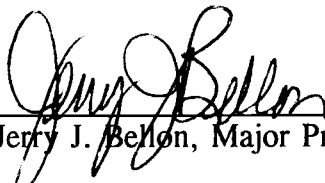
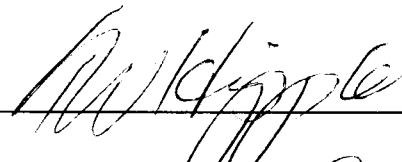
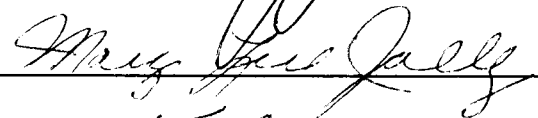


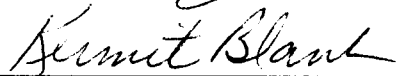
To the Graduate Council:

I am submitting herewith a dissertation written by Mary Lynn Brown entitled "The Administrative and Educational Practices of Shared Governance in Baccalaureate Nursing Programs in the State of Tennessee." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirement for the degree of Doctor of Philosophy with a major in Education.


Jerry J. Bellon, Major Professor

We have read this dissertation
and recommend its acceptance:



Accepted for the Council:


Associate Vice Chancellor and
Dean of the Graduate School

**THE ADMINISTRATIVE AND EDUCATIONAL PRACTICES
OF SHARED GOVERNANCE IN BACCALAUREATE
NURSING PROGRAMS IN THE STATE OF TENNESSEE**

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Mary Lynn Brown

August, 1995

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DEDICATION

This dissertation is dedicated to my father

Mr. Ernest Ferda

who impressed upon me since youth the value of knowledge
and supported me throughout my educational endeavors.

ACKNOWLEDGMENTS

I wish to express appreciation to the members of my doctoral committee: Dr. Jerry Bellon, my major professor, and committee members, Dr. Kermit Blank, Dr. Ted Hipple, Dr. Mary Lue Jolly, and Dr. Karl Jost. I appreciate their assistance in this study.

I wish to thank my husband, Gilbert, and my children, Brian, Karen, and Jennifer for their patience and support over the many years of my doctoral studies. I would like to thank my husband, Gilbert, for his expertise in analysis of quantitative data; my teenage daughter, Karen, who always expressed confidence that her mom would complete her dissertation; and my preschool daughter, Jennifer, who loved to help mom collect pages as they came off the printer. I would like to thank my parents, Ernest and Nancy Ferda, for giving me the opportunity many years ago to begin my college education. I wish to thank my friend, Ellie Brooks for her friendship, support, and professional guidance during the dissertation process. Finally I would like to express my sincere appreciation to my editor, Vicki Johns, for her guidance in preparing this dissertation manuscript.

ABSTRACT

The purpose of this study was to determine the practices of shared governance leadership in approved baccalaureate nursing programs in the state of Tennessee and to identify the skills and experiences that graduate nurses need to function in health care organizations that practice shared governance.

Quantitative and qualitative methods were employed through the use of a Leadership Survey and semi-structured interview guide. These instruments were specifically developed from leadership characteristics and dimensions defined in the literature and research questions to address the study.

Eight schools of nursing in the state of Tennessee participated in the survey phase of data collection. One hundred sixty-seven surveys were mailed to potential participants. Eighty-nine (53%) surveys were returned. Thirty-four participants were willing to be interviewed; 18 participants representing five of the eight schools of nursing, were subsequently interviewed.

Survey data were analyzed using frequency distribution and Chi Square. Interviews were audiotaped and transcriptions were analyzed using the content analysis method.

The following findings emerged when comparisons were made between groups of survey participants: Perceptions of shared governance practices varied among groups depending on education and experience. For example survey participants with administrative titles stated they modeled the shared governance leadership style.

Master's prepared survey participants stated that shared governance was used between nursing administrators and faculty; however, they were either undecided or stated that shared governance was not used with nursing students. Doctoral prepared survey participants perceived the use of shared governance at all levels more frequently than did master's prepared participants. Some survey participants employed 14 years or more stated that the chief nursing administrator at their school did not practice shared governance. Survey participants with tenure stated that faculty and nursing students were more likely to practice shared governance than was the chief nursing administrator.

The following conclusions emerged from findings: The majority of survey and interview participants believed nursing students should learn and experience practices of shared governance in classrooms and clinical agencies. However, some participants were unable to describe how that would be accomplished because they did not have knowledge or experience with shared governance concepts.

Survey and interview participants also provided information about the current administrative leadership structures at their nursing school. Participants had different understandings of the term shared governance; therefore, a wide variety of perceptions about its use and effectiveness were delineated from data analysis.

The majority of survey and interview participants believed they had professional autonomy in some of their roles. Interviewees' perceptions of professional autonomy were influenced by the number of years they had been employed at the school and their academic responsibilities.

Based on responses, the researcher concluded that committee structures were utilized to empower faculty in decision-making. Nursing leadership at participating schools was multidirectional. Participants stated that they had many opportunities to provide input and influence decisions.

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CHAPTER I

INTRODUCTION

The women's movement has changed society's perceptions of women's roles and has caused the number of women in business, professional, and political realms to increase dramatically. According to Porter-O'Grady and Finnigan (1984), the history of the nursing profession "parallels the long and arduous struggle of women to establish their identities and to create spaces for themselves in a tradition of male-dominated societies" (p. 1).

Florence Nightingale founded the nursing profession during the Crimean War (1853-1856). In the United States, hospitals were the birthplace of modern nursing. During the founding period (early 1900s), hospitals had rigid, hierarchical, authoritarian administrative structures. The core of nursing activity was housekeeping, feeding, comforting, and implementation of simple physician orders. Schools of nursing became closely associated with the authoritative hospital structure and value system. In exchange for free room and board, nursing students worked long tedious hours staffing hospitals (Porter-O'Grady & Finnigan, 1984).

The recent movement of nursing education away from the control of the hospital and into colleges and universities is a great achievement for the profession. This change has enabled nurses to develop and achieve a greater professional role by means of a curricula which includes the liberal arts, natural and social sciences, and

nursing courses (Porter-O'Grady & Finnigan, 1984).

When a student nurse graduates and begins to practice, a health care institution, usually a hospital or medical center, frequently becomes the practice setting. Most health care organizations are highly bureaucratic in organizational structure and culture. A bureaucratic model dictates policy downward, with the power base for decision-making at the apex. Hospitals have created leadership structures that bypass nursing staff. Staff nurses and patients are at the lower levels of this hierarchy (Jones & Ortiz, 1989; Shidler, Pencak, & McFolling, 1989; Barker, 1991).

Health care organizations instill their own values, relationships, rules, and experiences into new nurses, who frequently are considered employees first, professionals second. The new nurses' knowledge, skills, and contributions are adjusted as the administration, the organization, and the medical staff increasingly define their institutional role. Over time, nurses adapt their behaviors to institutional expectations and relinquish their ability to define, control, influence, and evaluate their professional practice (Porter-O'Grady, 1991).

During the past 15 years, professional nursing organizations and technological advances have created change in the learning and working environment for nurses. However, nurses still feel that they have great responsibility but little autonomy (Porter O'Grady & Finnigan, 1984; Barker, 1991). They are concerned that they do not influence decisions about their practice. Instead nursing service administrators develop practice standards and make major decisions. This restrictive climate is in

conflict with the professional nurse's emerging desire for autonomy (Ortiz, Gehring, & Sovie, 1987).

During the past decade, hospital and nursing administrative practices have slowly shifted from traditional autocratic bureaucracies to a more democratic structure, moving from centralized to decentralized nursing units, directive to participatory management, authoritative power to individual empowerment, and managerial governance to self governance (Wellington, 1986; Allen, Calkin, & Peterson, 1988; Barker, 1991).

Nurses are increasingly demanding the right to participate in policy formation that influences their nursing practice (Anderson, 1992). Their main sources of dissatisfaction include limited autonomy, lack of communication with superiors, exclusion from participating in decision-making, and lack of adequate compensation (Shidler, Pencak, & McFolling, 1989).

However, moving from a bureaucratic structure to a decentralized participative approach is difficult for hospital administration and staff. Participative management requires a change in beliefs, values, and delegation of responsibility. Hospital management must shift from leading, organizing, and controlling to integrating, facilitating, and coordinating (Porter-O'Grady, 1989; Wilson, 1989; Jacoby & Terpstra, 1990; Caramanica & Rosenbecker, 1991).

As a professional practice model, shared governance embodies a vastly different philosophy from the traditional bureaucratic structure. Shared governance supports professional practice by encouraging nursing councils' decisions.

Professional collaboration replaces the hierarchy chain of command. Shared governance moves nurses from an autocratic, bureaucratic environment to one of empowerment and control (McDonagh, Rhodes, Sharkey, & Goodroe, 1989).

As the nursing profession matures, there is a movement toward models that support shared governance. With the primary care model of the sixties and seventies, nurses developed increased accountability and responsibility in the care of their primary patients. Nurses are now seeking increased autonomy and responsibility for their professional practice (Jones & Ortiz, 1989). Shared governance gives nurses the opportunity for decision-making and autonomy in professional practice (McMahon, 1992) and provides them with the ability to address the many challenges facing health care.

Statement of the Problem

In our highly technological age, the nursing profession has come face-to-face with complex ethical, legal, and professional issues. The education of nursing students and continuing education of professional nurses has assumed a status of prime importance. To gain professional status and respect, nurses need concentration and reinforcement of critical thinking, clinical judgment and assessment skills, and empowerment to make autonomous decisions in practice settings. Nursing education is a lifelong career process, requiring constant updating of professional roles and practice.

Nursing education has historically utilized a training paradigm, with nursing educators being the prime knowers and nursing students the passive recipient of knowledge. In this paradigm, nursing education is primarily content-oriented: nursing students memorize facts and learn to perform skills. However, nursing graduates of the 1990s need preparation for a more sophisticated professional role than a training paradigm provides. They need process-oriented education to function as autonomous decision makers capable of taking an active part in policies that influence their practice.

Over the past 100 years, nursing has struggled to establish itself as an independent profession. Modern professional nursing models support increased autonomy, accountability, and responsibility in clinical practice and shared responsibility for governance. Shared governance is an example of an organizational model that provides an environment for autonomous practice. Nurses must be prepared to function in organizations that practice shared governance (Jones & Ortiz, 1989).

University nursing educators and administrators are beginning to recognize the value of faculty participation in decision-making and are implementing some shared governance concepts in their programs. However, limited research has been conducted on the efforts to establish shared governance models in nursing education. Over the past decade, most implementation of shared governance has taken place in hospitals and medical centers.

In response to the increased implementation of shared governance in practice

settings, academic nursing programs should study and evaluate the implementation of shared governance in nursing education. Baccalaureate nursing program graduates need preparation to function in a variety of health care organizations, including those with shared governance leadership models.

The concepts of shared governance leadership need to be explored and understood as part of nursing higher education. In particular, shared governance needs to be examined on administrative and academic levels to determine what faculty and nursing students are experiencing and practicing regarding shared governance leadership.

Purpose of the Study

The purpose of this study was to determine the practices of shared governance leadership in approved baccalaureate nursing programs in the state of Tennessee and to identify the skills and experiences that graduate nurses need to function in health care organizations that practice shared governance.

The following questions guided the research:

1. What practices of shared governance are being implemented by nursing administrators and faculty in approved baccalaureate nursing programs in the state of Tennessee?
2. What practices of shared governance are being implemented by nursing faculty in classrooms?

3. What practices of shared governance are being implemented by nursing faculty in clinical areas?

4. What educational experiences do nursing students need to prepare them to function as graduates employed in shared governance organizations?

Significance of the Study

The study of shared governance models of leadership in nursing education is meaningful. More and more, hospitals and medical centers are implementing shared governance models of leadership. The nursing graduate educated in a traditional bureaucratic organization is not prepared to work in organizations with a shared governance model. Nursing programs have the responsibility to prepare graduates of their nursing programs to practice in a variety of leadership models.

The intent of this study is to report practices of shared governance by nursing program administrators and faculty members in approved baccalaureate nursing programs in the state of Tennessee. The results of this study will provide needed insights into the practices of shared governance by higher education nursing program administrators and faculty. In addition, the research will provide information on what nursing students need to know and experience to prepare them for practice in shared governance organizations.

The implementation of shared governance models of leadership in hospitals and medical centers is well documented in the literature; however the practice of

shared governance in nursing education has limited documentation. More research is needed on the position of shared governance in nursing higher education. Results of this research can be utilized to assess the status of shared governance models of leadership in nursing higher education in Tennessee. Additional information can be obtained about what preparation nursing students need to function in shared governance organizations.

