practice models to work, there must be some alteration of the basic assumptions surrounding nursing work groups. There must be a way to reorganize the groups along a structure that more appropriately fits and reinforces the professional caregiver's role. The culture of the group must change to accept that new structure and the new relationships that coincide with the new structure. The traditional view of all the team members being the "same" or "equal" needs to be addressed.

### Equal but Different

Most professional nurses identify with the support staff. Nurses recognize the value support staff members bring to the system. The professional nurse also recognizes the desire of these individuals to feel needed and valued in the roles that they fulfill. Too often, however, nurses sacrifice their own professional values and fail to act as responsible, accountable professionals to help satisfy the support staff's need to feel "equal" to nurses. The word "equal" is what creates problems. Everyone agrees that all staff members are equal as human beings. Everyone deserves the same respect and treatment. This basic belief is one of the underpinnings necessary for the introduction and maintenance of a truly decentralized professional structure. However, the central point is not "equal"—rather it is "different." That perspective needs to be communicated to the staff nurses frequently so

that they understand that being different does not mean that one person is a better human being than another; it merely means that one has a different role and a different set of responsibilities than another. To acknowledge less than that leads to compromise of one's professional responsibilities.

Traditionally, the system has recognized and treated nurse managers differently than staff nurses. There is the perception that staff nurses are not equal to nurse managers. This is reinforced by the historical bureaucratic structures that afford the decision-making authority to management. Society indirectly reinforces these beliefs by perpetuating the concept that the importance of an individual's work and worth within an organization is based solely on a person's salary. That attitude has been a great disservice to all systems.

Nurses must recognize that they are *different* from others, including their fellow support staff members and their nurse managers. Nurses must recognize these differences and accept them without placing a value on the differences. Placing a value, or allowing others or society to place a value, on the differences is the mistake that will lead others to feel they are not being treated equally as human beings. The difference is critical in the implementation of a professional practice model. Management's understanding and integration of this belief into everyday functioning is also critical to success of the transition. The popularity of clinical advancement programs that afford nurses the opportunity to be recognized through the more traditional indicators of success (increased salary and benefits) is a tribute to the nurse executives and nurse managers beginning to respond to the need for permanent changes in traditional attitudes toward the basic "hands-on" care provider. The pyramid that has been the foundation of the traditional health care organizational structure is starting to disappear.

## Uses of Licensed Practical Nurses in Hospitals

Prior to strict enforcement of state practice acts and more rigid accreditation standards, licensed practical nurses (LPNs) functioned in expanded capacities beyond their original preparation and education. These support staff members were used to perform advanced procedures and were expected to fill in when registered nurses were not readily available or desired by some systems. Registered nurses sometimes provided supervision for the care given, but overall the LPN was fully responsible for providing the level of care delivered. As the profession of nursing became more organized and nursing started to closely examine the practice of nursing, the differentiation of the practice of "nursing" was questioned. Not only did nursing question the difference in role of the LPN and the RN, but also the difference in role of the RN compared with another RN with different educational levels. Nursing as a profession began to mature and state practice acts followed. Accreditation standards became more rigid and the role of the RN versus another staff member became an issue. For years LPNs had been told, both directly and indirectly through behavior and complacency, that they were prepared to plan and provide the care necessary for the patient. As times changed, nursing began to question whether or not that standard needed to change.

Health systems began to redefine the role of the LPN. LPNs as an organized group have encountered much difficulty and misunderstanding regarding the differentiated practice movement that has entered nursing. It is easy to understand

some of the emotional elements experienced by LPNs. The issue at stake, however, is not "equal" but "different." Nursing care systems must stop sending mixed messages to LPNs. The new differentiated roles are clear and understandable. Stability and consistency of application are needed to reinforce the appropriateness and legitimacy of the critical role LPNs play. If inconsistencies exist, there will be continued unhappiness and unrest. The message must be clear and precise—the role is critical as care support staff; however, the final decision making, planning, and evaluation must be provided by the professional practitioners. If that perspective is not accepted and understood by both the professional practitioner and the LPN, then group growth will be inhibited. Reformatting work groups not only involves sometimes redefining who the members are, but also adjusting roles and responsibilities among the members of the groups.

