Both leading and following are active processes in the change to shared governance. The manager initially provides the leadership until others can begin to develop their leadership skills. The role of the manager in facilitating this process of consensus and empowerment is discussed next.

TRANSITIONAL ROLE OF THE MANAGER

Letting Go

Careers of most managers have been focused on taking charge, taking control, and being responsible—in other words, having the "final say" in all decisions for which they are held accountable by the organization. For example, most present quality assurance programs are more concerned with monitoring problems than with providing a forum for innovation. Until recently, control of staffing and scheduling was considered the final bastion of necessary managerial control.

It is understandable that most managers have trouble relinquishing control. To move from a role of director and controller to that of facilitator of empowerment is equivalent to a paradigm shift. The shift is best seen in communication between management and staff. Communication is no longer on a parent-to-child level but has become adult to adult. Management no longer provides a solution; staff now decides on the solution. The manager's role in this paradigm shift is one of helping the staff solve problems, giving them authority, and supporting them in accepting accountability.

Shared governance demands of a manager increased risk-taking because of the necessity for divesting management of the ultimate decision-making power. The more inflexible, dogmatic, and controlling a manager is, the more painful the process. Such managers need coaching from the nursing executive to relinquish control.

Managers also should understand the important difference between delegation and empowerment: delegation is assignment, whereas empowerment involves helping staff to accept responsibility and accountability. Delegation of duties exists simultaneously with empowerment of staff; it is an empowerment tool, but delegation is not empowerment.

Sharing Power

There are many forms of power, and principles that govern its use. In the shared governance model, the power of expertise is a dominant force. As a nursing manager gives up being the only "legitimate power" and shares decision making with practice, education, quality assurance, and governance councils, shared governance is born.

The speed with which a nurse executive and managers share power depends on the nature of the organizational culture. Some organizations publicly affirm support but continue to practice power brokering on a daily basis.

Many individuals in such organizations believe in the scarcity model of power and therefore have difficulty with the implementation of shared governance. The basic difference between scarcity models and empowerment is that the former focuses on the concept that a limited amount of power exists to be distributed among

a few individuals, whereas empowerment in shared governance is based on the power sharing of all in a collaborative effort. This collaboration fosters a sense of personal power in members and power of collected energy in the change process.

For example, as education needs are determined by staff, a nurse manager no longer needs to force people to attend in-service training through legitimate power. Instead, through communication and collaboration of the education and quality assurance councils, immediate and long-term educational needs surface. A nurse manager may facilitate consensus decision making for educational priorities, but needs and solutions are developed primarily through action of the councils.

Facilitating Consensus

Consensus decision making lies somewhere between majority rule and unanimous agreement. Facilitating consensus involves helping the group reach an agreement on decisions. This requires all members to approve the decision, even though they may not agree with it. Therefore consensus decision making requires that all opinions be heard, that discussion of the issues occur, and that every member agree to support the decision.

In majority rule, individuals are pressured, either overtly or covertly, to agree with the decision. In consensus decision making, individuals are not coerced. To avoid coercion, the nurse manager must allow differences to be voiced and facilitate working through them to accomplish the goals of the group.

The transitional role of the nurse manager involves facilitating consensus in a variety of decisions. This process involves modeling the method to achieve consensus, keeping the group focused on the subject, and helping determine when and how to accomplish the chosen decision. All members should articulate concerns, each using individual skills.

The manager needs to provide information to the group so that the councils can make decisions while linking executive management to the process. The manager initially takes an active role in facilitation of group process and provides effective structure for meetings. Gradually, as their skills develop, staff members will join in facilitating others.

In the role of facilitator, the nurse manager begins to identify blocks to effective group decision making. Individuals who squash suggestions in the group need coaching. If the issue is a dysfunctional group norm rather than individuals who inhibit action, the entire group needs to hear the feedback.

For example, a nurse manager facilitates consensus in the practice council if she or he encourages several new members to talk about models of practice they experienced in institutions where they previously worked. The new members can offer a different perspective, and they can also begin to understand the practices in a new organization. Unchallenged practice standards negate the quality improvement stimulated by the quality assurance council's questions and changes.