Assumptions

This investigation was based on the following assumptions:

1. The participants in this study would provide open and honest responses to a leadership survey and interview questions.
2. The instruments used to obtain data would be able to identify shared governance practices.
3. The inclusion of all baccalaureate nursing programs in the state of Tennessee would provide a sample of shared governance practices in higher education.
4. The list provided to the researcher by the Tennessee Board of Nursing would be current and represent all approved baccalaureate nursing programs at the time of the research.
5. Experiencing and participating in a shared governance model of leadership is important for the preparation of graduate nurses.

Limitations and Delimitations

This investigation focused on approved baccalaureate nursing programs in Tennessee; therefore, the conclusions drawn from the research cannot be generalized to Tennessee associate degree and diploma nursing programs or programs in other states.

Quantitative and qualitative research methods were used to measure practices of shared governance. Qualitative data were collected from selected program administrators and faculty. Since the opinions of a select group in a limited geographic area were examined, it would be difficult to generalize conclusions from this study to other populations.

The researcher has been a practicing professional nurse for twenty-four years, eighteen years in the state of Tennessee. Because she has held a variety of positions, it is possible that some survey participants knew the researcher and may not have been as forthright in their responses as participants unknown to the researcher.

The state of Tennessee approves three types of undergraduate nursing education programs: two-year associate degree programs, three-year diploma programs, and four-year baccalaureate programs. This study included four-year baccalaureate nursing programs only.

Definitions

For the purposes of research, the following terms were operationally defined in the following manner:

Shared governance is a model of leadership that provides an environment of trust and respect for autonomous decision-making and policy formation by nurses. Nurses are empowered to be responsible and accountable for their practice decisions.

Leadership is a process involving various relationships that represent the values, aspirations, and expectations of both leaders and followers. Through the leadership process, individual and organizational goals are developed, strived for, and achieved.

Methods and Procedures

This study utilized descriptive methodology, which allows researchers to determine and report on the way things are. The researcher who uses descriptive techniques identifies the status of what is being studied.

Data were collected to answer research questions concerning the practices of shared governance in nursing education. Data were also collected on what nursing students need to know and experience regarding shared governance to prepare them for professional practice.

Descriptive data are usually collected through a questionnaire survey,

interviews, or observation. This study utilized quantitative and qualitative techniques to gather data. Several steps were involved in data collection.

First, the Tennessee Board Nursing was contacted by phone and asked to provide the researcher with a list of approved baccalaureate nursing programs in the state. Next, a letter of intent was sent to the dean or director of all approved baccalaureate nursing programs in the state of Tennessee. This letter described the purpose of the research and data collection strategies, and requested written permission to send quantitative data collection instruments to all nursing administrators and faculty at their school.

Before quantitative data collection instruments were distributed, they were reviewed by a panel of experts which included nursing educators, nursing administrators of medical centers, and the chairperson of an associate degree nursing program. Changes were made based on reviewers' comments and suggestions.

After a school agreed to participate, a letter of intent presenting an overview of the project was sent to potential participants. Two data collection instruments along with a stamped, addressed envelope for return, were included with the letter of intent. There were no identifiers on these instruments so anonymity was maintained. The first instrument collected general demographic data: age, sex, race, initial nursing education, highest degree held, academic rank, administrative title, years in teaching, tenure, and employment status. The second instrument had two parts. Part One listed statements to assess leadership variables relating to shared governance with Likert scale responses. Part Two listed a few statements with Likert scale responses

then asked participants to respond to an open-ended question following each statement, enabling participants to provide more detailed responses. Quantitative data were analyzed using frequency distribution and Chi Square. Relationships between various groups were analyzed and reported.

Anonymity was maintained during quantitative data collection. Therefore, in order to collect qualitative data, participants were asked at the end of the quantitative instrument if they would be willing to be interviewed. Participants willing to be interviewed were asked to provide their name and the name of their school so that an interview time could be arranged. A stamped, addressed envelope was provided for separate return of this page so anonymity of quantitative data collection instruments was maintained.

Qualitative methods enable the researcher to further describe and delineate specific beliefs, values, patterns, and practices relating to the shared governance model of leadership rather than merely quantifying them. Interviews produce more in-depth data than do questionnaire survey responses.

An interview instrument was designed based on dimensions of leadership and concepts of shared governance delineated from the review of literature. Research questions guiding the study were also utilized to design interview questions.

The interview questions were submitted to the dissertation committee and the panel of experts described above for comments and suggestions. The interview instrument was field tested through interviewing one nursing administrator and one faculty member. Pilot testing helped determine the length of the interview and the

need to revise certain interview questions from the guide.

Interview questions were semi-structured in order to elicit descriptive responses. To provide accurate responses, all interviews were audiotaped after obtaining prior written consent from participants. Tapes were transcribed only by the researcher. Transcriptions were then analyzed for recurring themes and patterns utilizing content analysis.

Organization of the Study

Chapter I includes the statement of the problem, purpose of the study, significance of the study, assumptions, limitations and delimitations, definition of terms, methods and procedures, and organization of the study.

Chapter II contains a review of related literature. This section includes concepts and dimensions of leadership, components and concepts of shared governance leadership, development and implementation of shared governance in health care organizations, and the effect of leadership and organizational structure on nursing higher education.

Chapter III describes the methods and procedures for data collection. This chapter includes methodological issues, sources of data, and techniques for data collection and analysis.

Chapter IV presents and analyzes research data.

Chapter V includes a summary of major findings, discussion and conclusions of the research, and recommendations for further research.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

American society is composed of complex organizations or groups in pursuit of specific goals who are able to achieve for themselves and others objectives that they could not achieve individually. People are born in organizations, educated in organizations, work in organizations, play and pray in organizations, and usually die in health care organizations.

Changes in society have affected how individuals view organizations. A new view of the world has emerged which emphasizes human relationships and "elements in the world that humans cannot control, that are ambiguous and uncertain" (Barker, 1991, p. 204). A general lack of confidence has existed since individuals realized that organizations caused harm as well as good. Job insecurity resulted from layoffs and reductions in work force (Peterson & Allen, 1986).

The authority base of organizations has also diminished. When society was stable, organizations served as stable symbols of job security and career mobility. In more recent years, our society has been in a state of flux, so the power and authority created by organizations has diminished (Peterson & Allen, 1986).

As organizational authority has decreased so has the job commitment of the

worker. The organization no longer rules the worker who seeks balance between the institution and other aspects of life. Nowadays, workers frequently identify themselves in generic terms such as "I am a", since relationships with a specific organization are not permanent. Furthermore, workers seek organizations that express values congruent with their personal values and lifestyles (Peterson & Allen, 1986). Workers now bring their beliefs and values to the work place (Barker, 1991).

The world of the manager has likewise been changing as organizations have become heterarchical, with communication and relationships overlapping and multidirectional instead of hierarchial, unidirectional, and well-defined. The technology explosion has increased the knowledge of rank and file workers and provided for rapid disbursement of information (Peterson & Allen, 1986).

According to Barker (1991), a new institutional paradigm is emerging. This paradigm is characterized by the following: "...mutuality and affiliation, acknowledging complexity and ambiguity, cooperation versus competition, an emphasis on human relations, process versus task, acceptance of feelings, networking versus hierarchy, and recognition of the value of intuition" (Barker, 1991, p. 204).

Byrd (1987) proposes a new frame of reference for leadership skills necessary for managing in open systems with lateral responsibilities. Organizational structures for closed systems are clearly defined and involve primarily planning, controlling, and motivational skills. Byrd (1987) suggests a new framework for leaders which includes development of the following skills: anticipatory, visioning, value congruence, empowerment, and self understanding.

This literature review is presented in four sections. Section One provides an overview of general leadership concepts, dimensions, and characteristics. Section Two presents components and concepts relating to the development of the shared governance model of leadership. The development and implementation of shared governance in health care organizations is presented in Section Three. Section Four explores the effect of leadership and organizational structures on nursing higher education.

Concepts and Dimensions of Leadership

Every organization has leaders and followers. Many styles and types of leadership have been identified and developed by researchers in the fields of sociology and business; therefore, an understanding of leadership concepts, dimensions, and styles is necessary.

Components of Leadership

The word "leadership" is defined in many ways. Burns (1978) defines leadership as "...leaders inducing followers to act for certain goals that represent the values and the motivations, the wants and needs, the aspirations and expectations of both leaders and followers" (p. 19). Furthermore, leadership requires institutional, political, psychological, and other resources to engage, stimulate, and satisfy followers (Burns, 1978).

Leadership is a form of power. "Power," Etzioni (1965) remarks, "is the ability, based on the personal qualities of the leader, to elicit the followers' voluntary compliance in a broad range of matters. Leadership is distinguished from the concept of power in that it entails influence, that is, change of preferences, while power implies only that subjects' preferences are held in abeyance" (pp. 690-691).

Burns (1978) characterizes power as a relationship that involves the mutual cooperation of both power holder and power recipient; it is not merely the manipulation of one person by another. Burns (1978) describes the fundamental process of power: "Power wielders draw from their power bases resources relevant to their own motives and the motives and resources of others upon whom they exercise power" (p. 17).

Bennis and Nanus (1985) perceive power as the reciprocal of leadership. They state: "Power is the capacity to translate intention into reality and sustain it. Leadership is the wise use of this power" (p. 17). McGregor (1960) believes that "The power to influence others is not a function of the amount of authority one can exert. It is, rather a function of the appropriate selection of the means of influence which the particular circumstances require" (p. 31).

Although leadership is closely related to power, Hall (1991) says that it "... involves more than simply the power allocated to a position in the organization or claimed by a member or members of an organization. Leadership is something that is attributed to people by their followers" (p. 136).

Power in nursing, Wellington (1986) believes, requires strong leadership

behaviors, including knowledge and communication skills, accurate perceptions of self and others, understanding motivation, personal competence, accountability, and conflict management. In addition, a leader must implement and evaluate change, understand the organizational power structure, and have the ability "to inspire others with a sense of purpose and professional satisfaction" (p. 38).

Bennis (1989) lists the following as being characteristic of leaders: They know what their strengths and weaknesses are and deploy their strengths to compensate for their weaknesses. They know how to communicate with others to gain their cooperation and support. Finally, they know how to achieve their goals. According to Bennis (1989), leaders are made, not born and they want to express themselves freely and fully.

Bennis (1989) states that leaders possess several qualities. They include a guiding vision, passion, integrity, curiosity, and daring. A primary ingredient of leadership is guiding vision; leaders know what they want personally and professionally. A second ingredient is passion. As Bennis (1989) remarks: "The leader loves what he does and loves doing it" (p. 40).

Another vital leadership ingredient is integrity, which has three essential parts: self-knowledge, candor, and maturity. Knowing one's self means "...separating who you are and who you want to be from what the world thinks you are and wants you to be" (Bennis, 1989, p. 54). The final ingredients are curiosity and daring. Leaders want to learn and are willing to take risks and try new things. Leaders embrace errors because they learn from adversity (Bennis, 1989).

Styles of Leadership

Leadership is a process through which individual and organizational goals are strived for. Burns (1978) defines three styles of leadership: transactional, transformational, and moral.

Transactional leaders approach followers with an intent to barter one thing for another. Transactions include gestures, promises, and tangible social, economic, political, or psychological changes. In transactional leadership the object is not a joint effort by persons with common aims for the collective interests of followers, but rather a bargain to aid the individual interests of individuals or groups going their separate ways (Burns, 1978).

Transformational leaders are dynamic, engaging, and mobilize followers to higher motivations and aspirations. The transforming leader recognizes potential motives and develops needs in followers. They engage the full person, creating in a relationship of mutual stimulation and elevation that converts followers into leaders and leaders into moral agents (Burns, 1978).

Transformational leaders bring conscious purpose drawn from values to their relationships and are concerned with liberty, justice, and equality. Transformational leadership shapes, alters, and elevates the motives, values, and goals of followers through the teaching role of leadership (Burns, 1978).

According to Peterson and Allen (1986), transformation is a philosophy of change and emphasizes, "an expanded sense of personal identity and an increased awareness of the interconnection of persons within an organization as well as the

relationship of the organization to a larger culture" (p. 10). Transformational leadership requires leaders to pull an organization toward a vision rather than push toward goals (McMahon, 1992).

Moral leaders find a broadening and deepening base from which to reach out to various social groups to establish and embrace "higher" values and principles. Leadership is a moral process to the extent that leaders engage with followers on the bases of shared motives, values, and goals. These are founded on the "true needs" of leaders and followers (Burns, 1978).