## Nursing as a Female Profession

Nurse executives must deal with the issue of nursing as a female profession. Much has been written about the nursing shortage and the predisposing factors that led to the situation regarding the salary compression issue. In fact, many authors attribute the root of the problem to the fact that most nurse are females. Females have a long history of inequality, and it is well documented that long-term oppression can cause behavioral changes in individuals. Beattie (1987, p. 28) defines the condition of "codependency" as "an emotional, psychological, and behavioral condition that develops as a result of an individual's prolonged exposure to, and practice of, a set of oppressive rules—rules which prevent the open expression of feelings as well as the direct discussion of personal and interpersonal problems." As a group, nurses have demonstrated codependent behavior as a result of long-term oppression in health care, coupled with long-term oppression in society by predominant masculine control. Nurses are beginning to recognize the caretaking behaviors that are not appropriate and are beginning to resocialize toward more appropriate acceptance of responsibility. Nurses will continue to be educated and resocialized to envision themselves in a professional context as more professional practice models unfold.

To accomplish this resocialization, consistency and education within a supportive culture are necessary. The change must begin with nurses themselves. Professional nurses must learn to solve problems effectively and to feel comfortable in that role. They must actively listen and communicate clearly and appropriately with their peers, colleagues, and support staff members. Nurses need skills to resolve conflicts constructively. They need to practice assertiveness in regard to their own needs. In short, they need to act and behave as adults in a professional world. They need to accept accountability for their own actions, and expect their peers to do likewise. Nurse executives have a critical role in supporting, encouraging, and rewarding these new behaviors as they occur. Staff nurses must take considerable risks to break out of the old mold and risk new behaviors. Some type of reward or reinforcement must be afforded those who take the risk.

The nurse executive plays a critical role in creating a supportive environment within which nurses will feel more comfortable in taking risks. Traditional management controls create question and doubt regarding the consequences of risk-

taking. What will the result be? Ultimately, actions speak louder than words, and nurses will be focused on management's response to the new behaviors. It is imperative that the initial responses be supportive and sincere. Nurse executives and nurse managers alike must portray an accepting attitude for the expression of opinions and ideas. Early in the change process it is important to reinforce the presence of participation and risk-taking as opposed to an in-depth critique of every action and decision. Management must clearly articulate its value for staff members' decision-making responsibility as it pertains to the practice of nursing.

## Issues with Staff Relationships

Nursing has always had some type of structure that allowed for the coordination and integration of nurses with other nurses, and nurses with support staff members. Those structures are changing as the environment toward professional practice evolves, but the need has always been addressed in the past. Nursing is comfortable in defining and redesigning its affiliation and linkages within its own "department." The unfamiliarity occurs in reaching out and setting up linkages and networks within the medical staff and other practitioner bureaucracies.

Historically, there has been conflict between physicians and nurses in health care. Some of the conflict is traceable to the history of conflict between men and women. Physicians and hospitals have a unique relationship that is not duplicated in other major industries. Physicians, by virtue of the American health care system, control access to hospitals. Hospitals depend on physician admissions to fill their beds. The critical nature of the relationship is such that the hospital will do whatever is necessary to keep its "customers" happy. Physicians have enjoyed this special treatment for years. Conversely, nurses have been oppressed generally, and have suffered for lack of input and participation in decisions affecting them. They have watched physicians influence decisions for years. Some nurses who have watched this process will even attempt to resolve problems and meet their needs by appealing to the physicians they know who hold power and are listened to by the hospital administration and board. It is natural for nurses to feel angry because of the historical treatment afforded them. However, rather than channel that anger in an appropriate avenue, some nurses direct their anger at the people who benefitted from the system's preferential treatment—physicians. Physicians' long-standing power base in health care systems is diminishing each year; however, it still affords the profession considerable influence beyond that generally afforded nurses and other professionals. Nurses must continually seek ways to resolve their anger and move on to construct better relationships with physicians in the future.

For nurses, physicians, and other allied health practitioners to work collaboratively, they will have to individually accept that their roles and responsibilities are different. "Different" but "equal" is again the key concept in this equation. Nurses and others alike often agree that the primary reason for lack of cooperation among them is that physicians and others are not truly aware of the unique contribution made to patient care by nurses. Hospital units are busy with acutely ill patients. Physicians often visit patients and write orders without seeing the primary nurse. Therapists' schedules are busy and rarely afford them time to discuss their pa-

tients' case with the nurse or physician. Physicians and therapists alike do not fully understand the level of education and knowledge needed to provide highly complex nursing care to acutely ill patients. Opportunities for one profession to educate the others regarding their work and its current developments will improve interdisciplinary relationships and levels of understanding. Such interaction will encourage equality as each group realizes the unique contributions of the other. Trust and respect are developed through interaction. The health care system has failed to provide any link for that interaction to consistently occur within health care institutions. As a result, professional groups have grown apart. Quality patient care depends on "fixing" that part of the system.