The Manager as Teacher and Leader

The role of the nurse manager changes dramatically in a shared governance model. No longer is the role of manager to control the staff to prevent irresponsibility and sloth. That method may have been appropriate in the industrial age,

BOX 6-2
Knowledge Base for Managers

- Leadership behavior
- Facilitation skills
- Knowledge of how to conduct a meeting
- Coaching and mentoring behavior
- Team-building
- Conflict resolution: assertiveness and negotiation skills
- Understanding of shared governance model and process

when tasks were the focus. However, in the information age, the nurse manager should act not as controller but as teacher and leader. By modeling each of these roles, the nurse manager literally teaches by example. The leader facilitates the department or unit in developing a vision and in taking the steps to achieve it, helping staff to develop the shared governance structure, and involving individuals in accomplishing their vision. A leader takes responsibility to act on the issues that the councils raise. As the organization develops, the nurse manager will be needed less as a spokesperson, but for the first several years is often the voice of the unit.

Part of the leadership role is to determine learning needs of staff members. Some of their needs can be met through predetermined in-service training and continuing education and through the manager's coaching, but some needs must be programmed. The education council and the nurse manager work together to determine educational needs. Because of knowledge of and access to numerous educational resources, the nurse manager's main role is that of facilitator and link to the organization and outside resources.

Role modeling naturally occurs as a nurse manager acts as a teacher to staff. To teach, a knowledge of several important subject areas is crucial. These assets are listed in the box above.

These areas are the basis for behaviors required of a nurse manager for successful change through shared governance. However, the test of the manager's ability to empower is not her or his own functioning but the capacity of the unit or organization to respond and grow in an ever-changing world. The following contributions not only help to define the construct of empowerment but can also be used as a firm foundation for implementing it*:

1. **Values.** Argyris' (1955) classic discussion of the management dilemma—company needs versus individual development
2. **Leadership.** The discussions of Tannenbaum, Kallajian, and Weschler (1954); Bennis (1982); and Lippitt and This (1967) on the characteristics of effective group leaders

*Reprinted from J.F. Vogt and K.L. Murrell (1990). Empowerment in organizations: how to spark exceptional performance, San Diego, University Associates, Inc. Used with permission.

3. **Environment.** Rogers' (1961) work on the environmental climate that allows facilitative (empowering) processes to become operational
4. **Adult learning.** Knowles' (1975) description of learning as a lifelong process, and its implications for the adult learner; and the conceptualization of experimental learning (Kolb, Rubin, and McIntryre, 1971)
5. **Organizational structure.** Gibb's (1964) recognition of the relations among individual needs (e.g., trust), communication, goals, and organizational structure
6. **Systems integration.** Recognition of the connections between organizational health and individual welfare and the postwar application of systems analysis to the integration of technological and human systems (Vogt and Murrell, 1990)

All of these contributions lead to our present understanding of empowerment. A nurse manager familiar with these concepts will be able to teach and model staff empowerment behaviors.

Leadership is currently a popular written and oral subject. It has been said that the United States suffers from a leadership crisis. What is leadership, and how can the nurse manager demonstrate it?

Leading, not managing, is the goal. In the shared governance model, a nurse manager is freed to lead as councils begin to function. The time this change provides can then be used for conceptualizing, for being a leader with vision and time to consider the forces that affect the realization of the vision. Development of a vision (management of attention) is one of the leadership traits identified by Bennis and Nanus (1965). The other three leadership traits necessary for nurse managers are management of attention, management of meaning, management of trust, and management of self (Bennis and Nanus, 1985).

Having vision is the first of four leadership traits identified by Bennis and Nanus. Annual retreats for top-level nursing management and yearly evaluation and commitment for the unit-level vision are structures that support this skill.

Mentoring is the second leadership competency. Leaders make ideas tangible to others, so that others can support these ideas. A nurse manager's own clarity concerning the shared governance model and effective communication skills are keys for success.

The third competency is the management of trust. People much prefer to follow individuals they can rely on, even when they disagree with those persons' viewpoints, than follow those who shift positions frequently. A manager must be perceived as willing to uphold his or her beliefs. Regardless of the staff members' stance regarding the belief, they know the manager is consistent. Followers need this level of integrity in all who assume leadership roles in shared governance.