Values mobilized and shaped by moral leadership and sharpened and strengthened by conflict, are the source of vital change. At the highest level of moral leadership individuals are guided by ethical principles of justice, concern for human rights, and respect for individual dignity. According to Burns (1978), moral leadership "operates at need and value levels higher than those of the potential follower" (p. 42). This type of leadership may also "exploit conflict and tension within persons' value structures" (p. 42).

Hall (1991) focuses on two approaches to leadership, authoritarian and supportive. The authoritarian leader is task-oriented and operates at the top level of management. According to Hall (1991), the authoritarian leader "can exercise power simply by giving orders and making decisions. This is simple power of position..." (p. 137) and leadership goes beyond deference to position. Hall (1991) states: "It is the persuasion of individuals and innovativeness in ideas and decision-making that differentiates leadership from the sheer possession of power" (p. 137).

The supportive leader is employee-oriented, democratic, and considerate of others. Leaders who are employee-centered treat others with dignity and their focus is not work-or task-centered. Decision-making is a process that involves consulting and participation with employees rather than issuing autocratic and arbitrary commands. The supportive leader supervises in a general manner, permitting employees to exercise discretion in their work (Hall, 1991).

Dimensions of Leadership

Tannenbaum and Schmidt (1973) discusses leadership patterns and propose dealing with the concept of leadership as a range of behaviors from which managers may analyze their behaviors. At one end of their proposed continuum is the autocratic decision maker, who makes all decisions with minimal or no input from group members. As the continuum moves to the midpoint, the leader and group members participate more equally in decision-making. At the other end of the continuum, the leader involves the group in most decisions. This type of sustained group involvement requires mutual knowledge, experience, and communication skills to maintain trust.

Tannenbaum and Schmidt (1973) contend that deciding how to manage is based on forces in managers, their subordinates, and their work situations. Factors that influence the managers' styles include: the managers' personal value systems, their confidence in followers, personal leadership inclinations, and feelings of security in uncertain situations. Factors that influence employees confidence in managers

include personality variables, expectations, knowledge, and experience.

Situational factors which affect a manager's behavior toward employees include type of organization, group effectiveness, the group's problem-solving abilities, and time pressures for tasks or projects. The type of organization is determined by the organization's values and traditions. Group participation and decision-making is influenced by group experiences, personal and professional backgrounds of individual members, and length of time the group has been together. The nature of the assigned task or project is a major determinant of manager authority; the more time available to complete a task or project the easier it is to involve subordinates.

Bellon (1988) examined dimensions of leadership, which are common themes flowing through research, theory, and practice. He delineated three dimensions of leadership: the ability to manage self, the ability to assist others to reach their potential, and utilization of processes to facilitate the organization.

According to Bellon (1988), the ability to manage ones self involves several interpersonal processes, including self-renewal, self-mastery, positive self-regard, and self-understanding. Management of others includes motivating others, empowering others, taking risks, and understanding your leadership style. Organizational processes are a critical dimension of leadership and include communication, decision-making, conflict management, management of agreement, and value congruence. These dimensions overlap and relate to each other and each is vital for effective leadership.

Senge (1990) describes an organizational model with the central idea that organizations work "because of how we think and how we interact" (p. xiv). According to Senge (1990), building organizations is a lifelong journey for all members of the organization. Senge (1990) developed five disciplines, including practices and principals that are required for innovative learning organizations. The necessary disciplines include personal mastery, mental models, shared vision, team learning, and systems thinking.

Personal learning and organizational learning are essential to learning organizations because organizations learn through their individual members. Senge (1990) defines personal mastery as "the discipline of continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of seeing reality objectively" (p. 7). Characteristics of individuals having a high level of personal mastery include possessing: a vision that is multifaceted and gives a specific goal, the ability to work with forces of change, inquisitiveness, and the ability to seek reality.

Mental models are another vital discipline of learning organizations. Mental models are "deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action" (Senge, 1990, p. 8). The discipline of mental models requires individuals to "unearth our internal pictures of the world, to bring them to the surface and hold them rigorously to scrutiny" (p. 9).

Senge's (1990) third discipline, building shared vision is "vital for the learning

organization because it provides the focus and energy for learning" (p. 206).

Additionally, shared vision is intrinsic, reflecting the commitment of many individuals. According to Senge (1990), shared visions are rooted in individuals' personal values, concerns, and aspirations. Individuals then begin to trust and identify with each other as a group. Shared vision changes individual perceptions from "their" to "our" company which is a time-consuming and ongoing process.

Team learning is a crucial discipline that requires mastery of dialogue and discussion. Dialogue involves group learning, or recognizing interactive patterns that undermine learning. "Team learning is vital because teams, not individuals, are the fundamental learning unit in modern organizations" (Senge, 1990, p. 10).

The fifth discipline is systems thinking, which is a conceptual framework. Systems thinking "integrates the disciplines, fusing them into a coherent body of theory and practice" (Senge, 1990, p. 12). Systems thinking requires shared vision, mental models, team learning, and personal mastery to realize its potential as a method of leadership. It is essential that the disciplines develop as an ensemble. For learning organizations, "are continually discovering how they create their reality" (Senge, 1990, p. 13).

Leadership Studies

Several studies have delineated and examined various characteristics and attributes of leaders. Some researchers have studied specific companies; others have studied individuals.

Peters and Waterman (1982) interviewed employees from 75 large innovative companies and established eight attributes manifested by their leaders. The leaders had a bias for action using practical devices to maintain "fleetness of foot and counter the stultification than almost inevitably comes with size" (Peters & Waterman, 1982, p. 14). Executives at these companies were willing to experiment with change.

The leaders of these companies stayed close to their customers and believed often the best product ideas came from customers. "They provide unparalleled quality, service, and reliability," Peters and Waterman found (1982, p. 14). The researchers also found that innovative companies encourage autonomy and entrepreneurship by fostering leaders and innovators throughout the organization.

According to Peters and Waterman (1982), innovative companies treat employees as vital organizational members: "Treat them as partners; treat them with dignity; treat them with respect. Treat them as the primary source of productivity gains" (p. 238.).

Excellent companies also have the attribute of being hands-on and value-driven. Every good company is clear on what it stood for taking the process of value shaping seriously. A sound set of values is essential for successful survival (Peters and Waterman, 1982).

Another major attribute is that "Organizations that do branch out but stick very close to their knitting outperform the others" (Peters & Waterman, 1982, p. 293). For these companies, excellent performance is related to staying close to other businesses. The underlying forms and systems of excellent companies are simple and

lean. Peters and Waterman (1982) found that simplicity facilitates flexibility in organizations.

A final attribute of innovative companies is their simultaneous loose-tight properties. Peters and Waterman (1982) explain: "Organizations that live by the loose-tight principle are on the one hand rigidly controlled, yet at the same time allow autonomy, entrepreneurship, and innovation from the rank and file" (p. 318).

The attributes identified by Peters and Waterman (1982) were essential for excellent companies in the private sector. Other researchers studied individual leaders in private and public organizations.

Bennis and Nanus (1985) interviewed 90 leaders, 60 were chief executive officers and 30 were public leaders. They differentiated managers and leaders: "Managers are people who do things right and leaders are people who do the right thing. The difference may be summarized as activities of vision and judgment - effectiveness versus activities or mastering routines - efficiency" (p. 21).

Bennis and Nanus (1985) revealed four areas of individual competency that can be learned, developed, and improved upon. They are:

Strategy I: Attention through vision

Strategy II: Meaning through communication

Strategy III: Trust through positioning

Strategy IV: Deployment of self through positive self-regard and the Wallenda Factor.

Bennis and Nanus (1985) described attention through vision as the process of

creating a focus because vision animates, inspires, and transforms purpose into action.

Gaining the confidence of followers is the first step to implementing a vision.

According to Bennis and Nanus (1985), leadership is a give and take transaction between leader and follower. McMahon (1992) also described vision saying that it has a twofold purpose. The first is to provide followers with a conceptual framework for understanding the organizational purpose; the second is to provide an emotional motivational pull.

Bennis and Nanus (1985) say that all organizations depend on the existence of shared meanings and interpretation of reality. The actions and symbols of leaders frame and mobilize meaning. Another essential leadership strategy is the ability to influence and organize meaning for members of the organization. A third strategy is trust through positioning. Leaders define their position and are knowledgeable, predictable, and relentless (Bennis & Nanus, 1985).

Bennis and Nanus's (1985) final leadership strategy is deployment of self through positive self-regard. Positive self-regard is a process through which "an individual recognizes strengths and compensates for weakness" (p. 58). The first step in this process is for an individual to recognize strengths and compensate for weakness. The second step is encouraging an individual's capacity to develop talents and improve skills. The final step is for leaders to have the ability to "discern the fit between one's perceived skills and what the job requires" (Bennis & Nanus, 1985, p. 60).

Bennis and Nanus (1985) describe the Wallenda Factor as another means for

developing positive self-regard. They define the Wallenda Factor as "the capacity to embrace positive goals, to pour one's energies into the task, not into looking behind and dredging up excuses for past events" (p. 75). According to Bennis and Nanus (1985), successful leaders view failure as a springboard of hope - an opportunity to learn.

Over an eighteen-year period Garfield (1986) identified the skills and strategies of over 1500 high business achievers comparing them to leaders in business, science, sports, and the arts. He concluded that America's most productive individuals share a set of basic skills regardless of their age, education, or profession. From his research, Garfield (1986) identified six traits of peak performers: missions that motivate, results in real time, self-management through self-mastery, team building/team playing, course correction, and management of change.

Garfield (1986) defines mission as "an image of a desired state of affairs that inspires action--determines behavior and fuels motivation" (p. 77). Peak performers consistently get results by achieving measurable goals and creating the appropriate mental environment. Garfield (1986) states that "The peak performing attitude is the mental environment in which one sorts out and evaluates goals, sets result producing goals, and implements tactics for achieving goals" (p. 112).

Self-management skills, which are vital to peak performers, emerge from self-mastery. Self-mastery involves self-confidence, micro/macro attention (analytical methods and delineating broad themes from information), and mental rehearsal of specific skills and behaviors leading to outcomes. According to Garfield (1986), team

building and team playing, another peak performance factor, requires three major skills: delegating to empower others, stretching the abilities of others, and encouraging educated risk taking.

Course correction is a major trait of peak performers and requires effective mental agility, concentration and adaptability, and the ability to learn from mistakes. Management of change is essential for peak performers who make many decisions for the organization. Some decisions require quick action, others need experimentation and integration. Managing change requires four basic skills: lifelong learning, powerful mental images of success, mapping alternative futures, and updating the mission (Garfield, 1986).

Leadership is a process involving complex relationships with others. The leadership paradigm is shifting to cooperation, networking, empowerment, and sophisticated communication credited to advances in technology. With these changes a new leadership style, shared governance, is emerging. The evolution and development of shared governance leadership will be explored next.

Components and Concepts of Shared Governance Leadership

"The struggle to establish nursing as an independent profession has characterized the development of nursing over the past 100 years," wrote Jones and Ortiz (1989, p. 11). Health care organizations have traditionally followed a bureaucratic hierarchy model in which authority and decision-making power begin at

the top. Hospitals have created leadership structures that bypass nursing staff, since decisions are made at the apex of the organization.

Hospitals and medical centers have introduced an institutional set of values, expectations, rules, and experiences into their employees and nurses have relinquished their ability to define, control, and evaluate practice. Professional autonomy and independent decision-making by nurses has not occurred, because the majority of nurses practice in health care institutions that are hierarchial, bureaucratic, and autocratic (Porter-O'Grady, 1984, 1991; Wellington, 1986; Pinkerton, 1988; Barker, 1991; McMahon, 1992).

Nurses have complained that they do not influence decisions about their practice. Administrators of nursing service have "the major responsibility of developing practice standards and making decisions frequently without soliciting staff nurses' input and participation" (Ortiz, Gehring, & Sovie, 1987, p. 923).

Sigardson (1982) studied nurses' reasons for leaving active practice. The most frequent reasons were long hours and understaffing. The second most frequent reason was treatment received from physicians and administrators.

In an interview with Curran (1991), Kerfoot stated that nurses need to create innovative cultures in hospitals. Organizational cultures would permit nurses to think and create, design work structures, and own their practices. Porter-O'Grady (1991) stated that to be accountable and responsible, "nurses must work in an environment that gives them authority for decisions, and control over the implementation and outcome of the decisions" (p. 459). This power must be "relearned by nurses who

for years have been socialized to trust the paternalistic hospital environment" (Haddon, 1989, p. 159).

Over the past 15 years health care organizations and the nursing departments within them have been moving from centralized to decentralized nursing units, from directives to participatory management, from power to empowerment, and from managerial governance to self governance (Wellington, 1986; Allen, Calkin, & Peterson, 1988; Barker, 1991). The next section defines and examines issues regarding decentralization, participative management, and shared governance.