Shared governance has contributed significantly to the system's ability to bring these practitioner groups together again. Although the initial application of shared governance principles and concepts was to nursing divisions inside hospitals, that has not precluded their natural progression to fields outside of nursing. Nursing recognized the need for the fundamental changes and was willing to take the risk to start the process. However, it is clearly evident that the process need not stop with nursing. The foundation of shared governance needs to be the driving force to accomplish the widespread restructure and redesign of all the professional components of the health care system.

The issues that confront nurses as professionals within hospital structures are the same issues that trouble other practitioners. Autonomy, control, responsibility, accountability, and participation are a few of these common issues. Sharing the experiences of how to address those problems across all professional groups affords an opportunity for all the professionals to realize their similarities. Nursing can help medicine find ways to improve peer review and quality assurance; medicine may help nursing achieve greater accountability for individual practitioner actions; nursing can assist other professional practitioners to find ways to more fully integrate their care with the overall plan of care. All these activities will ultimately bring the practitioner groups closer, improve relationships, and improve the quality of care provided. As the quality of care is improved, the relationships will become further solidified. The vision is clear. Shared governance is purely a catalyst to bring about change.

## EMPOWERING NURSES TO PARTICIPATE IN CHANGE
### Basic Beliefs

Nurse executives, regardless of their degree of motivation to create a professional practice environment, cannot do it alone. They need their managers' and their staffs' support. They need to create an environment that motivates managers and staff to participate. Empowerment is the goal. One of the basic beliefs needed to support the culture necessary for a professional practice model is that people have the right and the duty to influence decision making that affects them. In professional practice models, affected professionals also assume accountability and responsibility for themselves and their peers. These principles mandate involvement by the practitioner to a degree not previously experienced by most nurses. Participation has always been present in most systems, but participation is different from accountability for practice.

Nurses live out values that are different from those of management. The skills and knowledge needed to manage a group of patients differ significantly from the tools and information needed to manage a practice environment and a group of practitioners. How do systems provide the transition for their staff and empower them to get involved?

## Creating a Vision

The first step in reaching empowerment is creating a vision. Nurses and other professionals in hospitals have practiced for a long time in a system whose only vision was to survive financially and provide good care. Such goals are still appropriate, yet coupled with those goals is the need for a new vision of a changed work environment. Nurse executives need to create a vision of a true professional practice environment.

The nurse executive's role in creating and communicating the vision is critical. First, the vision must be a reflection of what the nurse executive thinks and feels. Nurses need to know that the vision is sincere, not just a result of a well-designed recruitment and retention campaign. Sincerity in what is said is as important as constant verbal reinforcement of these beliefs by the nurse executives. Second, the vision must be understood. The nurse executive must describe examples of the vision that reinforce the significance and meaning of the change. Personal commitment to the vision is reinforced when nurses perceive a deep level of understanding of the vision's impact by the nurse executive. Third, periodic implementation of specific actions that support the vision is necessary. General concepts are appropriate ways to focus on change; however, translation of those concepts into specific action steps helps reinforce support for the change over the long term. The nurse executive must be the expert, the cheerleader, and the matriarch of the vision throughout the transition.

Staff members must feel that the culture will be supportive and nourishing of the changes needed. There is no mandate for the final structure of the system to resemble the initial vision—in fact, if it did it might hamper creativity and innovation. The vision needs to be stated in conceptual terms and system beliefs, rather than by articulating structural specifics. Keeping the vision clear and always present will empower nurses and others to act. Their actions will bring the system closer to the goals described in the vision. The clearer the vision, the better the decision-making capability of those working toward the vision. The more people work toward the vision, the more they will identify with it, and thus increase ownership of the goals necessary to attain it.