The fourth leadership competency is the management of self. This is the ability of a leader to know his or her own skills and to use them effectively. It is equally important for the nurse manager to demonstrate the ability to admit a mistake. Mistakes must be seen as steps to success. Such leadership empowers the work force. Empowerment is the collective effect of leadership.

WOMEN AS LEADERS

The 1990s is seen as the decade of women in leadership. This is a force supporting nurses in taking leadership roles (Naisbitt and Aburdene, 1990). To be a business leader today, it is no longer an advantage to have been socialized as a male. Women may be at a slight advantage because they need to "unlearn" old authoritarian management behaviors. This new democratic, yet demanding, leadership encourages self-management, autonomous teams, the ability to employ vision that will be the driving force in the 1990s.

Time magazine dedicated an entire issue in the fall of 1990 entitled "Women: The Road Ahead" (Time, Fall 1990). A *Time* poll of 505 men and women ages 18 to 24 by Yankelovich, Clancy, and Shulman found that four of five believed it is difficult to juggle work and family and that too much pressure is being placed on women to bear the burden. Until now, women have been silent and followed the rules. Clearly, they now want a different set of rules. It is true that women have increased their participation in medicine and management by 300% to 400% since the early '70s. However, *Fortune* magazine found in July of 1989 that in the highest echelons of corporate management, fewer than 0.5% were female. It is evident that the female majority must still find a way to survive what they may feel are uncaring institutions, exploiting employers, and deep social inequities. Harvard psychologist Carol Gilligan (1982), author of *In a Different Voice*, a landmark study of gender differences, argues that women have greater moral strengths, a stronger ethical stance, and concern for making and maintaining relationships—all qualities of a good leader.

An effective leader for the 1990s, either male or female, will set an example of excellence and be ethical, empowering, and inspiring. A leader who is a facilitator knows how to elicit answers from those who are most knowledgeable. The primary challenge of a nurse manager is to encourage professional nurses to be more self-managing and oriented toward lifelong learning.

COACHING

In terms of importance, the consensus-building skills of leaders are closely followed by the coaching role for the nurse manager. During transition, some individuals demonstrate reluctance to move forward with the model. This is especially true if the organization has experienced other changes that lacked follow-through. This coaching role involves helping develop individuals to function in the new model.

Many nursing leaders like Dorothea Dix, Clara Barton, and Elizabeth Sanger faced both internal and external resistance when they tried to implement a model that would change the practice of nursing. Their patience, persistence, and constant focus on the desired outcome helped them overcome the direst circumstances. They achieved their objectives by continuous positive focus on their goals.

Nurse managers must remember why they agreed to the implementation of shared governance—there will be days like these nursing leaders faced. At such

TABLE 1
Stages of Team Development

	Member Behaviors	Member Concerns	Leader Behaviors
Stage I Orientation to group and task	• Almost all comments directed to the leader • Direction and clarification sought • Status accorded to group members based on their roles outside the group • Members fail to listen, resulting in nonsequitur statements • Issues are discussed superficially, with much ambiguity	• Who am I in this group? • Who are the others? • Will I be accepted? • What is my role? • What tasks will I have? • Will I be capable? • Who is the leader? • Will he or she value me? • Is the leader competent?	• Provide structure by holding regular meetings and assisting task and role clarification • Encourage participation by all, domination by none • Facilitate learning about one another's areas of expertise and preferred working modes • Share all relevant information • Encourage members to ask questions of you and one another
Stage II Conflict over control among the group's members and with the leader	• Attempts made to gain influence, suggestions, proposals • Subgroups and coalitions form, with possible conflicts among them • The leader is tested and challenged (possibly covertly) • Members judge and evaluate one another and the leader, resulting in ideas being shot down • Task avoidance	• How much autonomy will I have? • Will I have influence over others? • What is my place in the pecking order? • Personal level: Who do I like? Who likes me? • Issue level: Do I have some support here?	• Engage in joint problem solving; have members give reasons why idea is useful and how to improve it • Establish a norm supporting the expression of different viewpoints • Discuss the group's decision-making process and share decision-making responsibility appropriately • Encourage members to state how they feel as well as what they think when they obviously have feelings about an issue • Provide group members with the resources needed to do their jobs, to the extent possi-

