Bylaws create the setting for "win-win" agreements (Covey, 1989), one of the characteristics of organizational effectiveness in professional governance models. Clearly defining the framework and obtaining consensus before implementation creates an environment for success and clearly delineates standards against which individual, group, and system outcomes can be measured. Five elements cited by Covey as crucial to win-win agreements are:

- "*Desired results* (not methods) identify what is to be done and when.
- *Guidelines* specify the parameters (principles, policies, etc.) within which results are to be accomplished.
- *Resources* identify the human, financial, technical, or organizational support available to help accomplish the results.
- *Accountability* sets up the standards of performance and time of evaluation.
- *Consequences* specify—good and bad, natural and logical—what does and will happen as a result of evaluation." (p. 223)

It is evident in this framework that methods are not delineated. Bylaws, like win-win agreements, focus on results, boundaries, availability of resources, the meaning of accountability, and the consequences of performance. Bylaws operate on the basic assumption that the professional nurse is capable of self-direction and performance control and can be self-governed to do whatever is necessary within established guidelines to attain the desired outcomes. The consensus or mutual endorsement of the bylaws by nursing staff and the organization, coupled with involvement in their development, cements and broadens nursing's contract with society.

Bylaws provide basic guidelines and must be adaptable and flexible to the developmental stage of the professional governance structure within the organization. Initially more guidelines, visible resource availability, and systems performance evaluation may be necessary for successful development of true professional governance systems. As the governance model matures, fewer guidelines, less frequent accountability measurements, and longer-term intrinsic rewards will be supported by the bylaws. Ultimately the bylaws become internalized and are inherent in the governing process.

When bylaws are implemented, all systems within the organization must support the win-win situation that must occur for professional governance system success. Systems traditionally within the realm of the manager—job design, organizational structures, role definition, communication, budgeting, compensation, planning, operational activities, information, hiring, education, development, and evaluation—must be integrated for governance to be a success. Accountability is fostered by the bylaws and the basic nature of humans in their motivation to do whatever is necessary to accomplish desired results within the parameters of the system. This is further supported when individuals have input into the development of the system, have agreed to support it, and have received ongoing performance feedback to celebrate success or make necessary performance corrections.

During the development of bylaws nurses within an organization participate in the development and operation of the professional governance structure. As each section unfolds, the structure, responsibilities, and accountabilities within the set-

ting are further clarified. An example of bylaws is included in the Appendix as a possible guide for organizational thinking as bylaws are developed and sanctioned.

Definition of nursing staff membership, credentials, tenure, removal, and obligations of accountability are new concepts in most nursing organizations and will be discussed as they relate to bylaw development and implementation. Because the nursing staff has responsibility for peer-based activities of performance evaluation, competency, and accountability within the professional governance framework, it is imperative that members share in the credentialing process as well. Credentialing is a function of professionals for the appointment of staff that is clearly denoted in staff bylaws and supported by regulatory and accrediting bodies. Within the framework of the bylaws nursing staff membership should be clearly defined. Staff membership is granted by the nursing organization in accordance with the bylaws, rules and regulations, and policies of the nursing staff and the hospital. Each applicant for membership is oriented to the bylaws and agrees that his or her practice shall be bound by them. Criteria in the bylaws clearly delineate licensure, as well as education and professional experience requirements. Bylaws may also elaborate on the hospital's ability to provide resources for applicants as they participate in fulfilling their obligation to the institution in providing quality-based and cost-efficient care. In addition, each applicant for nursing staff membership consents to review of records and documents pertaining to licensure, experience, education, and other evidence of competencies. The process usually includes a personal interview to determine eligibility for nursing staff membership.

Peer recommendations can be part of the staff involvement process in recommendations for nursing staff membership. In some settings establishment of credentials begins at the initial formal contact of the nurse applicant with the organization as staff assumes accountability and responsibility for the interview and selection process of staff. Managers in this process act as consultants and facilitators to staff to ensure compliance with institutional and legal mandates related to hiring. In other settings applicants' credentials reviews are handled entirely by a credentials committee, a group reporting to the quality assurance body within the governance structure.

