coordination and integration of posthospital activities in a manner similar to that provided in the hospital was apparent, thus the emergence of a case management role. Table 3 explains the role functions of primary nurses and case managers.

Nursing case management is a natural extension of differentiated practice within an organizational context. Primary and associate nurses provide integrative nursing support to the client and family across the acute episode of illness within the hospital setting. Primary nurse communication occurs through the nursing process, with each nursing diagnosis resolved or referred to the primary nurse in the receiving unit. Those patients who need ongoing case management are then referred to the case manager (CNS) who provides continuing care throughout the illness episode in multiple settings. This type of care is best suited to individuals with chronic illness requiring support across the full spectrum of health care services (Figure 7-4), individuals with knowledge or financial deficits, or clients lacking support and assistance from a significant other. The following situation describes use of a case manager.

> A pregnant teenager of Native American background was admitted to the hospital in premature labor. As the primary nurse worked with the client, it was discovered that the individual had no resources or support. The family had removed her from their home, and she had no fiscal or significant other support. Her situation was referred to a case manager, who made arrangements for living quarters and subsidy support upon discharge from the hospital. The mother and infant were followed after discharge, and a successful outcome was achieved for all.

TABLE 3
Comparison of the role functions of the primary nurses and the case managers

Primary Nurses	Role Function	Case Managers
Integrate medical and nursing orders into a comprehensive plan of care	**Integrator**	Integrate medical and nursing plan of care with health patterns of client
Coordinate activities of various departments on behalf of client	**Manager**	Coordinate activities of various agencies on behalf of client
Communicate wishes and fears of client and family to other health care providers	**Advocate**	Communicate unique lifestyle and cultural issues to other team members and agencies
Develop and coordinate discharge teaching activities pertinent to illness episode	**Teacher**	Consult with various professionals on complex client care needs, teach patient and family health promotion or health maintenance activities
Negotiate for changes in medical or nursing plan of care as client condition changes	**Negotiator**	Negotiate for changes in agency services or reimbursement options as client condition changes

