3 *Redesigning the Nursing Organization*

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Words such as *disruptive, chaotic,* and *whirlwind* are used to describe current health care systems. In Cybernetics II theory, fluctuations are viewed as positive, expected, and the main vehicle for creating order in systems (Smith, 1984, p. 273).

CYBERNETICS II THEORY

Cybernetics II sounds like some space-age theory with no relevance to nursing; however, it is an applicable theory that affects the entire health care industry. It is a new system of thinking that expands on the traditional parameters of open systems theory (also known as Cybernetics I). One of the two principles central to this new theory is the concept of dissipative structures. Dissipative structures reflect the principle of "order through fluctuation" (Smith, 1984, p. 273). Generally, fluctuation has been viewed as a disturbance in the system. Disturbance was to always be avoided; disturbance caused problems. It was believed that fluctuations should be minimized at all cost to the system. Even the language used in systems today to describe change seems to validate that disturbances are regarded negatively. In organizations, extreme fluctuations and chaos are almost always perceived as conditions that should be slowed and "controlled." Chaos is not considered to have any positive impact on a system.

There is a cyclical nature to most things in this world. Within organizations, cycles are also present. Viewing change and fluctuations in a manner that represents them as a natural part of the cycle and a necessary part of organizational life is a necessary step before major restructure or reorganization. The energy and planning toward restructure need to flow with the cycle of change, not attempt to control the cycle. The new perspective should be that chaos produces change through a natural cycle, thus allowing opportunities to cleanse the system and move forward toward more productive means of meeting organizational goals (Smith, 1984, p. 275). Without the cycle, the system would stagnate. In addition, controlling the cycle and fighting its natural movement would disrupt and stagnate the system.

CURRENT FLUCTUATIONS IN HEALTH CARE
Staffing Fluctuations

The health care system suffers from a variety of fluctuations, none of which are part of the world's attempts to "control" health care costs. The health care system also suffers from a shortage of professionals in all fields of health care workers, especially nursing. Several studies have examined this phenomenon, and numerous suggestions have been made to organizations on how to correct the situation— how to control the losses (Aiken, 1990). Nurses and other health care professionals are leaving hospital systems. They desire numerous changes within the system to afford them the autonomy and professional opportunity they feel they need and deserve. These losses cause more disruption, which in turn causes more attempts to control the crisis situation that exists. The attempts to retain and attract nursing personnel made by some short-sighted systems include bonuses, differentials, creative weekend plans, increased use of agency personnel, etc. These "quick fix" ideas have limited value; however, independent of the acceptance and challenge of some basic system changes, they will ultimately have only short-term effectiveness. Some professional health care groups are so frustrated with the traditional systems' responses to these "fluctuations" and "disturbances" in the system that they feel the need to organize and unionize. Traditional responses from hospital administration to these attempts in the past have been to attempt to further "control" the situation—even not recognize the groups officially—a response that ultimately will not be accepted by most groups of health care practitioners.

A New Perspective on Fluctuation

In troubled organizations the average worker's frustration and emotion is doubled on the part of the average hospital chief executive officer or chief nursing executive. Such individuals are at a loss as to how to control these variables that confront them from all sides. They find themselves in the middle of what Peters so aptly calls "chaos" and recognize clearly that they must learn how to cope. It was no mistake that Peters titled his book "Thriving On Chaos"—that is the challenge (Peters, 1987). If Cybernetics II thinking were to be applied to the current health care system, the situation might be perceived differently. The new perspective might unfold in the following manner. The extreme frustration with the system proves that the system is still alive—that people are capable of caring deeply about things that affect them—that people are being afforded an opportunity to find a way to improve quality—that the chaos that many believe exists serves to convince everyone that it is time for change, time to restructure and rebuild. Would health care have ever changed its pattern of everyday existence in ineffective systems to seek radical new ways of organization if the chaos in the system had not forced it to do so? Cybernetic thinking encourages the practice of viewing turbulence and fluctuations as essential to the system's ability to ultimately survive. Survival is the finite and ultimate goal.