Decentralization

Decentralizing nursing service is a process that places the responsibility and decision-making for practice upon the professional nurse. Wellington (1986) stated "Decentralized nursing is purported to invert the traditional structure to one in which the patients are on top and the nursing service functions mainly as a support to the patient focus" (p. 36). With decentralization, the bedside nurse achieves increased power, authority, accountability, and autonomy.

Wake (1990) defines decentralized decision-making as the process by which "clinical nursing staff join nurse executives in shaping the context for practice" (p. 48). However, Hess (1994) says that although decentralization gives authority to nurses at the lower hierarchical levels, "employees can make only limited decisions, may not be involved in certain processes such as budget, or may participate in the

decision-making process without any authority to implement the decisions made" (p. 29).

Decentralization has strengths and weaknesses. Strengths include increased responsibility, authority, decision-making, and accountability for practitioners. In addition, decentralization increases innovation and professional growth in nurses, and fostered participative management and communication (Wellington, 1986).

A major weakness of decentralization is the lack of a definite meaning for the term "decentralization" and implementation guidelines. Wellington (1986) states that the meaning of decentralization varies: "to some, decentralization basically means that those directly involved in patient care have a major role in decision-making; to others, it refers primarily to a structural change that decreased the links in an organization's chain of command" (p. 37). Some nurses believed with decentralization, there was loss of coordination between departments with duplication of efforts. Some reported that one department did not know what the other was doing and mismanagement by unqualified personnel occurred (Wellington, 1986).

Wellington (1986) found that preparation for role changes in decentralization is essential because decentralization caused major changes at the unit level due to the changing roles of head nurses or managers and staff nurses. Wellington (1986) says that an essential first step in implementation of decentralization is to explain plans to all staff. Wellington (1986) concluded that a change from centralized to a decentralized system means "less rigidity and greater opportunity for creative nursing practice" (p. 39).

Participative Management

Participative management is another method seen in nursing departments in health care organizations. Participative management is a decision-making style that allows staff to have some measure of influence in management decisions.

Callahan and Wall (1987) discuss three critical elements that are necessary for effective implementation of participative management. Decentralization, the first element, involves "increasing of the subordinate's authority to make decisions at any given level in the organization" (p. 11). These authors equate decentralization with the distribution of some decision-making of the nursing department into several divisions or specialty areas.

Group decision-making is Callahan and Wall's (1987) second critical element for effective participative management. Group decision-making maybe formal or informal. Formal groups have specific needs or tasks to perform, are permanent or temporary, and are classified as either advisory or decision-making empowered to make decisions for the group.

Management by objectives (MBO), the third critical element, involves group and individual objectives. Management by objectives is a system establishing objectives at every organizational level including upper management, unit/department, and individual. Objectives are converted into action by members of the organization and priorities are established (Callahan & Wall, 1987).

Callahan and Wall (1987) state that participative management requires a responsibility-accountability-authority relationship "about the types of decision

participation procedures, and about the expected level of participation for planning decision implementation" (p. 12). This complex relationship between upper management and employees is determined by upper management.

Allen, Calkin, and Peterson (1988) found that a significant increase in decisional participation can produce a number of positive outcomes for individual employees as well as the overall organization. Allen et al. (1988) analyzed 50 research articles on participation in decision-making and determined that employees who participated in decision-making had increased satisfaction, were more involved in their work, exhibited more motivation, and were committed to the organization. Relationships between employees and the overall organization were stronger in employees with strong desires for achievement, responsibility, and autonomy. Hess (1994) determined from a review of literature on shared governance that participative management and decentralization were variable across time and situations and environments differed with the degree of participation and decentralization subject to managerial discretion.

Shared Governance

Shared governance, is a leadership model that goes beyond decentralization and participative management. McMahon (1992) states that "Shared governance vests ownership of practice decisions with the staff. Participative management merely allows the staff to give us (nurse executives) input, after which we will still make the decision" (p. 58).

Bernreuter (1993) comments on the differences between shared governance and other participative leadership models: "The true differences between shared governance and traditional hierarchical models and between various models of shared governance, seems to hinge on what decisions are made, and how and by whom they are made" (p. 12).

Porter-O'Grady and Finnigan (1984) outline a process that addresses "the complex transition to an organizational structure that provides for the full utilization of the nursing resource" (p.15). The authors also propose a system, called shared governance, for maintaining an operational framework for this organizational structure.

Shared governance became the buzz word of the nursing profession during the 1980s. This new leadership concept is vital for survival of the nursing profession. According to Hess (1994), "Shared governance is a radical departure from traditional management structures or practices in which nurses exercise limited governance with little authority and organizational control" (p. 28). Shared governance is a leadership philosophy and style that gives nurses more control over their professional practice and extends their influence to areas previously controlled by administration. Shared governance requires an atmosphere of autonomy in which mutual trust and respect give nurses greater control. However, some administrators have felt threatened by shared governance, believing that it has depleted their power (Pinkerton, 1988; Jacoby & Terpstra, 1990; Kerfoot, 1991; Totten & Scott, 1993; Hess, 1994).

As each health care discipline becomes more specialized, practitioners seek

more decision-making powers. However, autonomy and accountability must be balanced. Curtin (1987) states that: "demands for absolute autonomy, implied or expressed, are a sure impediment to the interdependent effort necessary for adequate delivery of health care services today" (p. 9).

Health care professionals must acknowledge their interdependence with each other and with patients, families, and communities. According to Curtin (1987), interdependence and cooperation would flourish if shared governance were to replace unilateral power. Gardner and Cummings (1994) believe that "Shared governance is a trust based system empowering the care provider with greater accountability" (p. 57).

Gardner and Cummings (1994) examine "shared" and "governance" as separate terms. "Shared" is defined as "the interdependency of people in organizations to operationalize the goals of the organization" (p. 57). "Governance" connects "the activities of the nursing professional into the decision-making process of the nursing organization" (p. 57).

Pinkerton (1988) defines shared governance as "the organizational structure that provides an environment for autonomous staff nursing practice...the structure that accommodates professionals in a bureaucratic setting, the structure that tackles a history of subservience and dominance" (p. 105). Shared governance is defined by Anderson (1992) as "an administrative model that provides an active role for staff nurses in decision-making and policy formation" (p. 65). Jones, Stasiowski, Simons, Boyd, and Lucas (1993) remark that shared governance is "the framework for

empowering staff nurses by involving them in patient care decision-making and providing accountability and responsibilities in nursing practice" (p. 208).

According to Ludemann & Brown (1989), shared governance is seen as a means for changing nursing from a subservient profession to one's that meaningful and autonomous. They also say shared governance requires nurses to be competent in their professional roles and motivates them to participate in decision-making.

According to Hersey and Blanchard (1982), shared governance requires job maturity, which is the knowledge, skills, ability, and experience to perform independently. Shared governance also requires psychological maturity, or the confidence and commitment to view increased responsibility as vital.

McMahon (1992) the vice president of nursing at Morristown Memorial Hospital, Morristown, New Jersey shared her personal account of the hospital's journey toward shared governance. Shared governance emerges "as the vehicle we would use to empower our nursing staff" states McMahon (1992, p. 56). Furthermore, McMahon (1992) remarks that shared governance gives nurses the opportunity for ownership and decision-making in their practices and education.

According to Jones et al. (1993), shared governance is a process that may take years to implement. Shared governance began with a vision that empowers a group to transform their practice roles. Implementation of shared governance "requires that the nursing executive and nurse managers devote time to program start-up and maintenance, and demonstrate an ongoing commitment to the philosophy of shared governance" (Jones, Stasiowski, Simons, Boyd, & Lucas, 1993, p. 213).

Bernreuter (1993) states that organizations must assess their readiness for change. She says that "A determination of the organization's ability to support shared governance should be made, with strong commitment from management and staff considered a necessity before attempting implementation" (p. 13). The shift to shared governance models requires changes in organizational structures and processes. Furthermore, changing from an autocratic bureaucracy to a shared governance model takes time and patience because shared governance concepts are abstract and difficult for some people to understand. According to Shidler, Pencak, and McFolling (1989) and Wilson (1989), it is important to develop a consensus on the meaning of shared governance for nursing.

Education of management and staff play a pivotal role in getting a health care organization ready for the change to shared governance (Bernreuter, 1993). Staff education helps clarify the meaning of shared governance and should include literature describing shared governance, group discussions, and discussions of the expectation of new roles. According to Wilson (1989), group dynamics are very important for determining readiness for change and facilitate decision-making and learning.

Peterson and Allen (1986) have developed ten strategies for transforming health care organizations to shared governance systems. Their organizational strategies include the following steps: Understand the philosophy and commitment to beliefs; operationalize the beliefs by translating beliefs into goals and putting beliefs into practice; define decision-making in the organization; communicate information quickly; and encourage feedback. According to Peterson and Allen (1986) several

strategies are necessary for preparing nursing staff for shared governance and included training staff in skills, encouraging accountability and responsibility, providing participative structures, developing humanistic leadership and guides, and directing, and teaching nursing staff.

Shared governance is a major departure from traditional management-driven systems. Shared governance "will revolutionize nursing with a system," state Shidler et al. (1989, p. 8). Shared governance requires commitment and investment from all nursing professionals both managers and practitioners. Moving toward shared governance changes the way professional nurses practice and relate to the organization. Shared governance is built on trust: trust in the commitment to high quality care, trust in management to provide resources, and trust that quality patient care will be supported. Shared governance increases and formalizes staff participation in nursing practice (Porter-O'Grady, 1989, 1991).

Porter-O'Grady (1991) defines the basic tenets of shared governance. He says that nursing practice must be controlled by the practicing staff nurses with practice issues originating and ending with staff. All quality assurance processes must reflect staff ownership. Staff competence and continuing education are a requirement of professional practice and management must support staff in their professional roles. All levels of the organization are included in management to provide consistency, communication, problem-solving, and decision-making.

According to Pinkerton (1988), changing from traditional bureaucratic structure to increased autonomy and decision-making helps nursing professionals in

many ways. For example, shared governance moves nurses from subservient to autonomous roles by giving nurses authority over practice decisions. It values nurses by recognizing their clinical expertise and builds trust between professionals by teaching groups to work together in an environment of openness, self-disclosure, and inner honesty. In addition, Pinkerton (1988) stated shared governance clarifies communication and reduces uncertainty by giving staff nurses direct access to information and access to persons who distribute the information. Furthermore, shared governance results in high productivity, low absenteeism, and low turnover by creating a work environment with high job satisfaction. Pinkerton (1988) concludes that shared governance values and promotes advancement in the profession.

Over the past decade, several articles have been published concerning the development and implementation of shared governance in health care organizations. Health care organizations and nursing departments within these organizations have been restructured. The next section of the literature review will examine the development and implementation of shared governance in practice settings.

Development and Implementation of Shared Governance in Health Care Organizations

Methods for implementing shared governance models vary from one health care institution to another. "Shared governance may be enacted differently in different organizations, but the underlying concepts remain constant," says Pinkerton

(1989, p. 36). Shared governance provides an environment essential for autonomous professional nursing practice. Shared governance models are founded on higher levels of autonomy, and participation in decision-making and policy formation (Fagan, 1991).

Shared governance may be implemented by the entire health care organization or by specific units. The development and implementation of shared governance affects all nursing roles in a health care organization. The next section of the literature review will address how health care organizations are affected.

Hospital Wide Models of Shared Governance

The method of development and implementation of shared governance models has varied among health care organizations. There is no single system for implementing participation in decision-making that fits every situation (Allen, Calkin, & Peterson, 1988). According to Porter-O'Grady (1989), key groups called councils, congresses, cabinets, or executive groups are created, chaired, and filled with management and nonmanagement nursing staff. Rules and bylaws of key nursing groups help define the shared governance model.

University of Rochester Medical Center, Strong Memorial Hospital, New York

The transition to a shared governance model at the University of Rochester Medical Center, Strong Memorial Hospital in New York was studied by Ortiz, Gehring, and Sovie (1987) and Jones and Ortiz (1989). The shared governance model evolved from the nursing management philosophy "that each staff member should be

encouraged toward full self-actualization" and that "we recognize each staff member's right to express his/her own view, to participate in decision-making, to be provided with information about fiscal management of patient care to practice in an environment conducive to learning and open to an exchange of ideas and peer support, and to engage in collegial and collaborative relationships with nurses and others" (Ortiz, Gehring, & Sovie, 1987, p. 925).