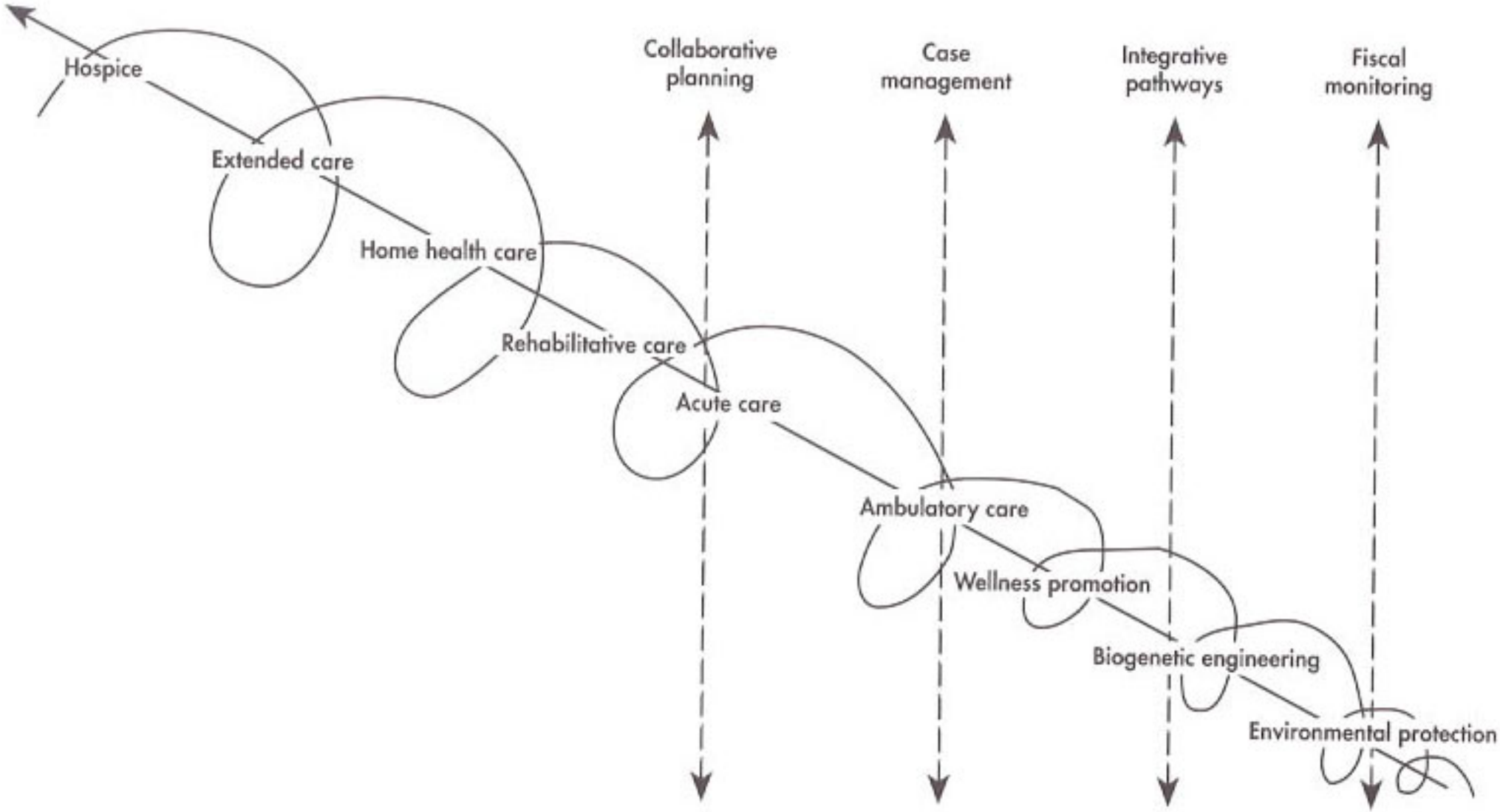

FIGURE 7-4. Continuum of health care services and integrating factors. (From *Differentiating a Nursing Practice: Toward the Twenty-First Century*. Kansas City, 1991, American Academy of Nursing. Reprinted with permission.)

The Contextual Environment

To more fully comprehend the totality of nursing, the work of nursing must be placed into the context of the entire organization and the health care industry. Gareth Morgan (1984) states that to avoid having the whole be less than the sum of its parts, it must be viewed within the concept of a hologram. This biologic brain metaphor emphasizes that organizational design for innovation is not a discrete event, but a process for integrating all the essential functions, organizational units, and resources needed to manage an innovation from beginning to end.

The holographic approach directs attention to activities that identify and combine the key resources and interdependent functions needed to develop an innovation on one organizational unit, so that it can operate as if it were autonomous (knowing that no unit is ever completely autonomous). Members of the unit are socialized to "think globally while acting locally" (Hrebiniak and Joyce, 1984). Each member comes to know his or her role and how it relates to the other specialties. Members also understand the master blueprint of the overall innovation. This facilitates interdependent action and survival of the innovation.

Critical dimensions of the institutional environment are present on the unit. The key resource for nursing practice at the unit level is the presence of a competent nursing team. The major interdisciplinary players are the physicians and other allied health personnel. Interaction among these various players permits unit members to develop and store rich patterns of information and uncertainty that are needed to detect and correct errors existing in the environment. Thus environmental scanning and clear communication become a responsibility of all unit members.

Collaborative Practice

Increasing fragmentation of patient care because of heightened acuity, shortened length of stay, increasing physician subspecialty, and consultation increases the need for shared communication, decision-making, and some standardization. The goal of collaborative practice is to integrate the nursing and medical data base and plan of care to enhance the quality of patient care.

> **Collaborative practice:** Mutual valuation of nursing and medical practice that fosters respect among the professions and potentiates the contribution of each for the benefit of the patient.

Opportunities for collaboration are strengthened through joint committee appointments of staff nurses as well as nurse managers to the hospital medical committees. Multidisciplinary grand rounds could be established in various specialties of practice. The establishment of integrative pathways (critical paths) on the major DRG categories on each unit may be done as a descriptive (not prescriptive) process to facilitate timely decision making and communication among all care providers. As trust emerges among team members, the pathway may assume a prescriptive focus to maximize cost efficiency.

The relationship that emerges between case managers and primary care physicians develops a unique characteristic of collegiality over time. As each partner learns to trust and respect the other's unique perspective of the client, true negoti-

ation regarding interventions occurs. In one agency the ability of a case manager to influence medical orders by assisting the physician to see the uniqueness of each client resulted in reducing the cost per hospice patient for laboratory procedures from $2.46 per day to $.02 per day. The open dialogue resulted in more focused decision making for both the nurse and physician, and less cost and discomfort for the client without reducing quality of care (Slack, 1990).

Collegial Practice

The need to improve collegial relationships in nursing requires a radical change to achieve freedom from an isolating practice orientation of power and control to a professional practice model of partnership. This requires a disciplined personal commitment to the other's and to one's own continued growth. Bunkers and Koerner, (1990) have identified that nurses need to understand that they are part of a community of caring. They have a responsibility to pay attention to the entire community of nursing to gain improvements for all nurses.

A primary goal for collegial practice is to establish professionalism as the unifying value for nursing, and develop a nursing center to assist nurses from all settings to meet evolving clinical and scholarly (education, research, and publication) goals.

> **Collegial practice:** Mutual valuation of individual nurse practice based on scientific principles that establish credibility, and a common language that facilitates clear communication.