Accountability is fostered within the system by the credentialing process. Nurses within the system are accountable for selection of staff members who they think will abide by the bylaws. Applicants who are bound by the bylaws as a condition of nursing staff membership will also be charged with accountability within the governance structure. Professional nurses who have been appointed in any membership category are oriented to the bylaws and accept the professional obligations stated in them as an expectation of clinical privileges.

The tenet of accountability in the process of professional governance is based on the innate desire to succeed and be responsible for achievement of mutually endorsed goals and responsibilities by those participating in the system. The following checks must be built into the bylaws structure related to credentials and privileges:

1. Expeditious review of applications
2. Delineation of additional organization approvals

3. Periodic review and reappointment process
4. An appeals process

If nursing seeks approval of the governing board for its bylaws, then the issue of approval from the governing board for applications for staff appointments must be addressed.

As nursing moves into the twenty-first century and continues its development as a profession, nursing organizations within health care institutions may explore the possibility of board approval of bylaws to obtain legal support for governance. Dialogue between executives and the board will determine the feasibility of the process and delineate issues to be discussed and approval processes. This approval by the board will cement the responsibility of nursing as a profession with its rights, obligations, and responsibilities within the health care organization.

Active credentials review must be an ongoing process. The requirements for reappointment and advancement within categories of nursing membership within the organization must be clearly delineated in the bylaws. Attainment of performance-based criteria by professional nurses provides the foundation for advancement within the system. Career advancement programs, peer review systems for performance evaluation, and appeals and grievance processes will need to be integrated within the organization with the credentialing process as the professional governance model unfolds. Part of the process of definition of accountability is the development of systems and processes for disciplinary action if obligations and responsibilities are not fulfilled by the professional nurse. These processes often reflect the organization's human resource policies related to these situations and are implemented within the health care organization's framework. If additional processes are developed within nursing, they must also be integrated with human resources.

All nurses (Porter-O'Grady, 1985) whose primary role is clinical nursing practice need to be integrated within the credentialing process. A system must be developed to ensure that this occurs and that all nurses currently employed in the setting as well as those who will be employed in the future in expanded roles participate in the process.

Granting of privileges is an important cornerstone in establishing accountability within the professional governance framework. It is imperative that the bylaws be clearly followed, decisions made expeditiously, and that documentation of reasons for action be related to patient care issues within the efficient operation of the nursing organization. These parameters should be integrated in professional staff governance activities whether they be related to initial application for membership, reappointment, performance review, or the grievance and appeal process. Only if the bylaws clearly address the basic concerns of the hospital and its nursing staff and clearly delineate that the procedure of earning credentials and granting of privileges is applied equitably will the process be insulated from attack. Immunity from liability should be included in the bylaws for those on the review committee. This issue can be discussed with hospital counsel to ensure compliance with state law.

Nursing staff bylaws clearly delineate the role of the professional nurse with clinical privileges in the care of patients throughout the system. Bylaws state pa-

rameters, rules and regulations, and either general or specific policies that support the nursing organization and the institution. The bylaws are designed to provide a framework for structuring the ongoing work of the nursing organization as it defines, delineates, implements, and evaluates activities related to the provision of patient care including individual professional development, peer relationships, and the governance structure. Periodic scheduled review of the bylaws ensures the opportunity to reconfirm important aspects about the function and structure of the nursing organization as well as ensuring that the bylaws reflect current practice with respect to the organization and its functions.

Bylaws development, as with any other major change in the organization involving a redefinition of the organizational culture, is facilitated by stakeholder analysis in the developmental process. Key stakeholders in this process of development of bylaws for the professional governance system in nursing include professional nursing staff, nurse managers, nurse executives, organizational administration, physicians, and possibly consumers. Professional nursing staff and nursing management must advocate the governance concept and development of bylaws necessary to support it or the transformation to professional governance will perish. During the planning phase, systems outcomes and criteria for measurement must be defined. Early in the process, after the initial buy-in at the nurse staff level, a political analysis of the organization will provide information about when and how to involve the medical staff, hospital administration, human resources personnel, and legal consultation in the development, approval, and implementation process of the bylaws. Validation of bylaws by key stakeholders within the organization provides additional credence for nursing professional governance and the belief that nursing can be responsible for its professional practice. The framework has been delineated and expectations for success of the model established by the bylaw process.

