From Bedside to Boardroom – Nursing Shared Governance

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Abstract

A brand-new nursing shortage is revitalizing shared governance. This innovative organizational model gives staff nurses control over their practice and can extend their influence into administrative areas previously controlled only by managers. But nursing shared governance is hard to define. Its structures and processes are different in every organization; and its implementation is like pinning Jell-O® to a wall. Is it appropriate for every situation? Is it worth the price? And can it really measure up to its glowing reputation? This article presents an overview of nursing shared governance, looking at themes and experiences from its rich 25-year tradition. The author identifies its essential elements, provides guidance for professionals who wish to embark on the journey, and describes the current status of shared governance as of 2008.

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"Can you name just one hospital that practices real shared governance around here?" a newly relocated nurse administrator asked me. A particularly poignant question in a time when shared governance programs were stalled by a sort of implementus interruptus, superseded by impending mergers or shotgun partnerships, or just plain threatened away from innovation by managed care. I did know of several hospitals that had shared governance. In a health care landscape that was wind-blown and torrid, they were flowering like prize blooms. What was it like to work in these gardens? One nurse told me: "We have a voice and are able to participate in decision making. We get to do what we want to as units" (Hess, 1998a, p.5).

This excerpt came from a 1998 editorial, "A Breed Apart – Real Shared Governance," that appeared in the *Journal of Shared Governance*. Shortly thereafter, like many of the governance programs it promoted, this unique periodical folded.

> ...a brand new nursing shortage is revitalizing shared governance and its promise is to put control over nursing care in the hands of practicing professionals.

As the last nursing shortage waned, shared governance – an organizational model through which nurses control their practice as well as influence administrative areas – disappeared from many of the some 1000 health care institutions where it had thrived. Some programs were victims of mergers and acquisitions, others just sputtered out from exhaustion. A few enlightened nurse administrators and staff kept their programs going. Others kept remnants of shared governance in play through less transforming participatory management and decentralized structures, which persist even today. With more than enough nurses, some shortsighted top brass turned their attention from addressing who

controlled practice to considering more pressing fiscal issues. One anonymous administrator spoke from the dark side: "Why should I care about what staff think? If they don't like it, I can replace them all tomorrow."

That was a time of plenty. But now a brand-new nursing shortage is revitalizing shared governance and its promise is to put control over nursing care in the hands of practicing professionals and retain these professionals.

Definition and History: Who's the Boss?

Unlike other disciplines, control over practice is a recurrent issue in nursing. As long ago as 1988, a national sample of 3,500 nurses identified that being "allowed" to exercise nursing judgment for patient care was one of the most important factors in their practice (Huey & Hartley, 1988). Even today, degree of control over practice persists as an important research area for Magnet hospitals (Kramer & Schmalenberg, 2003) and nurse investigators (Weston, 2006).

But why would this be an issue? Because education, professional standards, and judgment are not the only determinants of the practice of nurses who work in traditional health care institutions. As employees, nurses must structure their practice within rules imposed by their employers, often in the form of policies and procedures that have a profound effect on how nurses deliver patient care. The scope and amount of resources made available by the employing organization further influences their practice. Fortunately, administrators and managers who are also nurses help create these policies and budgets within most health care organizations. However, the nurses who actually deliver care are often absent from policy-making processes and structures. Nursing shared governance emerged as one way to give these clinical nurses equal footing with managers to allow them to participate in the decision-making processes that affect their practice.

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Governance is about power, control, authority, and influence. It answers the question in an organization, "Who rules?" Nursing shared governance extends that rule to nurses. It surfaced as a radical break from traditional hospital governance where nurses had little power within a rigid formal hierarchical bureaucracy. Nursing shared governance is a managerial innovation that legitimizes nurses' control over practice, while extending their influence into administrative areas previously controlled only by managers (Hess, 1998b).

Nursing shared governance has a distinguished pedigree. Christman (1976) first introduced the yet-unnamed concept in his description of the autonomous nursing organization, which would give nurses an equal voice with physicians within hospitals. Shortly thereafter, the label of shared governance first appeared in nursing literature in Cleland's (1978) adaptation of a university model of faculty governance. Cleland proposed a model that reconciled the interests of different organizational groups through the distribution of power to formulate policy.