## Decreasing the Fear

As mentioned previously, staff nurses are not familiar with management skills and practices. Historically, managers have taken accountability for all the areas of the practice system, including many of the decisions regarding patient care. For systems to smoothly transfer accountability for certain elements to the practitioners, not only does there need to be a structure in place to organize these new players, but there also must be education for the practitioners about systems and their operation. Most nurse executives would feel personal stress and chaos if asked to manage a full patient load in the intensive care unit because of significant

periods of time away from the environment and unfamiliarity with the equipment, new drugs, and practice. The same is true of the staff nurse who is suddenly asked to participate in managing elements of a system with which she is somewhat unfamiliar. In addition to the unfamiliarity with managing groups and systems, the staff nurse has an added element to deal with: fear. Walton (1986, pp. 72-73) refers to Deming's theory in his 14 points to improve organizational efficiency that fear in the average employee is higher in America than anyplace else he has observed. Many employees are afraid to ask questions and take positions. There seems to be an underlying culture that reinforces the fear. It is obvious that fear in a professional system seriously hampers the organization's efforts.

Education of management and staff regarding professional practice systems helps decrease the usual fear associated with change. Information and knowledge are critical elements to address through constant communication. Communication channels that are open and free-flowing will also assist in decreasing fear. The basic premise is that information reduces fear. As more information is available, workers will feel more comfortable in understanding the change, and therefore comfortable in discussing their involvement in the change.

As the professional system's structure matures and responsibility and accountability for the professional practitioner's actions and level of competence are transferred to peer levels, then the traditional management control over compensation and benefits will also be eliminated. Trust must be developed through careful planning and thoughtful collaboration among management and staff members regarding the gradual transition of these economic concerns into the arena of the practitioner. Careful planning itself is educational and greatly improves a person's success rate.

Perhaps staff members' greatest fear is the fear of being fired. Management has traditionally had such power over nurses in hospitals and still retains it in most systems. Physicians are independent practitioners who are not employed by the system and therefore are not concerned about being "fired." They are disciplined through peer review activities. There is generally a higher standard of "proof" associated with that activity than in a normal employee situation. In mature professional practice model systems there has been progress toward the nursing staff's control of entry and exit from the nursing division for professional practitioners. This trend will tend to focus practitioners on peer accountability issues but will also hopefully decrease fear of average staff nurses that the system would choose to fire them without appropriate justification. Professionals need to first feel accountable to themselves and their patients before they can feel accountable to the system that employs them.

## Power and the Need for Power Shifts

Power is a complex concept. It extends across all relationships and exists and manifests itself in some form at all levels of an organization. In most organizations, the locus of power still rests primarily with management. Hospitals are no exception. Transition to a professional practice environment will demand a shift in that locus of power and decision-making authority.

Having power implies having control over a situation or person. Generally,

people who have power feel "in control," whereas people who do not have power feel "helpless." Helplessness, the belief that one cannot influence the circumstances surrounding one's life, undermines the incentive to learn. It interferes with intrinsic motivation and satisfaction. Professionals are obligated to be accountable and to continue to learn and strive for improved outcomes. They need to feel in control of their practice in order to feel accountable for their practice. The mandate is clear—the focus of power over professional issues in professional organizations must shift to those professionals accountable for the outcomes.

## Managers, Challenges, and Changes

Peters (Peters, 1987, p. 345) writes, "I am frustrated to the point of rage—my files bulge with letters about the power of involvement. Sometimes it's planned . . . Sometimes it's inadvertent. But the result is always the same: *Truly involved people can do anything!*" The frustration described by Peters is proof of the power that midlevel management has over any change process. It is imperative that midlevel managers feel ownership in and support the change process.

Restructuring toward a professional practice model entails certain requisites. One is the decentralization of the system, especially the professional arenas. How the majority of nurse managers obtained their current positions is considered below.

Until recently, nursing has not created a clinical track that affords the same salary, benefits, and status as management positions offer. In the past, many nurses, because of internal and external motivators, felt the need to move into management positions to achieve the degree of freedom, flexibility, and participation that management could afford them. The salary and benefits at the management level were also significantly better. No other options for such growth existed. The hospital's most senior nurses frequently moved into management roles as positions became available. In most hospitals, managers continued to fill the clinical expert role in addition to the management role. Then professional practice models emerged. Nurse leaders started to discover that the old ways would not be effective over the long term. They realized that perhaps the system that forced nurses to leave practice and move into management was not the type of system needed for the future.