Resources will be invaluable to the nursing staff, nurse managers, and executive team as bylaws are developed to ensure that the mission, goals, and governance structure are feasible within the constraints of resource allocation. They must also meet criteria established by regulatory and accrediting bodies including but not limited to the state board of registered nursing, the labor board, and federal and state statutes, as well as the organization's insurer and the hospital's legal counsel. Hospital legal counsel should review bylaws before implementation to ensure they are in compliance with current state laws. Although the primary responsibility for development of bylaws rests with the professional staff, judicious use of resources ensures their development and implementation to facilitate positive outcomes for all stakeholders. The consultative and review process is inherent in the development of bylaws that support a system that fosters professional autonomy and accountability.

Development of bylaws and a professional governance model is a long and tedious process. Staff involvement, communication, education, staff and organizational approval, and building stakeholder support for the concept are critical to its success. The professional governance system must be based on organizational values consistent with common goals and supported by a strategic plan. Bylaws support the vision, values, and structure of professional governance to become a reality.

GOVERNANCE ISSUES

Professional governance models for nursing are transitional leadership models that will lead the profession into the twenty-first century. Several issues arise regarding the implementation of nursing governance functions within and perhaps outside the traditional boundaries of organizational structures.

Nurse Participation in Hospital Governance

One of the fundamental issues addressed is the need for nursing representation on the hospital governing board. Governing boards have been involved with medical staff issues and participation historically but not *with* nursing, whose role within the organization is critical to attainment of quality, cost-efficient clinical and organizational outcomes. A paradigm shift is beginning as "successful institutions see leadership as a critical mass that brings in components from governance, management, medical staff and patient services especially nursing" (Chapman-Cliburn, 1989, p. 48). Board members are beginning to seek advice from people other than the chief executive officer and are beginning to interact with senior and middle managers within the institution.

Several models have been implemented to foster productive, successful relationships between nursing services and the board of trustees or governing board of a health care institution. Sands (1990) states that board members who are nurses are the exception to the rule and that open relationships between nurse trustees and nurse executives can benefit the institution by better facilitation of information to the board. These open relationships, which enhance the nurse trustee's and nurse executive's perspective, can strengthen nursing's position within the institution while positively impacting hospital governance.

Smith (1986) cites that nurses "need direct access, indeed membership on hospital boards to represent themselves in a publicly responsible manner and to see that nursing resources are committed within justly accountable bounds. They need to be a visible presence just as physicians do." (p. 48). It is unclear whether future access to and participation on governing boards will be through nursing staff members who are independent and contract directly with a hospital for the provision of clinical nursing services and are organized in a self-governance model through nurse executives or through nursing representatives from the professional governance structure. Regardless of the model for participation in governance activities of the institution at the board level, nurses must learn new social and political behaviors. Translation of the clinical perspective must be succinctly presented, often in the language of economics and politics. Learning to function within this new political and power structure will challenge nurse executives and the professional nurses who deliver clinical services as nursing moves into more developed and sophisticated governance models.

Joel Edelman, president of Rose Medical Center in Denver, has stated "So too, then must nurses collectively generate a new spirit of self-sufficiency, self-determination and accountability" (Johnson, 1988, p. 8). Johnson, who has been a member of the board of trustees at Rose Medical Center for 10 years, identifies her role predominantly as that of a community lay person who shares an invaluable perspective of the practicing nurse and nurse executive. Since 1988 the president of Rose Medical Center's Nursing Congress has also been a board member.

Nursing within the institution has recognized participation on this forum as an opportunity to address professional issues and influence positively the quality of care within the rapidly changing health care environment. Another positive outcome of staff nursing representation on the board has been increased confidence in nursing abilities and increased power for nursing within the institution. Conversely, nurses in these governance structures have become increasingly accountable for their practice and governance activities, a quantum leap for nurses in most institutions. One of the major benefits of representation on the board by the president of the Nursing Congress at Rose Medical Center has been presentation of the unique view of a practicing professional nurse to the governing body as well as enhanced two-way communication between the board and practicing nurses who now have a better understanding of the rationale behind some of the decisions made in the current turbulent health care environment. As a professional group with employee status within a given organization, nurses need to address the issue of appropriateness of sitting on the board of directors of their employing organization. Perhaps nursing's collective needs could be more objectively and systematically represented and advocated by a nurse who is a true community member and not bound or limited by employment status.