The 1980s were a heady time for humanizing models, such as participative management and decentralization, which involved people in the organizations. In health care as well as academic environments, shared governance traversed the country, adapting along the way. An evanescent concept, it generated unique structures and processes wherever it was implemented. As an innovation, it arose differently from organization to organization. As administrators *adopted* the

models of early innovators, they changed those programs and *adapted* them to their own organizational environments. As others later adapted those models, permutations became endless.

Documented early implementation sites in major hospitals included St. Joseph's Hospital in Atlanta, GA (McDonagh, Rhodes, Sharkey, & Goodroe, 1989; On the Scene, 1982); St. Michael's Hospital in Milwaukee, WI (Pinkerton, Eckes, Marcouiller, McNicols, Krejci, & Malin, 1989; Pinkerton & Schroeder, 1988), Carondelet St. Mary's Hospital in Tucson, AZ (Ethridge, 1991; Ethridge & Lamb, 1989); and Rose Medical Center in Denver (Johnson, 1987). The thinking that fueled some of these initial experiences is eloquently reflected in such books as Porter-O'Grady and Finnegan's (1984) *Shared Governance for Nursing: A Creative Approach to Professional Accountability* and McDonagh's (1990) *Nursing Shared Governance: Restructuring for the Future*. One of the most precisely articulated visions of shared governance can be found in a letter to the editor of the *Journal of Nursing Administration*, "Researching Shared Governance – A Futility of Focus," [pdf] submitted by Porter-O'Grady (2003).

Organizational Structures: For the People, By the People

Structure is vital to shared governance. In fact, organizations that implement shared governance programs typically create new organizational structures, such as committees. However, it is important to remember that these committees are just vehicles that gather managers and staff together to make decisions. The committees generally address such issues as practice, management, quality, and education.

Structure is vital to shared governance.

Three general models of shared governance have emerged. The most common model is the **Councilor Model** (Figure 1 [pdf]) in which a coordinating council integrates decisions made by managers and staff in subcommittees. A second model, the **Administrative Model** (Figure 2 [pdf]) resembles a more traditional bureaucratic structure that splits the organizational chart into two tracks with either a management or clinical focus, although the membership in both tracks often encompass both managers and staff as implementation progresses. A third structure, the **Congressional Model** (Figure 3 [pdf]), relies on a democratic component to empower nurses to vote on issues as a group.

However, shared governance is more than a new organizational chart or committee configuration; structures can be deceiving. The number, titles, and arrangements of committees are not as important as the people who make up the membership. Rather, their expertise and knowledge that guide their actions, what they have power to do, and their commitment to both their profession and the mission of their organization are more likely predictors of success. The meaning of success in terms of shared governance and patient care should be the control of practice leading to better patient outcomes, although the research connecting the two has yet to be done.

Focus: It's About Practice

Nursing shared governance models have always focused on nurses controlling their professional practice. It's a theme that flows consistently through shared governance research and marketing literature. For example, one hospital noted that "unlike participatory management environments, [shared governance structures] ensure that the practicing nurse has not only the right but the power to make practice decisions" (Morristown Memorial Hospital abstract, 1991). The message

was even reflected in the name of the hospital's program, E.N.A.C.T. – Empowering Nurses with Authority in the Clinical Track.

A practice focus is evident in the current online representations of health systems' shared governance models. This practice focus is evident in the following examples and more found on a list of Shared Governance Hospitals online at the Forum for Shared Governance's website <http://sharedgovernance.org/sghospitalsonline.htm>:

1. American University of Beirut Medical Center http://nursingservice-lb.aub.edu.lb/users/subpage.asp?id=128 believes that shared governance functions as an essential framework for the participation of nurses in departmental governance, thus enhancing their professional autonomy. It empowers the professional nursing staff and managers to contribute collectively to the decision-making process and to the control of their own practice at the unit level. Incidently, this Magnet hospital holds one of the only American Nursing Credentialing Center's accredited providerships for continuing nursing education outside of the continental United States.

2. Overlake Hospital Medical Center in Bellevue, WA
www.overlakehospital.org/careers.aspx?id=598 created a Nursing Congress in 1984 to allow nurses to participate in patient care and practice decisions. However, the name was changed to the Clinical Care Congress in 2000 to encompass all multidisciplinary staff members in decision-making.