Staff nurse advisory boards (SNABs) and a staff nurse executive committee (SNEC) were key components for the successful implementation of the shared governance model at Strong Memorial Hospital. SNABs addressed practice issue problems specific to the service, standards of practice, and quality assurance reports. The SNEC addressed issues that concerned all practice areas and established the agenda for the nursing update forum held every other month for the nursing staff (Ortiz, Gehring, & Sovie, 1987).

A professional nursing organization (PNO) model was developed to guide nursing practice at Strong Memorial Hospital. The PNO provided an integrating structure for professional nursing efforts, enabling nursing staff to participate in the development of nursing practice standards and thereby to promote quality patient care. In addition, it influenced, contributed, and supported the professional education of nursing students and staff and encouraged and supported scientific inquiry for the continual improvement of nursing practice and health care. The PNO addressed the practice needs of all members of the nursing staff and promoted the continuing development of professional nursing (Ortiz, Gehring, & Sovie, 1987).

Jones and Ortiz (1989) also studied the shared governance model at Strong Memorial Hospital. They found that all nurses integrated practice, teaching, and research. Nursing leaders strived "to create and nurture an open, interconnecting, collaborative network designed to promote excellence in nursing practice, education, and research" (p. 12).

Jones and Ortiz (1989) also described the professional nursing organization (PNO) that guided nursing practice at Strong Memorial Hospital. The professional nursing organization was governed by a 43-member executive committee representing various nursing constituencies. The work of the professional nursing organization (PNO) was achieved through nine standing committees. Six committees addressed practice issues; the remaining three committees were instrumental in maintaining the shared governance structure and planning change.

Nurses at Strong Memorial Hospital found that "a shared governance model can cultivate and enrich the professional nursing model used in the delivery of patient and family care" (Jones & Ortiz, 1989, p. 15). Jones and Ortiz (1989) concluded that the role of the individual nurse was likewise enriched as nurses became more autonomous and accountable for their practice and took an active role in decision-making and problem-solving.

Rush Presbyterian St. Luke's Medical Center, Chicago, Illinois

The shared governance model for nursing at Rush Presbyterian St. Luke's Medical Center was described by Shidler et al. (1989). Primary nursing, decentralized decision-making, and a clinical career ladder provided the foundation

for shared governance at Rush Presbyterian.

The nursing division at Rush Presbyterian was composed of clinical nursing staff, managers, and faculty. All nurses were professional and unified in clinical practice, education, and research. The Professional Nursing Staff (PNS) and the Unit Advisory Committees (UAC) were the two key groups that implemented shared governance at Rush Presbyterian. The senate was the governing body of PNS and consisted of the vice president, associate vice president for nursing, chairpersons of the seven clinical departments, ten elected representatives from each nursing department, the president of the medical staff, and a vice president of administration (Shidler, Pencak, & McFolling, 1989).

The move to shared governance at Rush Presbyterian required changes in attitudes and behaviors and not all nursing management and staff identified with their new roles. Shidler et al. (1989) concluded that patience was necessary for all nursing management and staff and change to a shared governance model took time.

St. Joseph's Hospital, Atlanta, Georgia

Shared governance at St. Joseph's Hospital of Atlanta began in the early 1980s and is now a well-established shared governance model. McDonagh, Rhodes, Sharkey, and Goodroe (1989) described St. Joseph's shared governance structure, which consists of five major nursing councils: nursing management, nursing education, nursing quality assurance, nursing practice, and nursing executive.

According to McDonagh et al. (1989) nursing management council has provided the human and material resources that staff nurses need to practice. Nursing

education has developed and refined the orientation and preceptor programs. Nursing quality assurance has monitored the effectiveness and appropriateness of nursing care. Nursing practice council has defined, implemented, and maintained the standards of clinical nursing practice consistent with national, regional, and community standards of practice. Nursing executive council has served as the central means for communication, exchange of ideas, and coordination of activities.

Roseville Hospital, Roseville, California

Roseville Hospital in Roseville, California began a management model called Collaborative Governance, which was studied by Jacoby and Terpstra (1990). They found that Roseville's management structure provides a forum for nurses to set standards of practice and develop policies for nursing practice (Jacoby & Terpstra, 1990).

Jacoby and Terpstra (1990) found that four central committees formed the decision-making group at Roseville Hospital and each nursing unit had representatives on each committee. The Clinical Practice Committee was responsible for revising and updating clinical standards. Quality Assurance evaluated established standards of practice and analyzed all incident reports and plans for corrective action. The Administration, Policy and Procedure Committee developed general guidelines for self scheduling and establishment of a career ladder for clinical nurses. Nursing Operations and Development was responsible for the professional development of the middle management role.

Jacoby and Terpstra (1990) concluded that "the underlying philosophy of

Collaborative Governance has to be accepted by the entire management team" (p. 44). Involvement of all staff was essential for efficient implementation of the model. The process of incorporating the Collaborative Governance model at Roseville Hospital took almost five years. Trust, leadership, and group maintenance were critical to its success.

Miami Valley Hospital, Miami, Florida

Anderson (1992) studied shared governance at Miami Valley Hospital. At Miami Valley Hospital shared governance took two years to implement. The process began with the creation of task forces in practice, education, management, quality assurance, and research. According to Anderson (1992), the purpose of task force members "was to involve staff nurses in group process and decision-making" (p. 65). A primary outcome of task force groups was to lay "the groundwork for trust building, respect and ability to debate in a nonjudgmental atmosphere" (p. 65).

Implementation of shared governance began with formation of a 26-member nursing council. The council developed a new philosophy for nursing that incorporated institutional goals and values. The philosophy then was shared with all nursing staff, who were asked for input, evaluation, and change. "Communication was identified as a major goal of the nursing council," stated Anderson (1992).

According to Anderson (1992), progress during the first year of shared governance at Miami Valley Hospital included an atmosphere of open communication with improvement of interdepartmental communications, establishment of a fair way to choose new council members, and evaluation and revision of the hospital dress

codes. The nursing council identified ten goals to be achieved over the next two years and began to develop bylaws.

University of Alberta Hospitals, Alberta, Canada

Hibberd, Storoz, and Andrews (1992) studied implementation of shared governance at a medical center in Alberta, Canada. The process did not fair well; a year after shared governance was implemented, the vice president of nursing left and major financial cutbacks resulted in layoffs of nursing management and staff. At the University of Alberta Hospitals, implementation of shared governance was originally conceived and designed by the vice president of nursing with support from the hospital administration and board of trustees. The shared governance model consisted of three levels of decision-making: committee decision-making, unit decision-making, and clinical decision-making.

According to Hibberd et al. (1992) the University of Alberta Hospitals faced several barriers to success. First, apart from initial educational presentations, no formal or published plan for sustaining shared governance was involved in bringing about the change. Skepticism arose among nursing staff, and some thwarted the empowerment process.

Secondly, the vice president in 1990 resigned after 21 months on the job and an internal successor was named. Major cuts in operating budgets also occurred in 1990, resulting in layoffs and termination of nursing staff.

Thirdly, the nurses' union proved to be an important stakeholder in the existing system. The major goals of the union were: 1) to promote the

socioeconomic interests of its members through collective bargaining; 2) to protect rights contained in the agreements by monitoring management decisions; 3) to provide advice and practical assistance to members in filing grievances; and 4) to lobby on behalf of members concerns. Union members viewed shared governance with suspicion. Following the layoffs in 1990, the nurses' union refused to recognize or take part in the nursing council or any of its subcommittees. Some believed that union-management relations were more defined under traditional bureaucratic models. The nursing union attempted to suspend shared governance operations (Hibberd, Storoz, & Andrews, 1992).

Despite numerous problems, staff nurses and management at the University of Alberta Hospitals were committed to making shared governance work. A task force consisting primarily of staff nurses was formed to refine the shared governance model so that it would meet the needs of the nursing staff and patients (Hibberd, Storoz, & Andrews, 1992).

Economics

Nursing divisions in health care institutions were increasing adopting shared governance models. Jenkins (1988) addressed the cost of maintaining shared governance models. Administrators of health care are aware of the need to remain competitive in today's price conscious health care environment. Costs are dependent on the culture and resources in the health care organization at the time of implementation. A major concern about the change to shared governance was the cost of meetings for nursing councils and unit clinical practice meetings that take

practitioners away from the bedside. Jenkins (1988) found that nurses need time to plan, assess, and develop clinical standards.

In her analysis of committees Jenkins (1988) found that chairpersons were counseled to set an agenda, stick to the agenda, and manage group dynamics. According to Jenkins (1988), timing of meetings is important. Members are fresher and ready to focus in early morning, while afternoon meetings are not as productive and have poor attendance.

In this section, research regarding the development and implementation of shared governance at several hospitals and medical centers was presented. In each case, the health care organization had councils and committees in place to empower professionals, enhance communication, and provide an avenue for decision-making. Research shows that shared governance is a process that requires ongoing commitment by all members of the health care organization. The next section presents research on the importance of implementing shared governance at the unit level.

Unit Specific Shared Governance Models

In an interview with Curran (1991), Kerfoot remarked that the future of hospital nursing is in unit-based shared governance models. In order to provide high quality patient care, nurses must participate in running their units. Kerfoot continued to say in the interview that shared governance works best when a group of experienced nurses want to advance their professional practice roles. According to

Porter-O'Grady (1991), unit-based shared governance is essential to the general success of shared governance and clinical nurses on the unit must be responsible, accountable, and committed.

According to Skubak, Earls, and Botos (1994), shared governance requires collaboration between staff on units and empowers nurses to assume accountability for their nursing care. With increased autonomy came "increased responsibility for personal, professional, and overall unit growth" at Mt. Carmel East Hospital (p. 801).

Jacoby and Terpstra (1990) recognized the uniqueness of nurses working in their specialty units at Roseville Hospital. Each nursing unit had unique characteristics which defined its culture and played a role in how nurses handled conflict, adapted to change, and provided nursing care.

In an interview with Curran (1991), Kerfoot states that nursing needs a cultural milieu that rewards innovation and ideas. Furthermore, Kerfoot states "nurses must have the freedom to participate fully in running the unit in order to provide a high quality of patient care" (Curran, 1991, p. 142). Kerfoot concluded in an interview with Curran (1991) that staff nurses must be involved with the development and implementation of shared governance on their unit or another bureaucracy may form.

Children's Hospital, San Diego, California

Is it possible for a nursing unit to successfully implement a shared governance model within a hospital when the nursing department has not embraced the principles of shared governance? This question was posed and answered by Fagan (1991) as she

described the efforts of a Pediatric Intensive Care Unit (PICU) at Children's Hospital in San Diego, California to institute a shared governance model for their unit.

The shared governance format at Children's Hospital PICU began with a new management team of manager, assistant manager, and clinical nurse specialist. Nursing staff were committed to participate in unit decisions and management and unit goals were established and prioritized. Staff nurses participated in the units' four committees, which included clinical practice, professional issues, education, and communication (Fagan, 1991).

According to Fagan (1991), the nurses in the PICU learned many things through implementation of a shared governance model. Shared governance brought nurses together through consensus decision-making. Committee meetings agendas were clear and chairpersons were trained in group dynamics. The role of committee members was clear (Fagan, 1991).

The unit shared governance model survived and thrived at Children's Hospital but not without the pain of isolation. Fagan (1991) states that "Our nursing staff have evolved to a point where they want and expect to participate in decision-making. When the decisions are outside the realm of the unit and participation is not the rule, discord ensues" (p. 104P). Hess (1994) concurs that "If units are isolated within an unchanged bureaucratic hospital structure, organizational governance may be virtually unchanged with no innovation occurring" (p. 29).

Mt. Sinai Hospital, Hartford, Connecticut

Caramanica and Rosenbecker (1991) reported on the implementation of a

shared governance unit model at Mt. Sinai Hospital in Hartford, Connecticut.

Nursing administration decided to ease into shared governance by gradually implementing a pilot project on the Rehabilitation/Pain Unit. Nursing staff on the unit began the process by forming councils for practice, management, education, and quality assurance. Nursing staff assumed new roles and responsibilities and established clinical professional goals.

Shared governance on the Rehabilitation/Pain Unit met problems similar to the PICU at Children's Hospital in San Diego, California. According to Caramanica and Rosenbecker (1991), nursing staff struggled to keep up with goals and had to balance the different structures of the nursing department and the Rehabilitation/Pain Unit. Unit staff members experienced responsibility overload. Caramanica and Rosenbecker (1991) concluded that "a pilot approach provided the opportunity to explore and validate our beliefs" (p. 48). Furthermore, "This strategy is not without complicating limitations" (p. 48).

Mercy Hospital and Medical Center, San Diego, California

Davis (1992) took a different approach when studying unit-based shared governance at Mercy Hospital and Medical Center. According to Davis (1992), having a shared governance model in place in a nursing division or department does not guarantee shared governance practice at the unit level. He states that "once this transformational visions of shared governance has been articulated at the hospital-wide level, the vision must be nurtured into reality by the professional staff at the unit level" (Davis, 1992, p. 46).