Resilience Versus Stability

How much change and fluctuation can the health care system withstand? At what point is it correct to plateau and stabilize? Historically, stabilization has been

viewed as a positive goal for an organization. Resilience, however, may be a more appropriate goal for today's health care organization. A clarification of the difference between the terms *stability* and *resilience* as made by Holling (1976) helps understanding of this goal. Holling defines stability as the capacity of the system "to return to an equilibrium state after a temporary disturbance; the more rapidly it returns and the less it fluctuates, the more stable it is." Conversely, resilience may be viewed as a "measure of the persistence of a system and of its ability to absorb change and disturbance and still maintain the same relationship" with other entities (Holling, 1976). As Smith (1984, pp. 275-276) postulates, "with these two concepts in place it is possible to think of an entity becoming more unstable as a result of large fluctuations, but that knowing how to survive with these fluctuations makes for greater resilience in that a lot of changes can be absorbed." Resilience clearly should be the goal.

PROFESSIONAL ORGANIZATIONS
Commitment to Change

Can anyone within the health care industry clearly and objectively observe its shortcomings and offer concrete, creative solutions? Is it possible to change perspective and perceive things differently? Several experts question this possibility without significant effort. Smith (1984, p. 290) says, "Consider the task of trying to determine how the rules of grammar shape the way we think. To do this we have to use a language that is governed by those rules of grammar to explore the impact those grammatical rules have on our thinking. To really understand we would have to use a metagrammar. But that metagrammar in turn will be shaped by a meta-metagrammar and so forth." In other words, could nurse executives and others be so familiar and comfortable with the current system that it impairs their ability to think about and explore new alternatives and ideas fully and completely? It is clear that most executives have been "raised" in the current health care system and thus are hindered to some degree by that past. It is also true that it is difficult to find the time and energy to creatively explore new alternatives and structures while expending most of each workday combating the current health care environment and its constraints. However, the cycle must change. Nurse executives must find the time and energy to find a more creative and long-term answer to the system's needs. Faced with the challenge of possible bias in their current perspectives and stressed by time availability, executives must analyze the options carefully.

Today's New Organization

The demands on hospital systems are becoming increasingly complex. That complexity places unique challenges on the need to find and develop new organizational structures to address the need. How workers are integrated into the operations of any system varies, depending on the structure of the organization. The main goal of health care systems is basically the same—to meet the health care needs of the client in the most effective, efficient manner possible. Different systems organize to meet that goal differently. Today's health care systems are com-

plex entities and as such need to coordinate their essential activities in a variety of ways. The structure of any organization basically defines the ways in which its tasks are divided and then coordinated to accomplish the work of the organization. There are several ways of coordinating an organization's work. Mintzberg (1989, pp. 100-103) has identified six:

1. Mutual adjustment through informal communication between parties
2. Direct supervision (one issues orders—others carry them out)
3. Standardization of work processes—specifies work processes of people carrying out interrelated tasks
4. Standardization of outputs—achieves coordination by specifying the results of different work
5. Standardization of skills and knowledge—in which different work is coordinated by virtue of the related training the workers have received
6. Standardization of norms—in which it is the norms infusing the work that are controlled (convent, for example).

As the organization's work becomes more complex, the usual movement seems to shift from mutual adjustment to direct supervision: to standardization, preferably of work processes or norms, of outputs or skills, finally reverting to mutual adjustment (paradoxically also the mechanism best able to deal with the most complex forms of work), according to Mintzberg (1984, p. 102).

Structure in Hospitals

No organization can rely on any single component of the system. Different levels in the systems need different coordination links. Historically, in hospitals and in nursing, direct supervision and standardization of work processes have been the preferred coordination methods. The development and utilization of the nursing policy and procedure manuals is a prime example of that choice. Management also has been the major decision-making entity in the practice of nursing. Management has assumed responsibility and accountability for the practice of nursing. It is only within the past few years that structures have begun to emerge that will carry nursing from the direct supervision/standardization or work coordination mechanisms to more progressive mechanisms to organize and deliver services. Over the past few years as nursing has developed as a recognized profession with its own professional standards, the system has changed toward increased flexibility, as Mintzberg (1989, p. 101) has suggested is the normative progression.