3. Barnes-Jewish Hospital in St. Louis, MO
www.barnesjewish.org/groups/default.asp?NavID=1543 shared governance councils to give staff nurses a formal mechanism for participation in nearly all decisions regarding care of patients.

4. Seton Family of Hospitals in Central Texas
http://www.seton.net/employment/nursing/nursing_at_seton/ shared-governance model has been so successful that The Advisory Board referred to it in a 2005 national publication, Toward Staff-Driven Decision-Making: Assessing, Building and Sustaining a Shared-Governance Model. Their shared-governance model has become an example used to educate other healthcare organizations about how to create and sustain a successful, professional nursing practice environment.

5. Hartford Hospital in Hartford, CT
http://www.harthosp.org/nursing/StrategicPlan/default.aspx?sitesearch=true implemented a nursing shared governance council structure to empower caregivers closest to the patients in decision making. Most councils at Hartford Hospital are chaired by a practicing nurse.

Advocates from shared governance hospitals say that their nurses control practice. But do they? Although few solid statistics support this claim, there is some evidence that nurses working in these institutions at least believe that they control their practice. The "Index of Professional Nursing Governance" [pdf] (IPNG) (Hess, 1994; 1998b) is an 86-item survey instrument that measures nurses' perceptions about who governs the professional environment, including control over practice. During the IPNG's initial development, nurses in two out of three shared governance hospitals self-reported significantly greater control than colleagues working in more traditionally governed hospitals. However, one shared governance hospital scored no differently than traditional hospitals. Remember, structures and labels may not be all that they appear. Subsequent hospital research (Anderson, 1997; George, Burke, & Rodgers, 1997; Lee, Yang,

Lee, & Wu, 2001; Lee, Yang, Wu, & Lee, 2001) and repeated hospital evaluations of shared governance with the IPNG (Butts, Helms, Kinker, 2007) have consistently revealed that nurses in shared governance hospitals do have greater control over decisions affecting their practice.

The same control over practice may characterize some U.S. Magnet hospitals that have put in place formal structures for empowering nurses, such as shared governance programs. A comparative analysis by Kramer and Schmalenburg (2003), who interviewed 279 nurses at 14 Magnet hospitals, found the highest staff nurse ownership of practice issues and outcomes occurred where there were visible, viable, and recognized structures devoted to nursing control over practice.

Of course, nurses cannot effectively practice without the right resources...

Of course, nurses cannot effectively practice without the right resources – an appropriate amount and mix of caregivers, supplies, and supporting systems. To control practice, nurses must also have some influence over these resources.

...one of the most distinguishing characteristics of a shared governance environment is that nurses feel that they have access to the information necessary to make effective governance decisions.

In shared governance, as in nursing, the primary resources for practice are the providers themselves. Thus, to control practice, nurses must have influence over themselves as a professional group. The importance of this emerged in the 11-hospital study that validated the IPNG as a measure of governance (Hess, 1994; 1998b). The most important factor in differentiating shared governance hospitals from traditional organizations was nurses' ability to exercise control over personnel in such areas as hiring, transferring, promoting, and firing personnel; performance appraisals and disciplinary actions; salaries and benefits; and the creation of new positions. Other significant areas that set shared governance hospitals apart were nurses' involvement in staffing, supplies, and budgets. This finding was consistent with an earlier follow-up to the initial Magnet hospital study, which found that in these enlightened work environments staff nurses had extended their influence into personnel and finance (Kramer, 1990). The IPNG study also found that along with practice and resources, nurses in shared governance participate in setting goals and negotiating conflict. However, one of the most distinguishing characteristics of a shared governance environment is that nurses feel that they have access to the information necessary to make effective governance decisions.

Implementation and Issues: Bumps in the Road

The implementation of shared governance is not easy. It can be riddled with conceptual ambiguity and resistance from the old bureaucratic guard and new professionals struggling to establish their skills. Not everyone will share the enthusiasm for this wonderful innovation. Some petulant participants http://sharedgovernance.org/PetulantParticipants.htm will refuse to participate outright. But for those who maintain confidence and keep their eyes on the vision, a rich 30-year plus tradition can help anticipate issues that might arise during implementation by remembering the following insights.

The implementation of shared governance is not easy.

1. Shared governance is a journey, not a destination. Organizations pursuing shared governance move incrementally from past orientations where the few rule to an orientation where many learn to make consensual decisions. Organizations that implement shared governance are in a constant process of revitalization and renewal. There's always more power to share and more members to bring along on the journey.