Nursing has had to confront both gender and class barriers in its attempts to determine its own destiny and assume a meaningful role. Class and gender issues place women in a submissive status, creating an oppressed group mentality within the profession. Because of this background, nurses have much difficulty articulating the value and worth of nursing, impacting the image of the profession and relationships within it.

In the 1980s women made a shift from people who serve others, defer to others, and define themselves through others, to people who are visible in their own right, and who stand as separate individuals while still connected to others (Eichenbaum and Orbach, 1988). Once a woman has learned to be autonomous, both her work relationships and her intimate relationships are usually healthier (Hagberg, 1984).

Facilitating collegial relationships must be a major goal of any nursing practice. Analysis of the situation reveals that trust is basically missing in many nursing relationships. Lack of clear and concise communication and misunderstanding of the various nursing roles within the organization are key elements that contribute to the existing distrust.

Two vehicles specified to facilitate clear, concise, and accurate communication are nursing diagnosis and the nursing process. Norms for communication in nursing diagnosis language and nursing process format must be established for planning, charting, and change of shift report. Collaborative, ongoing care planning and clear delegation would increase teamwork. Thus a clear norm for delegation would state that within the department of nursing, delegation occurs through nurs-

ing orders. Failure to execute a nursing order would require a variance report just as omission of a medical order, as they are mutually valued.

Mutual respect among colleagues would be further fostered through increased understanding of the various roles within the nursing department as well as individual preference for a specific role. A nursing center could be established to assist individual nurses with career planning and developmental needs. An administrative nursing director would develop the center and integrate its activities into evolving needs within the organization, as well as beyond its walls. Services offered to professionals might include:

- Career assessment activities that focus on interest inventory and job placement activities
- Formal educational opportunities in academic centers with scholarship and loan support toward an advanced degree
- Continuing education of an experiential nature through participation in fellowship and professional exchange programs, as well as traditional in-service programs
- Personal growth opportunities in leadership and team-building skills, ethical competence, and creative innovation

The nursing department may also be committed to supporting the education and practice needs of the larger profession. Affiliating and rural hospitals employ nurses with varying needs in meeting the unique health care requirements of rural communities. Activities might include:

- Educational outreach activities for professionals and the community
- Provision of nurse managers and directors in various hospitals seeking a nursing management contract, or management development programs for rural nurse managers with limited access to resources
- Fellowship programs in obstetric nursing and emergency nursing, offering affiliate nurses an intensive week of didactic and clinical experience in a low-volume, high-acuity aspect of their rural practice

Relationships with the nursing schools would also be strengthened through the development of "middleground" (Figure 7-5) (Bunkers and Koerner, 1990). Student experiences at the hospital would be enhanced through summer externships and a 6-month residency program for new graduates. Five fields for interinstitutional integration between nursing education and nursing service may be developed by:

- Staff development courses offered for college credit
- Shared faculty/joint appointment wherein educators and administrators plan and teach courses collaboratively
- Consultative services—the hospital hires faculty to design and implement research as well as consulting on specific nursing issues
- Joint decision-making with both administrative and faculty personnel serving on college curriculum and hospital management committees

Another area for further development is group practice, in which administrators and educators would carry a caseload of clients, engage in peer review and quality

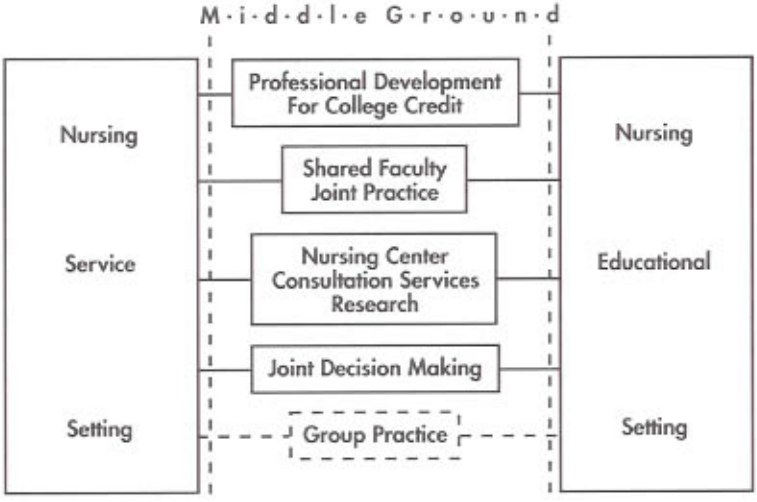

FIGURE 7-5. A model for interinstitutional integration of professional nursing. (From Bunkers, S. and Koerner, J. [1990]. The M-I-D-D-L-E-G-R-O-U-N-D: A model for interinstitutional integration. Nursing Connections, 3[1], Spring.)

assurance, and cover another's practice when one is absent. Through collaboration among nursing peers, the integration of practice and research is strengthened in a way that can contribute much to the advancement of professional nursing.