Shared governance currently is the most well-known and concretely organized example of a structure for nursing systems that provides movement away from the more concrete systems of the past toward a more truly flexible, professional practice model. It allows work to be organized so that it reinforces and demands accountability from the professional practitioner for the practice of nursing, and returns to managers the role of managing the environment so that practitioners can focus on the provision of professional care (Porter-O'Grady and Finnigan, 1984, p. xi).

EMERGING PROFESSIONAL PRACTICE ORGANIZATIONAL MODELS
Characteristics of Current Structures

Professional practice organizational models have existed and are constantly evolving in industries throughout the nation. Interestingly, in professional organizations today such as universities, accounting firms, and some hospitals, a certain "core" structure has consistently emerged. It is primarily a bureaucratic structure, yet is decentralized. There are a minimal middle-line management hierarchy (i.e., there are wide spans of control over professionals in the environment) and large, fairly mechanized organized support staffs. In addition, there are somewhat autonomous professional groups functioning primarily under the regulations of their profession rather than the regulations of the institution. Two opposite structures apparently develop within these systems—one for the professionals that is flexible and allows them autonomy for practice; and one for the support structures of the system that is controlled and somewhat centralized. Some level of decentralization has reached the nonprofessional organizational structure but the finite control for decisions clearly still rests with management (Mintzberg, 1984, pp. 174–188).

Approaches to Future Models

In his new book *The Fifth Discipline*, Senge (1990, p. 4) states that the organization that will truly excel in the future will be the organization that discerns how to tap people's commitment and capacity to learn at all levels in the organization. In other words, the capacity *to learn how to learn* may be the key to excellence in future systems. Future professional practice models will need to focus less on structure and more on relationships to meet the newest challenges facing the field. Hierarchy and control issues will be replaced with issues such as professional accountability, professional judgment, and models of integration for professionals. This new system must be an open system capable of intense flexibility.

Today's organizations are full of internal politics and game-playing, widely accepted as the "norm." The professional practice model of the future will address this issue and lead a return to an environment wherein a shared vision between the system and the professionals creates a new level of openness for all (Senge, 1990, p. 274).

In *Megatrends 2000* Naisbitt and Aburdene (1990, p. 298) claim that the great unifying theme at the conclusion of the 20th century is the triumph of the individual. This new focus on the individual is evidenced diversely—from human rights movements to new trends in the management of organizations. Futuristic organizations realize that they are made up of individuals. Organizations do not grow and change—*people* grow and change.

Futuristic organizations also recognize that individual accountability is the foundation of future systems. Individuals provide the service of industries, and individuals provide for the determination and motivation for any changes in those industries. In the health care system, professional practitioners will continue to be

the direct link of the organization with its "product." Practitioners will continue to gain visibility and importance in the system.

Individuals will quickly learn that to accomplish the goals of the future system, they will need newer ways to integrate and coordinate with each other. Individuals will learn to work in new types of teams. Senge (1990, p. 10) says that the discipline of team learning starts with "dialogue," the capacity of members of a team to suspend assumptions and enter into a genuine "thinking together." This new art of "dialogue" will be seen in integrative matrixed organizational structures that will link professionals so that they can continue to provide care and learn and grow in the system. Professionals will be the foundation of the future health care system. Management and support staff alike will be the spokes of the wheel, whereas professionals will be the hub. New structures are already emerging that support and validate that premise.

Characteristics of a Profession

Blane (1975, pp. 13-16) identifies six characteristics that are consistent among all professional groups:

1. A defined body of knowledge with specific skills acquired through an educational process
2. An orientation that is service based rather than productivity based or financially based
3. Discipline, peer review, and a code of ethics
4. Autonomy in practice with appropriate legislative and legal sanctions for workers who practice the profession
5. An organized system composed of professionals recognized by society to carry the mandates, roles, and responsibilities of the profession
6. A culture that supports the professional activity

Regardless of the ultimate structural design, the system must allow for all professions to practice and grow. Nursing systems must support the needs of the profession. The developed structure must support and encourage attainment and retention of the attributes listed above. The first of these characteristics regards knowledge and professional education.