New Roles and Focus

Governance seems to be undergoing a metamorphosis from the governing bodies of the past that provided advice and counsel, discipline value, and acted in crisis situations. Carver (1990) presents a model of governance that helps boards focus on leadership responsibilities for policy making, articulating the organization's mission, and sustaining the vision. Inherent in this process are strategies of boards to create goal-dominated policies and work with management to ensure their achievement.

Fundamental to a discussion of new roles for governance boards and nursing's potential role in that arena is the need to address a parallel between medical practice in organized settings and nursing practice. During this century medicine has sought to strengthen and preserve the independent practitioner with an active voice in the definition of policy and procedures. Today more than 25% of physicians are employed by institutions (Osmond, 1980), and doctors are coping with issues of subordinancy over which the profession once had control. The role of medical director has emerged from this change in the organization of medical practice. The medical director is a liaison between the staff and administration and must establish power in both clinical and administrative arenas to be effective. Physicians (Astrachan and Astrachan, 1989) often assume these roles of authority and accountability with increasingly less time and opportunity to attain managerial competency. These organizational changes affect power, authority, accountability, and responsibility within the organization. As roles continue to change, physicians must be integrated into the organization so that both organizational and professional goals can be attained. Apparent in these new structures for employed physicians is the movement of autonomy over practice from individuals to the group. It also has become apparent that management and governance education must be provided if physicians are to be expected to participate responsibly within governance models.

Organizational structures impact both nurses' and physicians' autonomy, authority, accountability, and effectiveness. Governance models must be implemented that meet both patient and professional needs and outcomes for nurses and physicians within the health care organization of the future. Some issues that should be addressed include:

- What structures positively influence professional behaviors?
- How do these structures impact quality of care?
- How do organizations ensure group as well as individual accountability?
- Which models decrease professional stress?

The solution to these issues is highly complex and will become easier as more experience is gained with governance models in nursing and health care.

Shortell (1989) identifies new roles for participants in hospital governance of risk-taker, strategic director, expert mentor, and evaluator. He articulates that hospital boards of the future will be effective if they are able to:

1. Manage a diverse group of stakeholders
2. Involve physicians in the management and governance process
3. Meet the governance needs of multi-institutional systems and hospital restructures
4. Meet the challenges of diversification and vertical integration
5. Understand strategy formation and implementation as interdependent and interrelated processes (p. 7).

Hospital governance will be impacted in the future by health care shifts from a product-driven, professionally dominated, focus, operational base to a market-driven, customer-dominated focus, strategic management base. To be successful in this transitional environment, interrelatedness and interactions must occur among the professional staff of health care organizations, management, and the board. Nurses may soon assume hospital governance roles just as physicians currently do. Roles stated by Shortell (1989) are applicable to professional governance models within the nursing organization.

Individual participants in governance must be able to not only process information but also make strategic decisions expeditiously. Participants will have clearly defined roles and will participate in outcome-focused, criterion-based evaluation of their individual roles as well as the governance system.

Participation in governance, whether within the nursing organization or broader health care organization, will require nurses to have a broad base of industry and organizational knowledge in addition to their clinical knowledge. They will also need to structure their governance models to facilitate rapid decision-making through empowerment of committees and subcommittees, and to move toward an outcome orientation with less preoccupation and valuing of process issues. Inherent to success of governance activities in these new models will be:

- Clearly defined parameters of autonomy and accountability for decision making
- Involvement of nursing professionals, who may either be employees of the hospital or independent practitioners contracting for the provision of clinical services

- The definition of nursing governance models within multiple hospital systems
- The redefinition of nursing governance in vertically integrative and diversified systems
- The ability of nurses to participate in planned strategy formation and serendipitous processes related to opportunities

Trust and information sharing will be vital for all participants at all levels within the professional governance model for nursing. A major thrust now and in the future will be balancing the accountabilities for meeting societal expectations for quality, cost-efficient care with implementation of the organization's mission, values, and philosophy.