			ble (when it is not possible, explain why)
Stage III Group formulation and solidarity	• Members, with one another's support, can disagree with the leader • The group laughs together; members have fun; some jokes made at the leader's expense • A sense of "we-ness" and attention to group norms is present • The group feels superior to other groups in the organization • Members do not challenge one another as much as the leader would like	• How close should I be to the group members? • Can we accomplish our tasks successfully? • How do we compare to other groups? • What is my relationship to the leader?	• Talk openly about your own issues and concerns • Have group members manage agenda items, particularly those in which you have a high stake • Give and request both positive and constructive negative feedback in the group • Assign challenging problems for consensus decisions (e.g., budget allocations) • Delegate as much as the members are capable of handling; help them as necessary
Stage IV Differentiation and productivity	• Roles are clear and each person's contribution is distinct • Members take the initiative and accept one another's initiative • Open discussion and acceptance of differences among members in their backgrounds and modes of operation • Challenging one another leads to creative problem solving • Members seek feedback from one another and from the leader to improve their performance	• (Concerns of earlier stages have been resolved)	• Jointly set goals that are challenging • Look for new opportunities to increase group's scope • Question assumptions and traditional ways of behaving • Develop mechanisms for ongoing self-assessment by the group • Appreciate each member's contribution • Develop members to their fullest potential through task assignment and feedback

Reprinted with permission from Moosbrucker, J. (1988). "Developing a Productivity Team: Making Groups at Work Work." In W.B. Reddy and K. Jamilson (Eds.), *Team Building: Blueprints for Productivity and Satisfaction* (pp. 91-92). National Teaching Laboratories Institute.

times the nurse manager needs to encourage, enliven, console, and boost the spirits of staff if they are to move forward in the empowerment process.

For example, staff members are usually enthusiastic about the shared governance model until they first encounter resistance. This resistance can take many forms, such as poor attendance at council meetings, noncompletion of assignments, or gossip about the leaders. Nurse managers must remain objective at these times and continue to coach the members to become effective leaders and to model teaching and leading.

A nurse manager in a leadership role acts as the team coach, guiding the individual in learning new behaviors. At times the manager stands back, watches the performance, and then provides feedback to the individual. As team coach the manager also assumes responsibility for effective functioning of the work unit team.

Much of the team-building work can be done only by the manager and other persons involved in activities for which the team was formed. A team-building consultant can help with some processes and can conduct specific events for the unit, but it is the daily influence of the nurse manager on the norms and team climate that is most important.

The nurse manager's guidance and sustained effort toward realizing a team's vision makes team-building happen. The manager guides the team through the four stages of team development, monitoring and assisting the progress of the group's evolution. A group model can have three, four, or five stages; however, the model that appears most useful is listed in Table 1 (Moosbrucker, 1990).

Many nursing departments languish in Stage II because they lack conflict resolution skills and fail to understand empowerment. For example, the nurse manager who cannot abide bickering among team members stops discussions. This is avoidance of conflict rather than conflict resolution. In this stage, the nurse manager must help group members deal with their differences with one another and between the group and the leader. If discussion becomes heated, then the leader's role is to ensure that each position is heard and, as much as possible, understood.

Dealing with staff members who are not "team players" is also a crucial role of the nurse manager. If a norm develops that such individuals are allowed to be disruptive and noncooperative and not perform their share of the work, then the team will not be effective and will waste time and energy dealing with nonteam players. At least initially, a nurse manager needs to be primarily coach and teacher for these individuals. As a peer review committee forms and as the council chairs gain strength and skills, they too can help in the coaching. The nurse manager, in addition to coaching, should work closely with one to two individuals, grooming them as replacements. This process of mentoring is discussed in more detail in the next section.

MENTORING

Is mentoring becoming a lost art? In the nursing community, a lack of mentoring is evident. Perhaps this lack is part of oppressed group behavior. Inferiors do not

turn to other inferiors for guidance. However, if nurses are to move forward as professionals, mentoring needs to become part of their repertoire.

What Is Mentoring?