Standards of practice and care.   In the last 20 years, the knowledge base of nursing has increased and become more clearly identified. The development of standards of practice and care for specific populations of patients has afforded nursing a clear knowledge base that is recognized as unique to nursing. Those standards are generally developed by professionals independent of the institution and are mandated by the professional organization. Staff nurses need a structure that allows them to determine the system's standard of care (based on the profession's defined standard) for themselves and their peers. Staff nurses need to feel accountability for that activity because of their identification as professionals. For years nursing management has defined the "standard" of care in most institutions. Management wrote the policy and procedure manuals. Management may have asked for staff nurse assistance in some of that activity, but the accountability and responsibility for standards clearly rested with management. New structures that

are consistent and that reinforce professional practice environments must be different from current practice.

Nursing as a Service

Nursing is a service profession. The service that is provided is nursing care. Nursing care is delivered to individuals based on assessed needs and modified according to the nurse's evaluation of the effectiveness of that care. A manual or policy book cannot dictate individual patient care. Judgment and knowledge guide nurses in providing care to their patients. Ultimately, the health care system's structure must provide for that element of flexibility that is necessary for professionals to operate. The system must not constrain the professional. It must encourage judgment and its application to meet each patient's needs in the most effective, coordinated, and integrated fashion possible. Finance, productivity, and other similar information should be elements that management monitors and provides to professional practitioners so they can integrate the information into their decision-making cycle. In professional practice systems, management elements must be merged with the practitioner's perspective so that an integrated perspective is available for the final decision maker. Trust that the professional practitioner will make appropriate decisions for the system is also necessary for management to fully understand and appreciate the practitioner's unique role in a professional system.

Autonomy in Nursing

Autonomy in nursing practice is virtually nonexistent in hospitals today. Numerous reasons for this lack of autonomy were suggested earlier, but the absence of accountability by individual practitioners is a primary reason. Nurses desire and need autonomy; however, the system consistently has rejected that opportunity through the controlling structures that have been implemented.

These controlling structures emerged from a traditional hierarchical, bureaucratic structure. They developed from a belief system that management should control all decision making, with little employee participation. It was thought that management should organize, plan, and develop systems so precise that employees merely had to implement the appropriate activities identified by management as appropriate. Management also sought to organize its own field in the same manner. Management created complex systems that encouraged preplanning for all scenarios. These beliefs were incorporated in the systems personnel or supervisory policies, nursing policy and procedure manuals, and other rules and regulations. The intent was to maximize efficiency and effectiveness by providing readily available explicit guidelines for employees and managers alike. The effect may have been consistency in application of like actions by different employees, but these control systems created a loss of individual accountability.

New structures must demand accountability from practitioners. They must establish peer review and disciplinary activities that will require accountability by nurses for all nursing care delivered. They must reinforce the new belief that accountability rests with the individual professional practitioner, rather than with the system.

The Role of Culture

Blane (1975, pp. 13-16) discusses the need for a culture that supports professional activity. Every organization, department, nursing unit, and specialty has a culture. How important is it? Can it shape behavior? What *is* culture? The answer from a typical employee is "It's just the way we do things around here." Culture is the way people act . . . it is the way they are supposed to act. Culture cannot be seen but can be felt. Everyone knows what it is. Culture is one of the most powerful elements in any organization.

Culture can be defined as the summation of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought characteristic of a community or population (Morris, 1971). Culture is derived from the basic belief systems of people. It comes from behaviors generated as a result of those beliefs and values. Those beliefs and values guide individual action and judgment. In creating or restructuring a professional practice environment, it becomes critical that culture be addressed. Hospitals have historically operated like machines or assembly-line bureaucracies. They have created cultures that have reinforced the lack of professional growth and expectations. Nurses have practiced within that culture for a long time. Other professional practice groups have also lived in that culture for a long time. Significant effort is required to change the culture to fully support a professional practice model. Careful planning and persistence are necessary to achieve the right outcome. Careful planning begins with some basic assumptions and beliefs. These basic beliefs that a system must embrace to create the right culture for the support of a new, more professional practice-based system include the following tenets:

1. People are basically good and are motivated to do the right thing when given the opportunity.
2. People want to work and provide services to others.
3. People, when given the right information and perspective, will make meaningful decisions that will be good for themselves and also for others.
4. People have the right and the duty to influence decision making that affects them.
5. Everyone has certain gifts and skills, but we must recognize that not everyone has the same gifts and skills. Everyone must respect diversity—it is the foundation for equality.
6. Everyone has the right to be needed, to be involved, to understand, to affect one's destiny, to be accountable for one's actions, to feel success, to feel meaningful.

These beliefs are the foundation of any professional practice structure. They are beliefs that management and staff alike must integrate into their value system. They are the foundation for decentralization. They are the foundation for organizational change.

PROBLEMS ENCOUNTERED WITH PROFESSIONAL ORGANIZATIONS

Accepting the need for a professional practice approach to restructure the health care system is the first step toward change. Recognizing the need for the expansion of the professional organization to include all professionals in the system—not only the physicians—has entailed new demands. Nurse executives know that the medical model itself is not faultless and thus those issues will also confront the newly formed professional practice groups such as nursing. Increased democracy and autonomy are the gains the professional organization gives to its professionals, but at the same time problems of coordination, innovation, and discretion remain to be resolved (Mintzberg, 1989, pp. 188-192).

Coordination

Problems of coordination involve finding ways to link the more autonomous professionals with the bureaucratically functioning nonprofessional groups. Traditional managers generally control nonprofessional workers and require employees to function and gain direction through the vertical lines of authority. Where does the professional integrate with this approach? The support staff's function is to support the professional practitioners. The need is for a method that enables professionals to clearly articulate their needs to those groups through management. In nursing, many nonprofessionals are delegated direct patient care activities and require the general supervision of the professional for that portion of the job. These same individuals, however, have responsibilities that can and should be supervised through the more traditional routes of the system rather than consuming the time of the professional practitioner. To maximize the time spent by professionals in their practice, the system must provide appropriate support for the professional groups that meet that group's needs. The professionals need to be able to clearly articulate their needs and control who performs certain delegated tasks that, in their view, affect patient care outcomes. Therefore, the resulting system must allow practitioners to make judgments not only about their independent practice decisions but also about some areas of the traditional system that they feel affect their practice. Professionals do this in several ways. First, professionals should coordinate with management to communicate system needs. It is management's responsibility to communicate and mediate the professional and nonprofessional components of the system. Traditionally in nursing, it has been helpful for such mediators to be nurses (nurse managers) who can understand the perspectives and needs of the practitioners and can administer the traditional system through appropriately learned management theories. It is important that a mediator be able to act as a professional practitioner advocate, much as nurses act as patient advocates.

Coordination needs exist between nursing and other professional practitioner groups. Structures are needed that allow practitioners to discuss practice issues and coordinate care in the most effective and efficient manner. Interdependent practitioners must have some mechanism through the formal structure to deal with long-term issues and development and coordination of the standard of care. They also need a culture that supports and encourages informal networking and coordination for day-to-day functions and needs. Collaborative practice committees are

becoming more common in hospitals and are meeting the needs for coordination between practitioners. Case management is another example of a coordination link used in some systems (O'Malley, Loveridge, and Cummings, 1989). Innovative systems of the future will continue to create new coordination mechanisms for their practitioner groups.