THE STRATEGIC CHALLENGE OF INSTITUTIONAL LEADERSHIP

Innovations not only adapt to existing organizational arrangements, they also transform the structure and practices of those environments. Because innovation is not the enterprise of a single entrepreneur, the network of individuals and units that have created, adopted, and transformed the innovation into good currency must be formalized within the infrastructure of the organization. A strategic challenge is the creation of an infrastructure that will maintain the innovation and the networks.

Reframing the Manager Role for an Empowered Environment

Within the organization institutional leadership is critical in creating a cultural context that fosters innovation, in addition to an established organizational strategy, structure, and system that maintains autonomy and accountability. There is growing recognition that innovation requires a special kind of transformational leadership:

> This type of leadership offers a vision of what could be and gives a sense of purpose and meaning to those who share that vision. It builds commitment, enthusiasm, and excitement. It creates a hope in the future and a belief that the world is knowable, understand-

able, and manageable. The collective energy that transforming leadership generates, empowers those who participate in the process. There is hope, there is optimism, there is energy (Roberts, 1984).

During periods of transition the leader is charged with the creation of the organization's character and culture. This is accomplished through four main functions: defining the mission, embodying purpose into the structure and systems being designed, defending the institution's integrity, and ordering the inevitable internal conflicts that arise.

Institutional leadership is at the heart of corporate institutionalization. An organization does not become an institution until it is infused with the value of being a vehicle for group integrity. Infusion of norms and values occurs over time, in a sporadic rather than a linear fashion. This activity is the key to social integration of all members within the organization (Van de Ven, 1986).

Shared Governance

Increased autonomy and responsibility are central goals that drive nursing's quest for professionalism. Decentralization, participation in decision making, and shared governance make organizational structure and professional practice more complementary. As nursing's role in patient care increases, so must its role in hospital management. The goal for shared governance must be to position nurses as esteemed business partners who assume more responsibility in integrating the allocation of human, fiscal, and material resources for improved patient care.

Shared governance: A governance system that distributes responsibility and authority between the business organization and the professional business partner. Nursing is challenged to couple the professional good of autonomy with business acumen to become a proficient and esteemed business partner.

Shared governance may be viewed as a twofold process: the strengthening of autonomy in decision making through further decentralization, and development of business acumen to strengthen positioning within the organization.

The Movement Toward Autonomy

A central principle in the development of models and concepts is to keep the management team "one step ahead" of the staff in the process so that they can lead and facilitate staff development. Thus a long-range strategy to prepare unit managers for their new role in a shared governance structure must be executed. Staff development would be initiated *after* management education is begun.

Teamwork and Creativity

Work in any setting comprises two component parts, tasks and relationships. A harmonious relationship will facilitate the responsibilities inherent in the task. Thus nursing administration might begin the management training program with a class designed to facilitate teamwork. A class entitled "Whack on the Side of the Head" (van Oech, 1983) was developed to strengthen the creative ability and

communication skills of individuals on the management team in one organization (Bunkers and Koerner, 1988). Co-taught by a nursing administrator and a professor from a local college, the course, which focused on principles of creativity and communication, was offered for college credit. Using adult learning principles and innovative teaching techniques, the class fostered new perspectives on well-known issues (i.e., the local zoo provided the setting and a manager to deliver a lecture that compared the management of a hospital unit to a zoo). During the course each member of the team created a change project for his or her unit, applying principles of design and development. Colleagues assisted in the identification of strategies for successful implementation, pledging support for co-worker success.

Management Principles

A second class on management principles was presented to the entire management team and reviewed concepts in planning, budgeting, staffing, resource allocation, quality assurance, and personnel management. Although the class was a review for many, it helped to frame those activities in the context of a health care delivery system experiencing corporate reorganization in response to changing environmental, economic, and demographic trends.

Participative Management

A third class, "Creative Nursing Administration for the 21st Century," helped the unit managers develop an understanding of the evolving need for participative management. Strategies to create a professional environment and foster staff accountability were identified (Porter-O'Grady, 1986). Needs and challenges facing managers in an empowered environment were addressed, providing them opportunity to vent their fears, frustrations, and expectations as the management process was changing.

Revitalizing Professional Commitment

The principle of temporal linkage is vital to successful implementation of an innovation. It highlights the necessity for linking past, present, and future to the innovation at hand. Celebrating the contributions of the past and integrating salient features of the current process into a future model assists people during the transition. They are then able to take investments, commitments, and values from the past into the future. Albert (1984) states that there is a need to create funerals, celebrations, and other transitional rituals that commemorate ideas, programs, and commitments that give way to new changes that must gain good currency for innovation to succeed.

The final class created for the unit managers and clinical nurse specialists, "Change, a Professional Challenge," began with a funeral. Each participant received an invitation to bring a symbol of something in nursing that they would like to release as they moved into a new model of professional practice. Managers were then taken to a local funeral home where the funeral director assisted with the burial of the old symbols of nursing and the resurrection of new, favored ways.