According to Davis (1992), increased nursing staff participation in unit shared governance is essential for staff empowerment and improved communication patterns to manifest themselves. At Mercy, hospital-wide goals and objectives developed by the practice committee were adapted to the intensive care units. Davis (1992) a surgical intensive care nurse, discussed the process his area went through to link the vision of hospital-wide shared governance to the unit level.

Goals and objectives developed by the hospital-wide practice council were used as a foundation to develop goal-oriented activities for the critical care units. The unit-based practice committee selected a wide variety of topics: primary care, critical pathways/physician collaboration, ethical dilemmas, and innovative change strategies for nursing culture. Each unit committee member read professional articles relating to the selected topics. Once consensus was obtained on the value of the activities, members formed subcommittees (Davis, 1992).

The intensive care units at Mercy Hospital and Medical Center adapted subcommittees linked to the unit practice committee to increase staff participation and empowerment. Strategies to facilitate staff participation included posting committee goals and objectives and articles related to outcome focused activities, discussing shared governance activities at staff meetings, creating alternative committee meeting formats, integrating shared governance activities with clinical ladder criteria, and soliciting staff input (Davis, 1992).

According to Davis (1992), fostering effective communication between the intensive care medical, surgical, neurological, and post anesthesia care units is vital.

Communication between the unit-based practice, education, quality assurance, and management committees is likewise essential and presented a real challenge for Mercy Hospital. Strategies for effective communication used at Mercy Hospital included establishing a representative system, establishing unit-based executive committees, maintaining an effective link between unit-based committees and house-wide councils, and focusing on developing trust.

Davis (1992) concluded that "the transformational vision of shared governance requires nurturing by all involved for it to become a reality for the nurse at the unit level" (p. 50). Unit-based shared governance requires education to support staff as they integrate new responsibilities of autonomy and accountability, improve peer relations, and have greater opportunities for personal/professional growth. Creating a vision is the beginning; nurturing the vision is the challenge.

St. Luke's Episcopal Hospital, Houston, Texas

Moss and Bailes (1993) studied the super unit concept at St. Luke's Episcopal Hospital. Super units are described by Moss and Bailes (1993) as "regular patient care units that serve as testing grounds to develop and implement innovative ideas" (p. 1006). Super units focus on innovation, dynamic change, collaboration, and collegiality. Nursing staff on super units are empowered to act and have the support of hospital management.

In the operating room at St. Luke's Episcopal Hospital, the super unit concepts were implemented, resulting in a residency program for new OR nurses and five committees, including policies and procedures, continuous quality improvement

(CQI), education and research, environmental, and perioperative council. In addition, peer performance appraisals, an OR Newsletter, and awards were implemented. The overall change in the perioperative unit was accomplished with commitment from nursing management and the talents and commitment of unit staff (Moss & Bailes, 1993).

Mt. Carmel East Hospital, Columbus, Ohio

According to Skubak et al. (1994), the shared governance model was implemented in the intensive care unit at Mt. Carmel East Hospital, Columbus, Ohio to alleviate problems of high staff turnover and job dissatisfaction. Implementation of shared governance in the Mt. Carmel East Hospital ICU unit included several phases.

First, informal leaders developed a shared governance model, the entire staff was then informed and involved. During in-depth nursing staff education, practice guidelines were presented along with the role and responsibilities of committee members. Four committees were established: staffing and scheduling, quality management, professional development, and recruitment and retention.

According to Skubak et al. (1994) surveys at 18 and 30 months after implementation showed significant support of the shared governance model in the ICU unit at Mt. Carmel East Hospital. In addition, results showed a sense of improved collegiality and participation, enhanced professional growth, and a turnover rate of less than 1 percent. Skubak et al. (1994) concluded that "Shared governance has given our staff a sense of empowerment and control over their own environment and everyone has benefited from the resulting heightened professionalism" (p. 80P).

St. Joseph Mercy Hospital, Ann Arbor, Michigan

According to Edwards, Farrough, Gardner, Harrison, Sherman and Simpson (1994), the change to shared governance at a medical intensive care unit (MICU) at St. Joseph Mercy Hospital was gradual, planned, and structured. Successful implementation was attributed to endorsement by the clinical nurse manager, clinical nurse specialist, and the nursing staff, who accepted the professional challenge offered by shared governance. After a year of planning several elements were in place, including participative leadership, a strong preceptor program, primary nursing care model, a high percentage of baccalaureate nursing staff, and a professional, ambitious staff.

According to Edwards, et al. (1994) the success of the first year was validated by pre- and post-staff satisfaction surveys which indicated a feeling of increasing job autonomy and participation in administrative decision-making. The second year of shared governance was demonstrated by continued commitment of nursing staff to the model and more opportunities for challenges and growth. Staff nurses in the MICU became consultants to other nursing units seeking to implement shared governance on their units.

Vanderbilt University Medical Center, Nashville, Tennessee

When the new orthopedic unit opened at Vanderbilt University Medical Center "the goal for redesign of this unit was to build a fundamentally different care delivery model by analyzing the services required by orthopedic surgery patients and reconfiguring who did the work and how it was accomplished" (Minnen, Berger,

Ames, Dubree, Baker, & Spinella, 1994, p. 35). According to Minnen, Berger, Ames, Dubree, Baker, & Spinella (1994), the desired outcomes of the work redesign were to reduce costs, enhance the quality of care, and increase satisfaction of patients, staff, and physicians.

Work redesign was dynamic, beginning with planning and continuing throughout implementation. A multidisciplinary approach was utilized through planning, training, and implementation phases. The multidisciplinary team members represented laboratory, nursing, physical therapy, occupational therapy, radiology, pharmacy, and physicians. Interest in quality care was a common denominator that reaffirmed the team's commitment (Minnen, Berger, Ames, Dubree, Baker, & Spinella, 1994)

Shared governance was being redesigned at the medical center during the time the orthopedic unit was being implemented. Unit boards were established and "assumed responsibility and accountability for making unit-based changes through the use of consensus decision-making" (Minnen, Berger, Ames, Dubree, Baker, & Spinella, 1994, p. 37). Unit boards were led by staff but did not make all unit decisions. Unit decisions involved communication, coordination, practice standards, service standards, and program development and evaluation. The unit board redefined the manager's role to "enhance(s) a manager's capabilities to use the team's innovations to drive patient care improvement" (Minnen, Berger, Ames, Dubree, Baker, & Spinella, 1994, p. 38).

In this section, the development and implementation of shared governance on

nursing units was explored. It was found that transition and change is a process that requires participation and commitment from unit staff. Committee structures are vital links for communication, decision-making, and empowerment of nursing staff. The next section will examine in more detail the roles of nursing management and staff in shared governance models.

Various Nursing Roles in Shared Governance Models

In shared governance the role of the nurse in the organization is altered, affecting everyone from unit staff nurses through nurse administrators. The changing roles of nursing administrators, nurse managers, and staff nurses in shared governance models has been studied by several researchers.

Nurse Administrators

Professional nursing practice is based on clear definitions of accountability. According to Porter-O'Grady (1987), "Nurse executives are struggling to keep up with the rapid pace of organizational change in health care" (p. 231). Nursing organizations must define service and the value of the service. According to Gardner and Cummings (1994), shared governance is utilized by nursing management, "to build the organization around its service provider and support the relationship between the service provider (nurse) and the client (patient)" (p. 57).

The transformation to shared governance requires a long-term commitment and stable organizational leadership. Porter-O'Grady (1991) explains that "Nursing leadership must commit to it from the outset. The nurse executive must fully invest

in the process and provide continuous support for the change strategies through all their phases" (p. 464). Wilson (1989) states that the "shared governance model requires nursing administrators who are committed, resilient, flexible, open, and creative" (p. 33).

Kerfoot (1991) notes that the implementation of shared governance has been an evolutionary process. The first shared governance models tended to replace the bureaucratic nursing CEO with elitist nursing councils. Creating these councils resulted in little shared governance throughout the nursing department; however, self governance is becoming more widespread as facilities implement self-managed teams at the unit level.

Nurse executives are vital players in the health care environment. Haddon (1989) explains that "Nurse executives are the only health care managers in today's institutions who by generic education have both the technical expertise that keeps us close to the customer and the management and group dynamics expertise with which to enable our staffs" (p. 160).

At St. Joseph's Hospital of Atlanta the nursing administrator plays an essential role in shared governance. According to McDonagh et al. (1989) "The nursing administrative team acts as both nursing advocate and patient advocate in multiple settings within the corporate structure" (p. 21). Nursing administrators interact with hospital administrators, medical staff, and the board of trustees to ensure that an environment exists for crucial nursing decision-making. McDonagh et al. (1989) feel that "without strong nursing administrative support, a shared governance structure

would have a great deal of difficulty surviving within the world of the hospital" (p. 22).

According to McMahon (1992), the implementation of shared governance "challenges the political savvy of the nurse executive" (p. 56), so the nurse executive must be credible. A major role of the nurse executive is managing others' reactions to the innovations of shared governance because the meaning of shared governance varied among health care professionals.

St. Luke's Episcopal Hospital in Houston developed the administrative nurse specialist role to facilitate change and help implement their shared governance model. Houston and Bevelacqua (1991) describe the administrative nurse specialist as someone who is "master's prepared preferably in administration, and has notable experience as a first-line manager" (p. 47). In addition, the administrative nurse specialist must possess strong interpersonal and leadership skills and be able to market expertise and services to nursing managers and their staff. The administrative nurse specialist assumes many roles and functions in the hospital.

According to Houston and Bevelacqua (1991), the administrative nurse specialist serves as a resource person and consultant to staff nurses on their units. The administrative nurse specialist assists staff nurses to become more self-governing by assisting them in developing skills in conflict resolution, group dynamics, and leadership.

At St. Luke's Episcopal Hospital nurse managers found the administrative nurse specialist served to enhance manager/staff relations. The administrative nurse

specialist lended support and facilitated smooth, rapid changes in the organizational culture (Houston & Bevelacqua, 1991).

Totten and Scott (1993) shared their experiences with a Knoxville, Tennessee medical center that took shared governance concepts to the level of nursing administration. The nursing department at Ft. Sanders Regional Medical Center in Knoxville, Tennessee had for many years been organized under a vice president of nursing. During the time that a shared governance model was being implemented at the staff nurse level, the vice president of nursing resigned. The five directors of the patient service areas formed a nursing administrative council with a shared governance format to administer the nursing department while a search was underway for a new vice president (Totten & Scott, 1993).

The directors on the nursing administrative council were committed to the shared governance model. The council expressed concern that a new vice president would not share their commitment to shared governance. The nursing administrative council proposed to the medical center administration a radical plan to rotate the directors through the vice president position on a yearly basis (Totten & Scott, 1993).

Over three months, the directors developed bylaws, guidelines, and job descriptions. The directors proposed three leadership positions: vice president elect, vice president for patient care services, and immediate past vice president. Each director would function one year in each of the vice president roles (Scott & Totten, 1993).

A job description was developed for each vice president position. The

immediate past vice president would provide mentoring and assistance for the vice president. The vice president elect would have a year to prepare for the vice president position. Each director would commit to staying at the medical center until they served in all three vice president positions. According to Totten and Scott (1993), the vice president "would have the total support at the nursing directors level since each would take a turn in the leadership positions resulting in a vested interest in the success of the model" (p. 30).

The success of the vice president rotation model was assessed through a survey which evaluated operations, communication, innovation, and implementation. In addition, a team assessment by the five directors evaluated role satisfaction, team effectiveness, and communication (Scott & Totten, 1993).

Totten and Scott (1993) believed implementing shared governance at the executive level offered tremendous opportunities for professional growth and brought in new insights to the vice president position. Although shared governance at the executive level was an unconventional approach, nursing professionals were challenged to seek and embrace new paradigms. The goal of the directors "was to be preeminent in moving all levels of nursing, including top management, into the shared governance arena" (Scott & Totten, 1993, p. 44). This group of directors believed they have lived a dream "of working in an environment where there is mutual support, respect, trust, honesty, and open communication" (Scott & Totten, 1993, p. 47).

Nurse Managers

The role of the nurse manager has become broader in a shared governance model. Nurse managers have shifted from traditional industrial roles to systems model roles. Historically, the nurse manager has played the role of coordinator, integrator, and facilitator. Porter-O'Grady (1991) examined the role of the nurse manager in shared governance and states that "while the nursing staff, through its various governance structures, builds the system for nursing practice, the manager ensures that the system works. The manager ensures that the activities required by the system unfold as they should and within the expectations provided for them by the nursing organization and its leadership" (p. 696).