Mentoring is a system of selection and guidance in which individuals senior in position and experience identify and educate their juniors and promote them to positions of leadership. Mentoring is supporting career advancement. Like parenting, mentoring requires sensitivity as to when to intervene and when to let go. A mentor serves as a career role model and actively advises, guides, and promotes another's career and training. Mentoring helps people adapt by increasing their confidence. It is a process by which staff members are guided, taught, and influenced in their life work in important ways.

The role of a mentor is to foster employee development through socialization and skill development. Mentors show responsibility for the career advancement of the protege. They provide opportunities to carry out activities that make the best use of a protege's ability.

Mentor Behaviors

The roles of teacher and leader in shared governance are aspects of mentoring. A list of mentor behaviors is provided below:

1. Shares career experiences as an accomplished practitioner
2. Provides ready access to organizational information
3. Channels opportunities to neophytes
4. Establishes mutual goals
5. Takes risks in people
6. Identifies talent
7. Risks emotional involvement
8. Gives constructive feedback to protegé on problem areas
9. Gives positive reinforcement (Campbell-Heider, 1986; Bidwell, 1989)

A mentor coaches, inspires, and supports the growth and development of individuals. Coaching behaviors are a major ingredient in mentoring. A list of mentor behaviors is provided below:

1. Stimulates enthusiasm
2. Maintains high expectations
3. Gives credit for performance
4. Approachable
5. Listens to new ideas
6. Encourages risk taking
7. Helps people learn from mistakes
8. Acts sensitively to feelings of others
9. Believes people can be more effective

In shared governance, the importance of offering opportunities to neophytes, listening to their ideas, and maintaining high expectations is self-evident.

Several studies on mentoring support these behaviors as being key in teaching mentoring. In the Fagin (1983) study, the traits that nurses selected as most characteristic of their mentors were the following:

- Disciplined and hard worker
- Dedicated to job
- Independent
- Honest
- Persistent and tactful

In the White (1988) study on nursing academic administrators and mentoring, the highest-rated characteristics were the following:

- Showed confidence in me
- His or her knowledge inspired me
- Encouraged me to achieve maximum potential
- Encouraged my intellectual development

Competency and intelligence were the most frequent characteristics listed of mentors. The study also showed that those who had mentors were more likely to mentor. Studies by Henning and Jardim (1977) concluded that it was essential for women to have a mentor.

The mentoring experience benefits the mentor in several ways. First is a feeling of fulfillment in seeing another nurse flourish. There is also a sense of fulfillment in contributing to the advancement of the profession. Because of the value of interdependence, the protege may act as a referral. Finally, a protege's questions act as stimulus to thought and research.

TRIALS AND TRIBULATIONS, JOYS AND ACCOMPLISHMENTS OF SHARED GOVERNANCE

As with any change, there are always unexpected problems as well as minor miracles. The implementation of shared governance reveals any unresolved problems in a nursing department and in the organization. A paternalistic culture will become evident, as will any internal strife in the nursing department and individuals who need coaching. As a nursing department reorganizes, all roles and responsibilities are questioned. People's relationships to each other change, and individuals, perhaps for the first time, begin to understand the meaning of accountability. The ripples of this change will be felt in other departments. It is important to remember that this change will create trials and tribulations for all who undertake it.

Trials take various forms. A person who is a source of annoyance or irritation may block shared governance, knowingly or unknowingly. Outdated policies and systems at times try one's endurance. The nursing department's commitment to the process will be tested many times. A few examples of typical trials faced in implementation are listed. All have been addressed previously except the last.

1. One or more nonteam players
2. Passive aggressive behavior

3. Lack of attendance or participation in meetings
4. Controlling manager
5. Lack of accountability

A nurse who accepts accountability thinks beyond his or her shift. Accountability comes from within. It cannot be taken away. For example, a clinical nurse is held accountable by law to the code of ethics and, therefore, the quality of practice. In shared governance, practice councils help individuals and departments develop methods to reward nurses for accountability. Peer review and quality assurance councils provide directions for the education a nurse needs in practicing accountability.

The joys that arise from accomplishments may seem distant at first, but they gradually replace distress, affording the participants renewed commitment. The most obvious change in staff is an increased sense of personal power. The "victim" mentality changes as nurses become assertive and negotiate with their peers and nurse manager. As they see the results of their efforts in more control over their practice environment, most exert continued effort. The expectation of peer review affords the opportunity for staff members to deal with the nonteam players.