This three-credit-hour course was co-developed and taught by nursing educators at a local college and nursing administrators at a hospital. It focused on principles of change, personal and professional development, and situational leadership. Each individual's philosophy of nursing and future career goals were examined along with personal issues that influence career choices and decisions. The process of influencing through motivation, initiation, facilitation, and integration was examined (Hersey and Duldt, 1989). After this group completed the class it was offered to supervisors within the organization. Staff nurses were then offered the class, which meets the "Introduction to Baccalaureate Nursing" course requirements for BSN degree completion.

Strengthening Staff Participation

While the management team is being reoriented, the staff must be introduced to activities that foster their participation in decision making. Committee work designed in a team-building format would establish staff accountability. As openings are posted for the first design team, there may be an apparent lack of interest in participation by the staff, with few people applying for the positions. A certain skepticism and mistrust exist among staff nurses who believe that nothing makes a difference, that their input has not been heeded in nursing's past. If this phenomenon occurs, individuals with a track record for innovation and participation may be invited to join the committee. As the first round of committee work is completed with results valued and implemented, an increase in staff participation will be noted. Thus a "new reality" would emerge for staff-manager collaboration in decision making.

Introducing Business Principles

"Ecology of Excellence" is a business program developed by an innovative nursing leader, Donna Davidson, and Dr. Frank Steiner (Steiner, 1986). It combines principles of empowerment, teamwork, and business to create a business partner for the entire health care setting. The program teaches all hospital staff a process that balances the quality of worklife with business performance, creating a corporate culture of excellence.

A business curriculum would teach the concepts of true communication, team leadership, idea marketing, wise negotiation, and intrabusiness skills. Ongoing activities would find staff creating work teams based on the Myers-Briggs inventory to address issues of concern and ideas for new program development. Interface agreements would be developed for problem areas within the organization by the parties in conflict. First-party communication would replace the nonproductive third-party communication so prevalent in practice today. Staff members could present any request desired after a cost-benefit analysis had been completed. Thus increased budgeting and systems information would be made available to staff members so they could evaluate the impact of their request on the organization, the client, and others within the institution.

A final feature of a business program is the development of baselines to evaluate and monitor the cost and quality outcomes of caregiver performance and care provided. Management of issues that impact quality and cost would be transferred

to the units. Staff would interview new business partners for hire, make purchasing decisions with their capital budget, and track lost charges and other activities that have a fiscal impact on both the client and the organization.

THE INTEGRATIVE CHALLENGE OF REUNITING THE WHOLE

After management and staff have matured to the point that shared governance would be successful, formalization of an infrastructure to honor and support the various components developed by staff through their innovative efforts would occur. The goal would be to create an infrastructure that integrates the various components of nursing practice while supporting ongoing innovation.

Alpert (1984) states that innovation is an institutional success to the degree that it exhibits authenticity, functionality, and flexibility over time. Authenticity requires that the innovation embody the organization's ideas. The organizational chart for the nursing department must reflect the new philosophy (Figure 7-6). An innovative, organizational model places the client at the center of the chart. The circular design reflects removal of hierarchy, depicting instead mutual valuing of all care delivery roles. Placement of the administration at the bottom of the chart identifies a role change of management from controlling, directing, and supervising to one of facilitating, coordinating, integrating, and supporting.

Functionality requires that the innovations work. Baseline data must be generated at the onset of the innovation in several major categories: patient, physician, and nurse satisfaction; cost and quality indicators; staff turnover; and informal assessment of quality of worklife experienced by the staff. Indicators in each area must be maintained or enhanced, especially as staff became more expert in a specific innovation.

Flexibility requires that the innovations incorporate input and suggestions from the institution's membership. Thus the governance model may centralize financial allotment, staffing philosophy, and policy formulation for the nursing department. Budget allocation, staffing patterns, quality assurance activities, standard development, integrated care delivery activities, peer evaluation, and continuing education activities would be decentralized to the unit level.

Three cybernetic principles based on the holographic metaphor have been identified by Morgan (1984) as essential in an infrastructure to address problems of managing attention, ideas, and whole-parts relationships over time. First, organizational members must develop the capacity to control and regulate their behavior through ongoing feedback. The organization must have values and standards that define the critical limits within which to function. Second, double-loop learning principles should be used so that the organization can detect and correct errors in the operating norms themselves. This focus permits the organization to adjust to changing environmental and professional technologies and ideologies. Finally, maintaining a certain degree of uncertainty, diversity, and turbulence maintains a bias for creativity. This could best be accomplished by developing a tolerance for ambiguity and risk-taking. Innovation would thus be enhanced and ongoing. These principles must be woven into the shared governance model.