According to Porter-O'Grady (1991), a key role of the nursing manager is providing support for practice, including managing finance, resources, staffing, interdepartmental conflicts, and problems with the delivery system. In shared governance, some roles that were the nurse manager's are now the responsibility of the nursing staff.

According to McDonagh et al. (1989), the role of the nursing manager in shared governance must be learned. At St. Joseph's Hospital of Atlanta, "success and satisfaction as a manager in a traditional hierarchial system do not ensure that the adjustment to a professional practice model will occur readily" (McDonagh, Rhodes, Sharkey, & Goodroe 1989, p. 22). The nurse manager assumes a major role in supporting and facilitating the shared governance model.

To succeed in shared governance, nurse managers must function as colleagues

and peers rather than in a maternal or paternal role. Kerfoot (1991) remarks that "Nurse managers must think strategically and leave the tactical thinking to the staff nurse" (p. 121). According to Kerfoot (1991), the best leader is one who helps others to help themselves. Super leaders equip their staff with knowledge and expertise, permitting staff to develop decision autonomy and behavioral control (Kerfoot, 1991). According to Jones et al. (1993), "Shared decision-making does not diminish nurse manager responsibility rather it broadens their responsibility to account for decentralized decision-making at the nursing unit level" (p. 213).

According to Shidler et al. (1989), the change to shared governance models requires a change in attitudes and behaviors for both nursing staff and managers. Nurse managers comfortable with traditional autocratic leadership styles will struggle with permitting and encouraging staff input and empowerment. Nurse managers must improve communication skills and group dynamics.

Professional development is crucial for nurse managers facing a shift to shared governance. At Roseville Hospital in Roseville, California nurse managers attended leadership classes in decision-making, team building, group dynamics, goals and objective development, interviewing skills, budget, and discipline to assist them in developing their role in a shared governance model (Jacoby & Terpstra, 1990).

It is imperative that the shared governance model be understood by the nursing manager and staff. Success at the staff nurse level requires commitment to the concept of professional nursing practice through staff decision-making. The successful nursing manager develops a leadership style so that shared governance is

not viewed "as an erosion of the managers power base or job responsibilities" (McDonagh, Rhodes, Sharkey, & Goodroe, 1989, p. 22). The traditional management roles of directing and controlling are not effective in a shared governance system.

Gillies and Franklin (1988) conducted a pilot study at a large city hospital to identify relationships between the clinical nurse leader's management style and job satisfaction of nursing caregivers. Data were obtained from 43 staff nurses who completed a Leader Behavior Description Questionnaire and Job Evaluation Questionnaire.

Gillies and Franklin (1988) found that caregivers rated their nurse managers as high in role assumption and task structure and low in integration and production emphasis and moderately high in tolerance of freedom and persuasion and lower in showing consideration. Caregivers reported higher satisfaction with professionalism and autonomy than with extrinsic factors of administration and pay (Gillies & Franklin, 1988).

Gillies and Franklin (1988) concluded that "to decrease staff nurse turnover, a manager should diagnose her own management style, measure subordinate's job satisfaction, measure such characteristics of the work situation as leader-member relations, task structure, and leader position power" (p. 44).

Staff Nurses

In shared governance, the role of staff nurses changes as they strive toward more professionalism, autonomous decision-making, and quality nursing care. Wake

(1990) believed that staff nurses in shared governance organizations "need competence not only in clinical decision-making but also in organizational decision-making", (p. 48). However, staff nurses have frequently brought a "history of practice experience in a bureaucratic environment that needed to be changed" (Eckes, Marcouiller, & McNichols, 1989, p. 37). For example, at St. Michael's Hospital staff nurses initially were reluctant to assume the added responsibilities of the shared governance model.

A study by Jones et al. (1993) evaluated the impact of shared governance on staff nurses at Richland Memorial Hospital. Staff nurses were evaluated on "perceptions of management style, group cohesion, job stress, job satisfaction, and anticipated turnover" (p. 208). Jones et al. (1993) concluded that shared governance improves staff nurses decision-making perceptions of their job and practice environment. Additionally, shared governance is effective in increasing involvement in decision-making and fostered professional practice.

In shared governance, nurses in practice define care and the standards that articulate it. Porter-O'Grady (1991) explains "The profession assumes responsibility for the definition of the standard; the individual assumes accountability for practicing within the standard and providing evidence of his or her efficacy or constraint" (p. 697).

According to McDonagh et al. (1989), staff nurses at St. Joseph's Hospital of Atlanta, who participated in decision-making reported beneficial results for both nurses and the health care organization. They concluded that "When staff become

involved in the decision-making process, they are acknowledging their ownership of the system and recognizing that problems are mutually owned. The result is that the atmosphere becomes one of solving problems rather than just identifying them" (McDonagh, Rhodes, Sharkey, & Goodroe, 1989, p. 23).

At St. Michael's Hospital, staff nurses who participated in the shared governance model had increased self-esteem, self-confidence, and job satisfaction, which led to an increased commitment to the health care organization. Eckes, Marcouiller, and McNichols (1989) found that the staff nurses were "developing confidence in their knowledge of nursing practice and...more willing to share their ideas" (p. 39). In addition, nurses were learning to collaborate, negotiate, and bring change.

Shared governance encourages professional development by returning professional practice to the staff nurse. Increased autonomy results in increased accountability which can be overwhelming at times (McDonagh, Rhodes, Sharkey, & Goodroe, 1989). Shared governance not only changes formal lines on the health care organizational chart but "adds the dimension of developing a shared mental model for nurses to prioritize values and develop processes focused on patient care as the core of the department's work," say Gardner and Cummings (1994, p. 59).

According to McDonagh et al. (1989) nurses at St. Joseph's Hospital of Atlanta found that shared governance "facilitates the development of future nurse leaders. Through participation on councils and committees, staff nurses acquire a global perspective of institution-wide problems and concerns" (p. 23). Staff nurses

learned to present ideas, led a group of peers, identify problems, and work to develop alternate solutions.

A study conducted by Howard (1987) sought to answer the question: Does increased responsibility by staff nurses increase professional autonomy? Two hospitals with identical pay scales participated in the study. One hospital had a credentialing system where reward and punishment, raises and promotions were assessed, the other facility did not. Data were collected from 23 nursing staff members (nine at the hospital with credentialing, 14 at the hospital without). Data analysis indicated nurses at the credentialing hospital felt more secure in their jobs, more satisfied with pay, and felt greater autonomy than those at the non-credentialing hospital. Nurses at the hospital without a credentialing system had greater satisfaction with supervision but lower pay and job satisfaction.

Craig (1989) studied the outcomes of shared governance for staff nurses on two nursing units of a public hospital. Craig (1989) identified four themes from the data. First, power was both satisfying and awkward. Second, staff nurses felt they needed more formal education on shared governance concepts. Third, staff nurses felt a leader was not clearly designated within the shared governance model. Finally, staff nurses felt they needed additional compensation for the additional time involved to participate in shared governance.

Ludemann and Brown (1989) conducted a descriptive correlational study in 1983 and 1984 on staff perceptions of shared governance at Rose Medical Center in Denver, Colorado. The purpose of the study "was to evaluate the effectiveness of the

shared governance structure through measurement of staff perceptions before and after the structural change in the organization" (p. 50).

The first survey was administered to the nursing staff one and one half years after the shared governance model was implemented. The second survey was done six months later to determine the reliability of the first survey. Research findings determined a more positive work environment after the implementation of shared governance (Ludemann & Brown, 1989).

Ludemann and Brown (1989) found that attitudes toward the work environment had improved; staff perceived that they now had greater personal power and autonomy, and the climate for innovation and change was improved. Furthermore, they found that commitment to the nursing congress and the hospital organization was influenced by age, years employed at the medical center, position in the organization, education, and employment status.

The implementation of shared governance requires commitment and determination by all nurses in the health care organization. Development and implementation of shared governance affects the way nurses practice and relate to each other and to the organization. The next section of literature review presents research on studies about nursing leadership in baccalaureate nursing programs and proposed changes in nursing curricula and classroom experiences.

The Effect of Leadership and Organizational Structure on Nursing Higher Education

Nursing educators have begun to recognize the value of faculty participation in decision-making. Nursing educators are also beginning to acknowledge the importance of development and implementation of shared governance in their nursing programs. However, limited research is available on the efforts to establish shared governance models in nursing education.

Shared Governance in Baccalaureate Nursing Programs

An analysis was conducted by Dean Chickadonz and Professor Keenan (1986) at the Medical College of Ohio's School of Nursing, to describe the efforts to implement shared governance at their college over a seven-year period. According to Chickadonz and Keenan (1986), "Faculty members must be competent in teaching, scholarship, and service" (p. 434) to effectively participate in shared governance. In addition, faculty must participate in the formation of the institution's goals and commit to their achievement.

The authors outlined the process the college went through to evaluate faculty competence. Faculty members began by setting professional goals that involved teaching, scholarship, service, and nursing practice. Faculty then instituted a peer evaluation system. The final step in faculty development involved setting expectations for autonomy and accountability in teaching (Chickadonz & Keenan, 1986).

A management structure was established in the college by appointing a chair for each department. This decentralized decision-making permitted faculty to handle and solve problems in their areas of expertise. Task forces were established to study problems and propose solutions in keeping with the school's goals. An executive committee was formed from one of the task forces (Chickadonz & Keenan, 1986).

The executive committee at the college developed codes of operation. Finally, the balance of power between faculty and dean was made clearer. The dean and faculty were able to use the shared governance model to create an efficient organization, participate in the university community, and interact more effectively with one another (Chickadonz & Keenan, 1986).

Volden (1989) envisions nursing administration and faculty "listening and talking to each other on issues requiring problem-solving and valuing the wisdom of each individual professional" (p. 17). She calls this process incorporating shared wisdom into shared governance. Sharing wisdom means empowering each faculty member to share knowledge and feel valued.

Curriculum Revolution in Nursing Education

Allen (1990) says that nursing education must be revised to prepare graduate nurses of the 1990s to function as autonomous decision-making professionals. He defines the curriculum revolution as "...an opportunity to step back and critically reflect on the entire educational paradigm underlying the history of nursing education and its current forms" (p. 313).

Nursing educators often align and identify with course content rather than with students. Since health care professionals are often involved with life and death, nursing educators feel morally obligated to create an educational program that educates nursing students and protects patients from unsafe nursing care. Historically, nursing educators have controlled students through a rigid curriculum with elaborate objectives (Allen, 1990).

According to Allen (1990), nursing students have been overwhelmed with information to memorize and are given a small amount of information about many topics. However, a curriculum revolution invites us to consider alternative models and to shift paradigms away from passively depositing information in student receptacles toward approaches that empower students to actively acquire and analyze information. Partnership is another theme for curriculum revisioning in which students are not thought of as "raw material" to be shaped into a "product" but rather as participants who share goals with whom faculty can negotiate (Allen, 1990).

Pitts (1985) discussed overt and covert nursing curricula asking the question, "What does nursing education really teach?" According to Pitts (1985), the overt curriculum in nursing education consists of core skills and techniques and information transmitted through instruction and practice.

Covert curriculum or the subjective experiences of student nurses, is "exempt from consideration and contributes to maintenance of nursing in its subservient state through transmission of a professionalism that differs markedly from the characteristics normally associated with an autonomous profession" (Pitts, 1985, p.

37). According to Pitts (1985), knowledge and skills alone do not make one a professional. Professional roles require interpretation of social interactions and environments.

Pitts (1985) observes that through covert curriculum, values of social service, work ethic, and subordination to power and authority are learned. Nursing students learn that "personal values are of little significance and that professionalism is earned through sacrifice of one's own history and values" (Pitts, 1985, p. 38). If objective reality is considered and subjective experience excluded, nursing students learn that being successful means conforming and adapting to the nursing role held by those with authority and power.

The covert curriculum must be identified and considered as a significant part of the nursing profession's socialization process. The central issue of overt and covert curricula is values. If the nursing professional values shared governance models that profess autonomy, decision-making, and empowerment, these values must be explored and encouraged in nursing education (Pitts, 1985). Bernreuter (1993) concurs that "nursing school curricula may need to be revised to stress concepts that are typically thought of as management concerns" (p. 14).

Shared Governance in Classrooms

Wake, Coleman, and Kneeland (1992) describe their experiences with shared governance in the classroom at Marquette University College of Nursing. They state that "models that promote teacher-student shared responsibility are congruent with the

curriculum revolution in nursing education and the shift to participative decision-making in practice settings" (p. 19).