2. The journey can be long and steep. Expect a sharp learning curve. Shared governance can be a consciousness-raising event that allows organizational members to thrive. However, attempts to elicit participation without allowing opportunities to acquire prerequisite skills can leave some people frustrated and others apathetic. Beginners in shared governance need initial and then ongoing education. For example, staff nurses will need management skills, such as how to delegate and how participate in and run meetings. Managers and staff need to learn how to share authority over key areas, such as scheduling, that may have been the exclusive domain of administration (McMahon, 1992). And when the learning curve is past, maintenance will be necessary to keep everyone's expertise current. Even those who are not directly involved in the model need to be educated and informed, because shared governance affects everyone.

3. Not every environment is conducive to shared governance. First of all, organizations must be ready. At the very least, the leadership group needs to be willing and able to shift roles and power. For specific areas in which staff nurses need to be adept and predisposed to share authority, readers can refer to Susan Reeves' 1991 study (unpublished) at Dartmouth Hitchcock Medical Center in Lebanon, NH, presented in Table 1. Reeves work draws on the situational leadership model by Paul Hersey and Ken Blanchard (1996).

Second, some organizations have inherent restrictions that may prohibit or limit implementation in every area. It is helpful to know these constraints beforehand to avoid unrealistic expectations. For instance, union or government restrictions may prohibit management from fully implementing a model. Howell, Frederick, and Ollinger (2001) examined the highly bureaucratic structure of a Veterans Administration (VA) hospital in North Carolina. They found that in spite of a shared governance model, nurses in this hospital did not have any more control over personnel, access to information, or the ability to set organizational and divisional goals than those in traditional organizations. The researchers attributed this lack of expected control to external constraints imposed by outside government agencies and legislation. However, the VA hospitals have been able to achieve shared governance in other geographical areas.

Finally, committees must have legitimate organizational authority congruent with responsibility and accountability to carry out their decisions. Loading an agenda with fluffy items or delegating historically irresolvable problems without appropriate resources are sure ways to damage the credibility of a shared governance model. Nurses who devote their time to participating in a model deserve relevant professional issues for their consideration. The point of shared governance is moving committees beyond simply making recommendations to empowering them to carry out their decisions.

4. Although not everyone might make the journey, it should be open to all. Because shared governance demands energy and attention from its participants, some nurses may decide to follow, but not participate. Others, including managers, may choose to leave. For those who stay the course, models eventually encompass everyone in the organization, including patients. Shared governance models that include only nurses can become exclusionary and eventually ineffectual by focusing on the goals of a single profession, instead of the organization as a whole.

Furthermore, for practitioners to have control over practice they need the participation of others in the organization who provide support.

5. Is the journey worth the price? Most nurse researchers have concluded that shared governance is good by its association with a sparkling array of projected outcomes and correlations. Researchers have studied nursing shared governance for its relationship to professional collaboration and collegiality; retention; autonomy and empowerment; morale and both nurse and patient satisfaction; values and organizational culture; quality and patient outcomes; and versatility, competency, and productivity. Unfortunately, many of the relationships reported are inconsistent and flawed. Small studies, inadequate methodology, the use of variables isolated from any unifying theory, and the lack of a clear measure of governance as an independent variable have muddied many research findings. Potential questions for future researchers are presented in Table 2.

In the current financial climate, the cost-effectiveness of nursing shared governance is an important question that has yet to be settled. Shared governance has been associated with savings from reduced turnover (Pinkerton, 1988), restructuring (Jenkins, 1988), and indirect revenue generation of $500,000 (Ethridge, 1987). DeBaca, Jones, and Tornabeni (1993) declared shared governance a "winner," when they calculated net savings in the reduction of management staff positions, the elimination of registry nurses, and a reduction in recruitment and orientation costs. On the other hand, Pruett (1989) suggested a financial liability between the level of implementation noting increased paid man hours per unit of service; shared governance nurses tend to spend more time with patients, reducing efficiency.