Self-scheduling, even with its many initial trials, provides individuals with a sense of authority and control over their work life. Nurse managers are often glad to be relieved of the burden that rarely yielded any source of satisfaction other than relief upon completion. A high level of staff flexibility and sense of team participation can make this process smoother.

As the autonomy of each individual in the department increases, individuals begin to understand the nature of professionalism. High standards, shared power base, and peer feedback all facilitate individuals' accountability. Individual concerns merge with professional concerns as members of the nursing department coalesce.

As more nursing department members actively participate in implementation of shared governance, they work with people from other units. Multilevel and interconnecting work teams form to implement changes. Rapport and closeness develop as power and control struggles are resolved. This cohesion is necessary to weather the tribulations that result from such a major change.

Collegiality—the sharing of authority among colleagues—is the process and the outcome of shared governance. In this environment, shared governance flourishes. Conquering each step along the way can offer individuals a sense of accomplishment. It is crucial for all to stay focused on the goal, to remain flexible, and to celebrate accomplishments as they occur.

SUMMARY

Shared governance provides a model for continuous management of change. Lewin's model of change (1947) (unfreezing, change, and refreezing) provides a process for fostering change and maintaining equilibrium. A set of eight guidelines also helps to maintain the focus on the empowering of the nursing staff.

Empowerment requires creating and maintaining motivation in a change process; organizational and individual strategies are necessary. An overview of six points in fostering motivation in the organization is followed by a focus on McClelland's theory of motivation (1971). Managers encourage people to participate by knowing how to stimulate individuals' enthusiasm, creating an expectation that what they do will make a difference, and providing a reward worth their efforts.

Another organizational strategy is team-building. The 12 characteristics of an effective team focus on the process and the task functions that build a team. It is noted that dysfunctional group norms can block the work at hand. Consultants are often used in the team-building process because they are able to provide an objective perception of the team's operations. They also help to decrease the team members' reluctance to confront their own managers. A consultant can assist in team-building effort in six ways.

One way is clarification of roles. Role clarification is important in the team-building process to reduce intragroup and interpersonal conflict. As the shared governance process proceeds, the role of the first line manager, her/his supervisor, and the staff changes. Four questions guide the role clarification process.

For effective implementation of shared governance, the nurse manager and council chairpersons encourage active participation of all members, allocate workload, and monitor group process. Moving forward also includes developing strategies to improve the process of conflict resolution and decision making.

Research suggests that people who have helped make a decision are better motivated to execute it. Involvement in councils provides opportunities for individuals and the group to commit to the process of shared governance. To facilitate commitment of nurse managers and staff, clear vision and conflict resolution skills are needed to deal with those who lack commitment.

To sustain the commitment to shared governance, nursing departments need to continually resolve intradepartmental and interdepartmental conflicts. Communication ground rules and education on conflict resolution thus require attention early in the process. Excellent communication skills in the nurse manager help the manager deal with the inevitable conflicts and provide staff with a role model.

The transitional role of the nurse manager involves relinquishing control and moving to the role of facilitator. By facilitating consensus, the manager helps the group reach an agreement on decisions. In the role of facilitator, the nurse manager also identifies blocks to effective group decision making.

The role of the nurse manager changes dramatically in the shared governance model. The change to a leader and teacher requires education of the nurse manager to coach the staff in the roles required for the success of shared governance. A list of subjects is provided in Table I.

A leader who is a facilitator knows how to elicit answers from those who know best about their work. The primary challenge of a nurse manager is to encourage professional nurses to engage in more self-management and to be oriented toward lifelong learning. This is best accomplished through role modeling, coaching, and mentoring.

Studies indicate that those who had mentors themselves are more likely to mentor, thereby fostering a supply of nursing leaders in the organization.

Finally, there are trials and tribulations as well as joys and accomplishments in shared governance. As a nursing department reorganizes, all roles and responsibilities are questioned. People's relationships to each other change, and individuals, perhaps for the first time, begin to grasp the meaning of accountability. The "victim" mentality changes as nurses become assertive and negotiate with their peers and nurse manager. The confusion that develops from working together as a team is seen as necessary to weather the tribulations that result from such a major change.

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