Innovation

The second problem that professional organizations face is the issue of innovation. As Mintzberg (1989, p. 190) aptly states, "Major innovation depends on cooperation . . . new programs and improvements usually cut across multiple professional lines . . . professional bureaucracies create reluctance of the professionals to cooperate with each other and the collective processes can produce resistance to innovation." Professionals, by their nature, are independent and autonomous. They are familiar with controlling their own decisions. Creating mechanisms to encourage cooperation and thus freeing innovation is a requisite. Professionals must face responsibility for coordination and cooperation. As technology becomes increasingly complex, issues arise that illustrate this point. In the past it was workable to divide the "tasks" along section lines in most medical staff organizations. With the changes in available technology and the current competitive economic environment, traditional section members "cross over" into practice areas. Radiologists, cardiologists, gastroenterologists, and surgeons now all perform the same "tasks." Similarly, in nursing it was formerly easy to compartmentalize patients based on the need of certain skills and knowledge by the nurse caring for the patient. Today it is less clear as nurses find they are asked to care for sicker patients with more complex problems. The need for interdependency and cooperation among nursing specialties is increasing as the system grows more complex. For the system to survive, leaders need to ensure that they address ways to improve the system's viability despite competition among professional practice groups and in spite of the tendency of the professional groups to become rigid, bureaucratic, and independent of others. Freeing professionals to practice more autonomously requires integration of democratic actions. Health care system relationships will not permit these groups to independently become bureaucratic and fail to integrate with the system as a whole. Recognition of that reality is key to the system's viability.

Discretion

According to Mintzberg (1989, p. 190), the third major problem with professional organizations is discretion. Professional organizations force and focus discretion into the hands of individual practitioners, whose skills require the exercise of considerable judgment. The system works well when those professionals are competent and conscientious. Problems arise when they are not. Mintzberg (1989, p. 190) relates this to several factors. One factor is that professionals have been reluctant to counteract their own interests, perhaps because of the intrinsic difficulty of measuring the outputs of the professional's work. Second, professionals have been traditionally loyal to themselves and their professional association and not the system they practice within. Health care executives must ensure that checks and balances are available within the system that require practitioners to

address peer incompetence and other relational issues. The Joint Commission on Accreditation of Healthcare Organizations and other accrediting agencies have quality assurance requirements in place because they recognize these natural tendencies of professional groups. There has been considerable publicity about the lack of professional control over peer practitioners in the medical field. This issue led to the establishment of a national data bank for professional practitioner information. Information about all physicians is stored in a computer bank and systems are mandated to access that information before the initial appointment and reappointment of medical staff members to hospital staffs. Nurses and other professional practitioners will soon be mandated to participate in similar activities as a result of consumer demands. Hospitals are the primary locations where these professionals practice, leading consumers to demand access to hospital accreditation information. The trend is clear. Access to such information is being demanded because the system did not implement structures to adequately monitor and police its individual practitioners. Systems of the future will demand that those components be in place. In the future, quality assurance information will need to be collected not only in the aggregate form but also by individual practitioners for every professional in the system.

THE NURSING ENVIRONMENT IN PROFESSIONAL ORGANIZATIONS
Individual Accountability

Individual accountability is the key to effectiveness in professional organizations (Mintzberg, 1989, p. 193). Accountability originates and rests within an individual and creates a sense of ownership for one's actions and their impact on others. With accountability and ownership come obligations for action and follow-up. As an individual practitioner the professional must be dedicated to working with the client first and foremost: attorney and client, educator and student, nurse and patient. The professional's power base within professional organizations is derived from the working relationship that exists with clients. The structure that exists in professional organizations is primarily built around the needs of the professionals—the need for support and coordination that practitioners have to be able to individually provide service to their patients. The basic relationship remains one-on-one between the professional and the client. Changes within the system must carefully address the need to maintain this relationship of individual accountability between professional and client.

Nursing Groups

Most hospitals are organized by departments or divisions. This practice allows a system to organize delivery of patient care around like-client groups based on the similarity of work processes and equipment required for each group of patients (cardiology, oncology, rehabilitation, etc.). In addition, similar groups of patients are usually cared for by a fairly focused group of professionals who usually serve a specific patient population. This practice encourages the achievement of common standards of care and provides for peer review among like professionals. Well-diversified nursing units allow for increased flexibility and a greater degree

of control over individual operations. Unit-based professionals can virtually create their own support structures and build a reasonable, independent, functioning subsystem within the hospital system. Examples of this are seen every day. Diversification of units or divisions within hospitals has only increased in the past few years. As the trend toward more professional practice models increases, so too will the trend toward more independent unit-based systems.