All members of the nursing department would become members of the con-

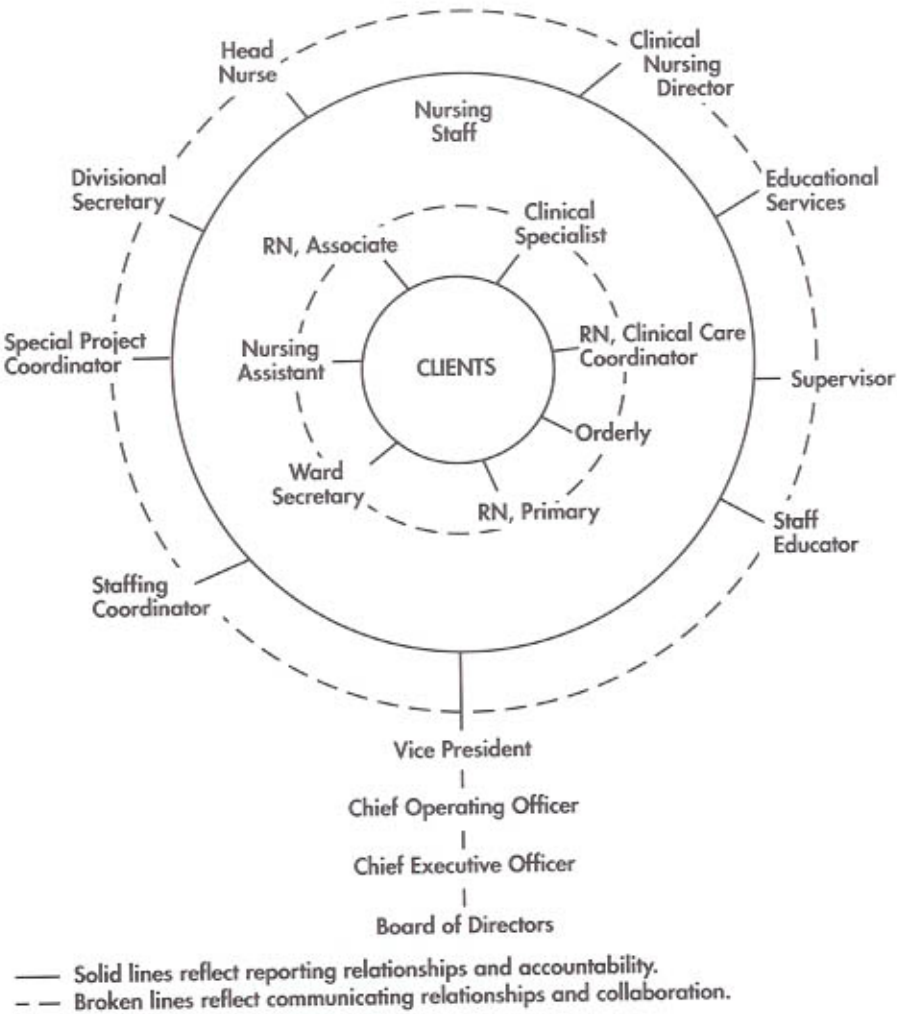

FIGURE 7-6. Department of nursing divisional chart. (Used with permission from Sioux Valley Hospital, Sioux Falls, South Dakota.)

gress (nursing practice) on the basis of credentials, in a manner similar to that of medical staff. After an initial interview with a staff nurse, the applicant would go through an admissions process based on criteria for professional expertise developed by staff. Professional portfolios would be maintained by each nurse in practice to demonstrate proficiency in nursing process for peer evaluation and further professional development.

Four councils would coordinate activities for the nursing department. The council on practice would establish nursing standards; the council on management would support those standards through allocation of fiscal and human resources; the council on education would educate to those standards; and the council on quality assurance would measure standards of professional performance and qual-

ity outcomes for the client (Porter-O'Grady and Finnegan, 1984). Unit-based councils would be micro-elements of the departmental councils. The nursing executive council, composed of the departmental council chairpersons, clinical directors, and the vice president of patient services would monitor and facilitate the activities of the various councils and the congress. Bylaws would govern the activities of this model based on professional accountability.

SUMMARY

A sense of crisis has erupted in the nursing profession as a result of heightened aspirations for nursing's role along with recognition of inadequacies in performance and opportunity. Conflict exists within nursing because of a lack of unifying values and vision. Nurses must accept and value themselves as true autonomous professionals. They must move from the current procedural orientation that reinforces division, to a professional orientation that is concerned with the essence of nursing. Enhancement of professional opportunity and accountability must be the primary motive underlying the creation and implementation of an innovation for nursing practice.

Development and implementation of an innovation based on systems theory, using the holographic brain metaphor, will assist transformation of the profession. Cybernetic principles, woven into an infrastructure, would ensure ongoing maintenance and further development of the model established.