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Studies agree on one thing – shared governance costs money in terms of time and energy. Some believe that the cost can be simply quantified, for example, one nurse executive quickly stated that shared governance cost her agency what the agency would spend on committees anyway. Others, however, are eager for research findings that will provide firmer documentation for the financial benefits associated with shared governance. In a worsening nursing shortage, money invested in shared governance can be a sound investment. Current estimates for replacing a staff nurse run from $50,000 (Cohen & Sherrod, 2003) to as high as $64,000 for a critical care or labor and delivery nurse (Health Care Advisory Board, 2000). As research strengthens the connection between shared governance and work satisfaction, the savings from a single retained nurse in a small hospital could provide a substantial reason for underwriting a program.

Conclusion

In spite of the failure of shared governance to "take" at some hospitals, and its demise at others as fallout from takeovers, makeovers, participation fatigue of administrators, and staff nurses weary of meetings, there's hardly a bad note among true believers.

The current nursing shortage in the US and Canada has sparked new and renewed interest in shared governance in health care administrators who are eager to enhance nurse retention in their organizations. The global shortage is bolstering the popularity of shared governance in other countries where it has emerged only during the last few years. For example, the United Kingdom (UK) has established its own tradition of shared governance (Doherty & Hope, 2000; Gavin, Ash, Wakefield, & Roe, 1999; Mitchell, Brooks, & Pugh, 1999; O'May & Buchan, 1999; Williamson, 2005 http://netstation1.us/sg/reportedresearch.cfm?EditRecord=Yes&ID=46). However, even

more popular in the UK is the concept of clinical governance, a framework that focuses clinicians on improving quality and safeguarding standards in patient care (Royal College of Nursing, 1998). Information on clinical governance can be found at www.data.rcn.org.uk/services/promote/quality/guidance_for_nurses.pdf and a bibliography is posted by the King's Fund Library at www.kingsfund.org.uk/pdf/clingovnur.pdf. Other English-speaking nations, such as Australia, as well as countries such as Taiwan, have also joined the US in adopting shared governance models in their health care organizations.

Shared governance may be new to many hospitals while at other hospitals it has had a significant impact for many years. Just ask Linda Rusch (NRLRUSCH@aol.com), the chief nurse executive at Hunterdon Medical Center in Flemington, NJ, where, despite changes in leadership, a strong model has been in place since 1990. When she received the results of a regular survey of nurses about the best practices at Hunterdon, what was the number one thing that made a difference in their health system? Shared governance, naturally.

Table 1.- Excerpts from 1991 Readiness Study by Susan Reeves, RN, MS, Vice President, Dartmouth-Hitchcock Medical Center, Lebanon, NH
In this study Reeves identified the following staff nurse skills considered critical in successful professional governance models: 1. **Demonstrates ability to engage in decision making about patient management issues.** (Examples: Is a vocal advocate for patients with family and other health care providers; does not shy away from controversy over patient management issues; has an adequate knowledge base to participate in decision making regarding treatment.) 2. **Demonstrates ability to engage in the development of standards of practice.** (Examples: Knows what current standards are for patient population served; is aware of current nursing/health care research in specialty area; has worked on committees to set standards of practice for the unit.) 3. **Demonstrates ability to engage in quality assurance (QA) monitoring.** (Examples: Is active on unit-based QA committee; is knowledgeable about nursing department QA program; can state desired outcome measures for patient population served on the unit.) 4. **Demonstrates expert conflict resolution skills.** (Examples: Rarely requests/needs intervention by managers to solve conflicts; manages intra- and inter-departmental conflicts in a constructive way; has acquired formal skills in conflict management via continuing education.) 5. **Demonstrates expert negotiation skills.** (Examples: Is able to negotiate requests for scheduling with peers; is able to negotiate with patients in the setting of patient goals; has acquired negotiation techniques in formal continuing education programs; is able to identify situation where negotiation is an alternative to win-lose situations.)

Table 2 – Questions Awaiting the Right Researchers
1. Does shared governance ward off union activity? 2. Is there any association between shared governance and improvement in patient outcomes? 3. Can nurses' perceptions of control and power in shared governance

organizations be correlated with acquisition and control of scarce organizational resources? Do their perceptions of their power correlate with the perceptions of other organizational members?

4. Are there certain shared governance implementation designs that produce consistent outcomes in similar and different organizational environments?
5. What theoretical models and conceptual frameworks should guide the investigation of shared governance?
6. Is shared governance different when other professionals beyond nurses are involved?
7. Is care more cost-effective in environments where nurses participate in shared governance?

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