Organization of Professionals

The typical nursing unit is organized around a patient population. There are several groups of professional practitioners who provide care to the patient population based on their role and responsibilities. Physicians, professional nurses, and professional allied health practitioners all play varied roles in the provision of care to their patients. Each has an individual relationship with the patient for the care directly provided. In addition, each has a responsibility to the other practitioners to participate in coordinating the patients' care. The nurse generally fulfills the coordination role. The nurse is usually the professional practitioner who has the most primary relationship with the patient by virtue of the requisites of the work of nursing. The coordination of professionals must be accomplished quickly and be maintained throughout the patient's stay to optimize patient outcomes. However, coordination should not preclude the individual's accountability that must exist and be felt by each practitioner toward the patient. Individual accountability is accomplished through an understanding and appreciation of each member's unique role.

Facilitation of patient care conferences helps to provide effective coordination of care. It also allows time for education of each discipline to the other's role and the contribution that professional can make to the patient. Most health care disciplines have become so specialized that most collegial groups do not really know the areas for which specialized practitioners are educated and prepared to assume responsibility. Grand rounds and other educationally focused sessions bring the professional groups together and offer an avenue to increase coordination in the system.

Newer professional practice models also must provide for a structure for the various professional groups to meet as a whole. There are numerous professional issues that should be addressed and organized by like practitioners. Among these issues are development of the professional groups' standards of practice, guidelines for credentials and privileges, standards of performance, disciplinary procedures, quality assurance reviews, educational needs assessments, and establishment of research. The system as a whole must address a structure for nurses to organize themselves as a body of professional practitioners to accomplish all activities that are essential to their practice. In addition, many of these issues must be readdressed at the subunit level or specialty level of organization. Structures must be developed, usually through the use of groups, for the professionals to coordinate on a unit level and establish the specialty standards of practice, monitor compliance to those standards, and plan for educational and research needs.

By their nature professional organizations demand the use of groups to coordinate the diverse types of practitioners. The key to effective functioning is finding a way to organize the individual professionals so that their individual and

interdependent/collegial responsibilities can be accomplished in the system with minimal conflict between professional groups. Each professional has individual accountability to the client. Members also have collective responsibility for control of their profession and their members in the system.

Organization of Support Staff

Nursing units have several groups of support staff available to assist the professional practitioner in the system. The support staff can be divided into two categories: the care support staff and the material support staff. Responsibilities are delegated from the professional practitioners to the care support staff for selected direct or indirect care activities.

Coordination of resources is critical to the delivery of nursing care. The structure in the system must provide for a linkage of the professional practitioner to either directly delegate and control the care support staff, or arrange for management to provide for the delegation and supervision of the support staff through preestablished agreements.

The material support staff generally assists in arranging and providing for the effective organization and efficiency of the environment. Management staff, along with the material support staff in most professional organization models, exists as a support mechanism for the professional practitioner. Management's role is to manage the human, material, and financial elements of the system so that the work of the practitioner can be accomplished. This implies constant communication from practitioners to management as to their needs. Communication is usually accomplished through group meetings established through the development of a management structure. The structure integrates with elements of the practitioner groups as needed so that management receives the information needed to perform well. The practitioner is at the center of the organizational model with management providing a linkage to the rest of the system.

Shared Governance as a Model

Developing and creating a model structure that meets all the critical elements of a professional practice model is a difficult task. It would be difficult enough to create such a structure in a new organization free from any bias or history that may complicate such a task. It is seemingly a monumental task in a system typical of most hospitals. The critical elements are reasonably clear: individual professional accountability by the practitioner, coupled with professional responsibility and accountability for all issues relating to practice. Such issues include standards of practice and care, assurance of the quality of care provided, responsibility for the professional development of the practitioners, and professional review responsibility. The challenge is to create a workable structure that allows all these elements to operate at the same time. Porter-O'Grady and Finnegan (1984, p. xi) are recognized as individuals who initiated the first such structure for nursing in the early '80s. The concept has been called "shared governance."

Shared governance is more accurately described as a set of concepts and beliefs that can emerge from an existing organizational structure but forces significant fluctuation, which brings about changes that are more consistent with behaviors expected in professional organizational models. Shared governance is an