Nursing must accept and value the institution as an esteemed arena for practice if the institution is to accept and support the profession as a valued partner in business. Gilb (1985) has observed that freedom in a complex, interdependent economy is derived through organizations. Without an organization to define and sustain the area of freedom, the individual professional is seldom free. Thus the practice role of nurse must be differentiated and placed within an organizational context, or informally connected to it.

Nurses must become autonomous professional business partners with other major players in the health care system to strengthen hospital nursing and improve patient care. Recognizing the importance of nursing to quality patient care, organizations must support the nursing department in creating a practice model that positions nurses as esteemed professional business partners within its walls and beyond. Professional nursing practice must also be expanded to include political acumen and business skills that influence patient care decisions, both clinically and economically.

Four major partnerships for nursing are essential for ongoing success: **integrated practice,** partnerships with the clients served within the organization and external to it; **shared governance,** a partnership with the hospital; **collegial practice,** partnerships among the nurses themselves both within the institution and external to it; and **collaborative practice,** a partnership with physicians and allied health colleagues.

Professional nursing business partners must be placed in a strategic position within the hospital and the larger health care community. An integrative care delivery model would create a foundation for future research and theory development in nursing practice. By combining the strengths of professional practice and

a business acumen that influences quality and cost-conscious decisions, nursing will become a highly influential and valued integrative link between the client and the health care industry in this time of unprecedented change.

Nursing administrators must accept the challenging role of transformative leadership in redesigning the position of nursing within their organization as health care delivery is transformed. Their vision and courage can liberate nursing from limiting thoughts and actions. As nurses' imaginations are freed, fear, closed thinking, and poverty of spirit will be abandoned. This is the key to successful transformation of nursing for the twenty-first century.

REFERENCES

Albert, S. (1984). A Design Model for Successful Transitions. In J. Kimberly and R. Quinn (Eds.), *Managing Organizational Transitions* (pp. 169-199). 1984. Homewood, Ill.: Irwin Press.

Argus, R. and Schon, D. (1983). *Reasoning, Learning and Action*. San Francisco: Jossey-Bass.

Ashleym J. This I Believe About Power in Nursing. *Nursing Outlook, (21)*, 11, 737-641.

Bates, B. (1970). Doctor and Nurse: Changing Roles and Relationships. *New England Medical Journal, 283*, 3, 129-134.

Benner, P. (1984). *Novice to Expert*. Menlo Park, Calif.: Addison Wesley.

Boston, C. (1990). Introduction. *Current Issues and Perspectives on Differentiated Practice*. AONE, Chicago: AHA Catalog No. 154830, 1-5.

Brooten, D., Human, L., and Naylor, M. (1988). *Leadership for Change*. Philadelphia: J.B. Lippincott Co.

Bunkers, S. and Koerner, J. (1988). Making the Glue Stick: A Group Experience. *Journal of Nursing Administration. 19*,(2), 41.

Bunkers, S. and Koerner, J. (1990). The M-I-D-D-L-E-G-R-O-U-N-D: A Model for Inter-institutional Integration. *Nursing Connections, 3*,(1), Spring.

Deane, C. and Campbell, J. (1985). Developing Professional Effectiveness in Nursing. Reston, Va.: Reston Publishing Co.

Eichenbaum, L. and Orbach, S. (1988). *Between Women*. New York: Viking Penguin Inc.

Fiesta, J. (1983). *The Law and Liability: A Guide for Nurses*. New York: John Wiley & Sons.

Filley, House, and Kerr. (1976). *Managerial Process and Organizational Behavior*. Glenview, Ill.: Scott Foresman.

Gilb, A. (1985). *Hidden Hierarchies*. New York: Harper & Row.

Griffin, A.P. (1980). Philosophy and Nursing. *Journal of Advanced Nursing, 5*,(3), 261-272.

Hagberg, J. (1984). *Real Power*. Minneapolis, Minn.: Winston Press.

Hersey, P. and Duldt, B. (1989). *Situational Leadership in Nursing*. East Norwalk, Conn.: Appleton & Lange.

Hrebiniak, L. and Joyce, W. (1984). *Implementing Strategy*. New York: Macmillan, p. 8

Janis, I. (1982). *Groupthink* (2nd ed.). Boston: Houghton Mifflin.

Johnson, P.E. (1983). The Expert Mind: A New Challenge for the Information Scientist. In M.A. Bemmelsmans (Ed.), *Beyond Productivity: Information Systems Development for Organizational Effectiveness*. Netherlands: North Holland Publishing.

Kanter, R. (1983). *The Changemasters*. New York: Simon & Schuster.

Koerner, J. (1989). Implications of Differentiated Practice Models for Nurse Executives. *Aspen Advisor for Nurse Executives, 4*,(12), 1, 6-8.

Koerner, J. and others. (1989). Implementing Differentiated Practice, the Sioux Valley Hospital Experience. *Journal of Nursing Administration, 19*,(2), 13-20.