Today many systems are trying to make the transition to a more logical organizational structure that will enhance long-term survivability. However, through that transition the system is, in effect, "changing the rules" that affect those clinical nurses who moved into management at a time reflective of "older" values. In most hospitals today, these managers are usually the first-line contacts with most professional practitioners; this makes their support even more critical. These managers need the system's support for concentrated education to help them understand their changing role. They will have to understand the need for change and sometimes seek assistance during the transitional process. Finding ways for those who no longer want the management role to return to clinical nursing without economic or status loss will help the nurse executive deal with the frustration that some experience. Those who choose to remain in management instead of clinical nursing should do so because of an independent career choice, not because they are forced

to as in the past. Once all the managers realize they have a career choice, and know their role through education and information sharing, they should begin to support the change process and feel ownership for it.

## Urgency as Energy

In *Teaching the Elephant to Dance*, Belasco (1990, p. 345) says that a sense of urgency is the source of energy necessary to affect change. Urgency is a good descriptor for health care environments today. Nurse executives would agree that the climate is right, the timing is right, and the motivation is present to move the change through the health system. The urgency comes from the factors demanding the change in the system, including decreasing resources, both human and economic. These decreasing resources are demanding that attention be paid to how the work is currently accomplished and finding avenues to achieve the same results with less use of valuable resources. Numerous examples exist in systems that describe that attempt. Such changes include new nurse assistance positions, increased automation in charting and documentation systems, tighter utilization review programs, and standards based on newer research regarding patient care outcomes. There are also new accounting systems that help quantify the cost of the care provided so it can be coupled with patient care outcome, to bring about desired changes in utilization practices of practitioners. Several research projects have been funded and are ongoing to help clarify the critical factors that cannot be compromised without an undesired change in patient outcome. The urgency will continue as the population of America ages. Predictions are dramatic as to the impact this single demographic phenomenon will have on the health care system (Rubin and others, 1988).

The nursing shortage has had a dramatic impact on hospitals throughout the United States. It also clearly has increased the focus on nursing's problems with the current structure and systems, and has created a sense of urgency toward the resolution of those problems. Timing is a critical element in any change process. It is clear that timing is now prime for nurses and other professionals alike to be energized by the urgency of the situation and work toward change. Nurse executives need to appreciate the sense of urgency and understand it for what it is— energy moving toward action.

## OBSTACLES TO EXPECT
### Expect Change to Be Slow

No matter how well planned the restructure and change, problems will be encountered. The ability to anticipate some of the obstacles to be encountered helps maintain focus and momentum. Knowing that certain behaviors and situations are likely to occur provides the opportunity to plan to handle those problems even before they occur. Older organizations tend to have more formalized behaviors (Mintzberg, 1989, p. 106).

Change occurs slowly. Well-established systems have developed and formalized approaches to problem resolution. Historically, those approaches have not included employee participation to the degree that is necessary today. Changing the

basic concepts of operation of any complex system, especially one as complex as a hospital, requires extensive time and energy.

## Emphasize the Long Term

Managers and nurses alike will occasionally exhibit short-term memories. Frustration will be a nurse executive's companion. It will be challenging to remind people to think ahead and keep the vision clear. One way to sustain motivation over the long term is by setting short-term goals and short-term successes. Developing a timeline maps the change process. Periodic success—points that can be publicly acknowledged—should be included in that timeline. Staff and managers alike need to be reinforced; all influence the achievement of long-term success. Once achieved, everyone should hear about the success. Spreading the word spreads enthusiasm.

## Remind People the System is in Transition

Because change itself is a long-term venture, the change facilitator will encounter problems regarding expectations and timing. Even if the long-term vision is clear, it still takes years to complete and stabilize any new system. In the interim, people will be confused between the vision and the reality. It is important to inform people of the change process and the expected levels of compliance with the new system. The system will be in transition and, therefore, people need to be tolerant of the inconsistencies in the short run. To be tolerant, there must be understanding. Leaders must encourage everyone to take responsibility for the vision and begin to understand and appreciate the current position on the continuum of change. Formal and informal channels of communication are critical in keeping people informed. The change agent should stress that situations may seem to be in conflict with the long-range plan. Examples of successful systems help to remind people that the change is possible and working in other settings.