Governance tasks are inherently different from other management functions. Mueller (1981) ascertained that governance is an unfolding "driven by soft realms of thought and deportment. They are value laden, subjective, intuitive and characteristic of the art forms dealing with social interaction" (p. XII). Carver (1990) describes a governance model as a framework that organizes thoughts, activities, structures, and relationships of governance bodies. He hypothesizes that an effective model of governance should accomplish all of the following:

1. Cradle a vision
2. Address fundamental values
3. Demand an external focus
4. Establish an outcome-focused mission as the central organizing force
5. Separate large from small issues
6. Think in the future
7. Create rather than react
8. Facilitate diversity and oneness
9. Define stakeholder relationships
10. Define self-discipline
11. Delineate the governing body's role on specific issues
12. Determine appropriate information needs
13. Balance tight and loose control
14. Use time productively

Louden (1975) adds that "if we do not concern ourselves with how we can rule organizations, the organization will rule us" (p. 117). Nursing has the opportunity to implement professional governance models that exemplify the characteristics of futuristic models. Consideration of these facets of governance identified by Carver (1990) is clearly imbedded in bylaws of nursing organizations. Nursing is just beginning to address the issues of bylaw and shared decision-making implementation outside the nursing organizational structure within the broader organizational context.

As nursing moves into a broader arena of governance activities, it will be imperative that roles within the leadership team be clearly delineated. Multiple levels of leadership teams exist within the professional governance structure. The nurse executive and president of the nursing staff constitute a leadership team as do the nursing president and council chairpersons on the coordinating council. As with

any successful team, the roles, responsibilities, and accountabilities are clearly defined at the outset.

Evaluation is a relatively new concept in the broader governance process. Nurses within governance structures must develop creative methodologies to quantitatively and qualitatively assess individual and group performance that continually focuses on the following questions: How are we doing? What do we want to accomplish? How are we achieving it?

Traditionally, such evaluations focused on process and evaluative criteria have not been clearly defined. Models must be developed to address the question of whether the outcomes are worth the cost.

Mutual respect, support, and the ability of all participants to implement their responsibilities within a framework of defined control, responsibility, authority, and accountability result in the synergy characteristic of the high-performing work team. Creating a holistic integrated framework of values that encompass the organization is also a governance responsibility and often results in interpersonal challenges as individual members interact to convert divergence into a single viewpoint. This phenomenon is clearly observable as professional nursing staff members move toward governance—at the councilor or coordinating level, or within the larger health care organization.

Carver (1990) cites six strategies that apply to nurses who are participants in professional governance models. He advises participants to be obsessed with human benefits, think in the future, communicate concisely, be innovative in the selection and education of participants, rise above traditional thought, and continue to improve quality.

In summary, governance is really about empowerment. It is about risk, error, responsibility, authority, accountability, and trust. It concerns focusing on the bigger issues, defining and implementing visions within defined boundaries, thereby controlling the amount of risk. It is about flattening hierarchy and creating new roles and new partnerships at all levels within the organization. Governance is about structural systems and shared values that support professional nursing practice within a shared decision-making framework as nursing moves toward self-governance models in the twenty-first century. One final word about bylaws in professional governance models—they may be a hindrance, especially if they describe a framework that the professional nursing organization has already outgrown.

SUMMARY

Professional nursing shared governance models are transitional designs that will successfully position nursing as the primary professional organization within the health care setting. This position is particularly crucial as nursing moves through the 1990s and completes the redesign process of the health care organization. Central to successful development and implementation of shared governance models is the acquisition of new roles and values that redefine staff, manager, and executive roles within the nursing organization of the future. Staff empowerment models of the future must be designed to ensure partnerships between management and all

levels of staff within the organization. These designs should drive decentralization of decision making related to the work of nursing to the point of service: the professional nurse level. Definition and formal sanctioning of professional governance models are supported by bylaws that clearly articulate the framework for the professional nursing organization and delineate responsibility, authority, and accountability for the practice of nursing. Professional governance models provide the support for internal and external standards and the accreditation process. A multitude of interesting and complex issues regarding the implementation of nursing governance models within and perhaps outside the traditional structures of health care organizations will need to be addressed as nursing governance models mature and as the very essence of the industry undergoes radical transformation.

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