Koerner, J. (1990). Differentiated Practice: Relevance in Today's Environment. *Current Issues and Perspectives on Differentiated Practice* (pp. 35-51). Chicago: American Hospital Association Catalog No. 154830.

Kuhn, T.J. (1970). *The Structure of Scientific Revolutions*. Chicago: Chicago University Press.

Lawrence, P. and Dyer, P. (1983). *Renewing American Industry*. New York: Free Press.

Leddy, S. and Pepper, J. (1989). *Conceptual Bases of Professional Nursing*. Philadelphia: J.B. Lippincott.

Lewin, A.Y. and Minton, J.W. (1986). Organizational Effectiveness: Another Look, and an Agenda for Research. *Management Science, 32*,(5), 5.

March, J.G. (1981). Decisions in Organizations and Theories of Choice. In A. Van de Ven and W.F. Joyce (Eds.), *Perspectives on Organizational Design and Behavior*. New York: Wiley & Sons.

Marsick, V.J. (1990). Altering the Paradigm for Theory Building and Research in Human Resource Development. *Human Resource Development Quarterly, 1*,(1), 5-34.

McClure, M. and others. (1983). *Magnet Hospitals: Attraction and Retention of Professional Nurses*. Kansas City, Mo.: American Nurses Association.

Miller, G.A. (1956). The Magical Number Seven, Plus or Minus Two: Some Limits on Our Capacity for Processing Information. *Psychology Review, 63*, 81-97.

Mitroff, I. (1985). Why Our Old Pictures of the World Do Not Work Anymore. In E.E. Lawler III, A.M. Mohrman, Jr., G.E. Ledford, Jr. T.G. Commings and Associates (Eds.), *Doing Research That Is Useful for Theory and Practice* (pp. 18-44). San Francisco: Jossey-Bass Company.

Morgan, G. (1984a). Action Learning: A Holographic Metaphor for Guiding Social Change. *Human Relations, 36*,(37), 1-28.

Morgan, G. (1984b). *Beyond Methods*, Beverly Hills, Calif.: Sage.

Nicholai, C. (1990). Weighting Role Competencies Based on Job Role. *Nursing Career Pathway Project*. Sioux Falls, S.D.: Sioux Valley Hospital.

Ouchi, W. (1981). *Theory Z*. Reading, Mass.: Addison-Wesley.

Parse, R.R. (1987). *Nursing Science: Major Paradigms, Theories and Critiques*. Philadelphia: W.B. Saunders Co.

Pelz, D. and Andrews, F. (1966). *Scientists in Organizations*. New York: Wiley & Sons.

Peters, T. and Waterman, R. *In Search of Excellence: Lessons From America's Best-run Companies*. New York: Harper & Row.

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

Porter-O'Grady, T. (1986). Creative Nursing Administration: Participative Management Into the 21st Century. Rockville, Md.: Aspen Publishers, Inc.

Primm, P. (1987). Differentiated Practice for ADN and BSN Prepared Nurses. *Journal of Professional Nursing, 15*,(4), 218-225.

Roberts, E. (1984). *A Woman's Place: An Oral History of Working*. San Francisco: Jossey-Bass.

Schon, D. (1971). *Beyond the Stable State*. New York: Norton Publishing.

Slack, C. (1990). Utilization Review of Hospice Program: Fiscal Year 1989-1990. *Annual Report to Midwest Health Inc*. Sioux Falls, S.D.: Sioux Valley Hospital.

Statewide Project Steering Committee. (1990). The South Dakota Experience. *Current Issues and Perspectives on Differentiated Practice* (pp. 53-67). Chicago: American Hospital Association Catalog No. 154830.

Steiner, F. (1986). *Ecology of Excellence*. Corrales, N.M.: Educational Professional Services Inc.

Stenvig, T. and Koerner, J. (1987). State Collaboration for Nursing in South Dakota. *Nurses in Agreement: Controlling Our Future* (pp. 85-93). Indianapolis: MAIN.

Styles, G. (1982). *Towards a New Endowment*. 1982. St. Louis, Mo.: C.V. Mosby Company.

Torrens, P.R. (1978). *The American Health Care System: Issues and Problems* (p. 33). St. Louis, Mo.: C.V. Mosby Company.

Tversky, Q. and Kahneman, D. (1974). Judgment Under Uncertainty: Heuristics and Biases. *Science, 185*, 1124-1131.

van Oech, R.A. (1983). *A Whack on the Side of the Head*. New York: Warner Books.

Van de Ven, A. (1982). Strategic Management Concerns Among CEO's: A Preliminary Research Agenda. Presented at Strategic Management Colloquium, University of Minnesota, Minneapolis, October.

Van de Ven, A. (1986). Central Problems in the Management of an Innovation. *Management Science, 32*,(5), 590-607.

Van de Ven, A. (1989). *Nursing Practice Patterns*. Milwaukee: National Commission on Nursing Implementation Project.