## Expect Critics and Skeptics

Staff members need their questions and remarks answered directly and should be encouraged to participate in analyzing the issues they present. Respect for staff members permits them to voice their concerns. Hospital systems are complex. Managers use a vocabulary that is foreign to most staff nurses. Unfamiliarity usually creates caution. Unfamiliarity with a management change that could affect a worker can create fear and distrust. If the system does not keep nurses informed and up-to-date, critics and skeptics will increase. Free-flowing information and participation will alleviate unfamiliarity and thus decrease criticism. Talking directly with the critics is helpful. Determining what their issues are, if legitimate, facilitates some resolution. Another strategy is to enlist the help and support of critics. Finding a role for them to play creates a sense of ownership in the process. People usually want to do the right thing.

## Confront Procrastination

With today's dynamically mobile health care environment, when is there time to bring about large-scale change? Most days can easily be filled with "firefight-

ing" rather than determining long-term strategy. Most chief executive officers, nurse executives, and staff leaders find it difficult to maintain focus on long-term change amid chaos. Thinking about the world of the average staff nurse can be even more perplexing.

Staffing shortages are universal, as are cost constraints. Patients are more acutely ill. Patients and families are more informed and thus have greater expectations regarding nursing care. Doctors feel controlled from all sources and probably attempt to control whatever elements they feel they still can influence. Most nurses are female, wives, and mothers with increasingly complex role demands. Within such an environment, there is there room for nurses and time to participate in creating change? Convincing nurses that change is needed is not always necessary, but helping them find the time is vital.

Procrastination is a major problem for both the executive and the staff nurse. Procrastination is worsened by the fact that the change is long term. The strategies to deal with procrastination are similar to other strategies previously discussed. People need to be informed. Projects should be broken down so that small successes can be achieved. Successes should be visible so some outcome is recognized. Success encourages motivation and participation. Participation and success by some staff nurses in the change process will generate participation and eventual success by others.

## Exhibit the Right Attitude

A project of any length will naturally involve some mistakes. Mistakes are not a problem—negative reaction to mistakes is more generally a problem. Any negative circumstance can be viewed with a positive perspective: if nothing else, at least a lesson may be learned. The entire incident can become an opportunity for motivation. Staff nurses may fear participating in real change and risk-taking if they do not know their leaders' probable reaction to failure or mistakes. Attitude is important. Even leaders make mistakes. The organization can recover.

Change is inherently difficult. It brings joy and some pain and hardship. It causes people to question basic beliefs and challenge the past. It forces people to reexamine and question everything they do. Change forces people to become self-reflective and question their motivation and creativity. It creates uncertainty and confusion.

Change also brings revitalization and rejuvenation to the workplace. It allows people to relieve boredom and daily routine. It cleanses and challenges. Change brings opportunity and growth. Change challenges those affected by it to view it in the most positive light, and believe that chaos and creativity are positive experiences, exhilarating and finitely necessary for growth.

## SUMMARY

Today's health care system demands a new perspective from nurse executives. That perspective needs to be adaptive, responsive, facilitative, and supportive of change. Organizational structures of the past need to be reevaluated in light of this new perspective. Professional practice models such as shared governance are

emerging as concrete examples of ways that hospitals can address these new demands.

The foundation for professional practice models is accountability. Nurses must be accountable for the delivery of nursing care and have an obligation to fulfill the mandates of the system to achieve that end. The system reciprocates by offering appropriate levels of support to those professionals through human, material, and fiscal resource allocation and coordination. The relationship must be one of mutual respect and commitment to the goals determined by both parties. Problems occur in any system and will occur with professional practice models. Through a shared commitment, problem resolution becomes more effective and efficient. Systems for dealing with common problems related to professional practice models can be discussed and resolved early in the structure's development.

Hospital nursing divisions have historically been complex organizations. They have a history of reinforcing dependency-type behaviors in nurses and other professionals through complex controlling structures. Requisites for change include a firm, consistent set of values, long-term commitment by the nurse executive and others, constant evaluation and reevaluation of each element of the system, and education of all parties to keep the vision alive. Keeping the vision alive is the primary goal of the nurse executive. Other steps will follow more easily if the vision remains clear and understandable. Obstacles are to be expected during the redesigning of a nursing organization. Nurse executives should expect obstacles and view potential roadblocks as opportunities and validation that the change process is effective and the goals are attainable. The vision of change is not without problems or possibilities.

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