Wake et al. (1992) say that although student knowledge of shared governance concepts renders some preparation for participation in shared governance in practice it is not enough. Nurses students must also be prepared for shared governance settings with skills in independent decision-making, interdependent relationships, problem-solving, and group activities. A classroom that practices shared governance is one way of learning about empowerment and decision-making (Wake, Coleman, & Kneeland, 1992).

Wake et al. (1992) found that a shared governance classroom differs from a traditional classroom in the following ways:

1. Knowledge was mutually sought rather than teacher defined.
2. Teacher and students were co-learners and collaborate.
3. The major process of learning was inquiry rather than instruction.
4. The educator's role was one of facilitator and coach rather than director.
5. The student role changed from passive to active being co-responsible.
6. Evaluation was determined by peers, self, and teacher instead of only teachers (Wake, Coleman, & Kneeland, 1992).

The authors found shared governance to be an essential element of nursing education and of professional socialization for nursing graduates.

Research shows that the authoritarian environment of nursing schools shapes and reinforces passivity and compliance in graduates. Nursing graduates are not

prepared to work and practice in institutions that have instituted shared governance, which requires active participation, decision-making skills, and professional autonomy. As shared governance increases in health care organizations, it is essential that nursing students experience shared governance as part of their professional socialization.

Studies on Relationships of Deans and Faculty

Several studies have reported on relationships between nursing administrators and faculty. The leadership environment established by nursing administrators can have profound affects on faculty and nursing programs.

Grandjean, Aiken, and Bonjean (1976) examined characteristics of nursing faculty at four major state universities. Data were collected on the importance and satisfaction for 21 characteristics of a nurse faculty position. Each respondent was instructed to rate the importance of each characteristic.

Grandjean et al. (1976) found that the opportunity to be a good teacher ranked number one in importance, along with the opportunity to work with supportive colleagues and keep knowledge current. Professional autonomy ranked second in importance. Faculty members desired a dean who permitted faculty to define their responsibilities and give them a voice in nursing program policy. Data analysis suggested that job characteristics that faculty deemed important were similar in all four universities.

A low level of job satisfaction was noted on the characteristics that ranked

highest in importance. Extrinsic rewards such as pay and fringe benefits ranked in the middle for satisfaction. The least satisfaction was reported with the opportunity to do quality research. Data suggested that improvements in faculty autonomy and decision-making, opportunities for quality teaching, the ability to keep clinical knowledge current, and the provision of time and facilities for research would improve the work satisfaction of nursing faculty (Grandjean, Aiken, & Bonjean, 1976).

A study by Donohue (1986) assessed nursing faculty in selected baccalaureate schools of nursing in a three-state mid-Atlantic area. The author believes that a faculty satisfied "with their work situation should be able to demonstrate a strong commitment to the goals of the school, use their creative abilities to develop a curriculum well based in theory and practice, and create a more positive learning environment within which students learn" (p. 373). In addition, job satisfaction would decrease faculty turnover, provide stability to the school, and increase engagement in scholarly activities.

The purpose of Donohue's study was to examine the relationship of faculty perceptions of organizational climate to their job satisfaction. Donohue (1986) considered the size of the school, faculty members age, academic rank, highest degree earned, length of employment in a full time faculty position, and the number of years in full time teaching.

Donohue (1986) found that deans in private institutions were perceived by faculty to be more aloof and impersonal than deans in public institutions. Deans at

private schools were active, task-oriented leaders who provided close, direct supervision. The researcher also found that in large schools some faculty perceived that they were "merely going through the motions" (p. 377). Some faculty felt that the dean burdened them with bureaucratic detail and treated them impersonally. Faculty at smaller schools perceived more positive socioemotional relations among faculty, higher morale, and more personal treatment by the dean. Donohue (1986) reported that as faculty members length of service increased, job satisfaction, opportunities for promotion and supervision decreased. As the number of teaching years increased, pay increased but promotional opportunities decreased. An environment perceived by faculty to have positive socioemotional relationships was related to their increased overall job satisfaction.

Donohue's (1986) findings demonstrated the relationship between behaviors of the dean and job satisfaction among faculty members. Donohue (1986) concluded that "a dean who is knowledgeable of those elements in his or her situation that are predictors of job satisfaction should recognize the need to keep lines of communication open between himself or herself and faculty and make adjustment in those factors in the environment that have been identified as dissatisfiers by faculty" (p. 378). This has implications for nurses seeking faculty positions in baccalaureate schools of nursing. Potential faculty members should inquire about administrative structure, leadership, communication, and opportunities for promotion.

A study by Lucas (1986) investigated the relationships between the leadership behaviors of nursing deans and various organizational variables. A correlational

survey was utilized for the study. Deans were selected by random sample from NLN accredited baccalaureate nursing programs in the United States. One hundred seventy deans representing 45 states responded. The seven organizational variables measured were faculty expertise, faculty maturity, educational task, nursing program size, institution control, institutional task, and institutional size.

Higher consideration scores were associated with deans who had a higher percentage of faculty prepared at the doctoral level. This may be related to deans having closer identification with faculty having the same educational preparation. Data analysis also revealed statistically significant relationships between initiating structure scores and the variables of faculty expertise, nursing educational task, institutional control, institutional task, and institutional size. Deans with higher initiating scores had more doctoral prepared nursing faculty in larger doctoral granting public institutions (Lucas, 1986).

According to Lucas (1986), a major limitation of this study was that data were based on the dean's self-perceptions. Perceptions of faculty on their dean's leadership characteristics may have provided different data. Lucas (1986) concluded from her research that "organizational characteristics should be included in leadership studies of nursing deans in higher education" (p. 54).

A study by Frank (1986) explored the relationship between formal organizational structure and the dean's job satisfaction. Two hundred fifty two deans of baccalaureate and higher degree nursing programs participated in this study. Data were collected by asking participants to respond to a questionnaire measuring

security, social esteem, autonomy, self actualization, and job satisfaction. Another questionnaire measured formal organizational structures.

Results demonstrated that deans appeared overall satisfied with their jobs. A positive relationship existed between the number of undergraduates and self actualization needs satisfaction and the number of faculty and autonomy needs satisfaction. The number and types of nursing degrees were also related to overall job satisfaction. Deans who functioned in an autonomous school had higher autonomy needs satisfaction scores (Frank, 1986).

Kennerly (1989) conducted a descriptive correlational study to examine the relationships among administrative leadership behaviors, organizational characteristics, and faculty job satisfaction in baccalaureate nursing programs of private liberal arts colleges. The research population included deans/chairs and nursing faculty. Data were collected using a mailed two-part questionnaire. The questionnaire included faculty members' rating of perceived leadership behaviors of the dean/chair and their rating of their own job satisfaction.

Kennerly (1989) found that organizational characteristics such as size of faculty, number of students, pay, tenure, and structure of positions have varying degrees of influence on perceptions of faculty's work environments. Faculty indicated a high level of satisfaction with their jobs even in the absence of significant correlation with pay, structure, and tenure. Kennerly (1989) concluded that faculty do not perceive these variables as substantial factors influencing their work environments. Since faculty have few opportunities for advancement and low

salaries, the researcher concluded that "faculty must look to other organizational and leadership factors as a stimulus for faculty job satisfaction, and thus, individual development and productivity" (p. 202). According to Kennerly (1989), leadership behaviors of the dean are clearly predictive factors in the development of nurse faculty job satisfaction.

Limited research and publications are available relating directly to the administrative and academic practices of shared governance in nursing education. Studies on leadership in nursing programs, however, illustrate the impact on leadership by the chief nursing administrator.

This literature review has presented and examined many aspects of the styles, characteristics, and dimensions of leadership. Research on concepts of shared governance relating to health care organizations and the nursing profession was presented and investigated. Research describing the development and implementation of shared governance in various hospitals and medical centers has demonstrated the complexity of shared governance as it affects nursing administrators, nurse managers, and staff nurses. Finally, research on leadership and organizational structures in nursing education was examined, including an example of the development and implementation of shared governance in a BSN program. In addition, aspects of nursing curricula were explored and studies on the relationships of deans and faculty in BSN programs were examined.

CHAPTER III

METHODS AND PROCEDURES

Introduction

The purpose of this study was to describe the administrative and educational practices of shared governance in baccalaureate nursing programs in the state of Tennessee. Quantitative and qualitative research methods were utilized to collect data on practices of shared governance in baccalaureate nursing programs.

The first two sections of this chapter delineate methodological issues and sources of data collection. Section Three explains techniques for data collection, including rationale for and development of a demographic data instrument, survey instrument, and an interview guide and explanation of data collection strategies. The final section of this chapter presents techniques for analysis of quantitative and qualitative data.

Methodological Issues

This study utilized descriptive methodology. A descriptive study determines and reports on the way things are. A researcher who uses descriptive methodologies measures what already exists. Gay (1987) explains: "Descriptive research involves

collecting data in order to test hypotheses or to answer questions concerning the current status of the subject of the study" (p. 189). Descriptive research involves assessing attitudes, perceptions, and beliefs toward individuals, events, and organizations. A major challenge of descriptive research is to select or develop accurate data collection instruments (Gay, 1987).

Quantitative and qualitative data were collected to answer research questions concerning the status of shared governance in nursing education. More specifically, data were obtained to describe the practices of shared governance leadership in baccalaureate nursing programs in the state of Tennessee and to identify the skills and experiences that graduate nurses need to function in health care organizations that practice shared governance.

Differences exist between quantitative and qualitative methods. McCracken (1988) defines these differences as "two different sets of intellectual habits and frames of mind" (p. 19). Quantitative and qualitative methods are not substitutes for one another because "they observe different realities, or different aspects of the same reality" (McCracken, 1988, p. 19).

Theoretical Framework

The five disciplines of a learning organization, as presented by Senge (1990), were the guiding philosophy for this study. Researchers working within this frame of reference believe that how individuals think and interact affect the way organizations work.

According to Senge (1990), by changing individuals' thinking processes, embedded policies and practices are changed. The shared governance model of leadership is a radical departure from traditional autocratic bureaucracies. Thus, it is important to assess what members of organizations think about various leadership concepts relating to a shared governance model of leadership in organizations. If leaders can change how individuals interact, they can promote vision and understanding.

Redesign of both organizational structures and mental models are required to create innovative learning organizations. The major challenges to organizational change are sustaining efforts and profound cultural shifts.

Evidence of Senge's theory was represented in the design of the research instruments which examined and analyzed quantitative and qualitative data. The Leadership Survey instrument identified leadership variables related to mental models, shared vision, and team learning demonstrated by nursing administrators, faculty, and students. The interview instrument identified organizational processes, individual interaction, and personal mastery as they related to shared governance concepts of group decision-making, communication, and professional autonomy.

The framework and theoretical perspective of learning developed by Gardner (1991) also guided the study design. With the guidance of cognitive science, Gardner (1991) determined three characteristics of the learner: intuitive, scholastic, and "disciplinary expert". Gardner postulated that the third characteristic, the "disciplinary expert is an individual of any age who has mastered the concepts and

skills of a discipline or domain and can apply such knowledge appropriately in new situations" (p. 7). According to Gardner (1991), the purpose of professional programs is to educate students to be "disciplinary experts" in their professions.

The sources of data for this study were professional nursing administrators and faculty; nursing students were not included. These "disciplinary experts" identified leadership concepts and skills associated with shared governance models of leadership. Additionally, shared governance concepts implemented in classroom and clinical areas were explored to identify how nursing students learn about this style of leadership.

Sources of Data

All fifty states have nursing programs. Since the researcher lives in the state of Tennessee, nursing programs in the state were chosen for the study. In the state of Tennessee three different levels of undergraduate programs are approved by the Tennessee Board of Nursing: two-year associate degree programs, three-year diploma programs, and four-year baccalaureate programs.

The researcher chose to study only approved four-year baccalaureate programs. She desired to study nursing programs involved with the professional development of the nursing student rather than the more technical preparation of associate and diploma programs. Fourteen baccalaureate nursing programs are approved in the state of Tennessee and are represented in East, Middle, and West Tennessee.

Permission to conduct the research was initially received from the dean or director of eight nursing schools. Demographic data instruments and Leadership Surveys were mailed to 167 potential participants. Data were collected from both nursing administrators and faculty members so that contrasts and comparisons could be made between the groups.

All nursing schools participating in the study had participants willing to be interviewed and 34 participants returned interview forms. Potential interview participants at each nursing school ranged from one to eight.

Interviews were conducted at five out of the eight nursing schools that participated in this study. No interviews were scheduled at West Tennessee nursing schools due to travel distance and time constraints of the study.

Twenty-five potential interview participants were identified at nursing schools located in Middle and East Tennessee. The researcher made one visit to each nursing school between 100 to 225 miles from her home. As many interviews were prearranged as participants' schedules permitted.

Techniques for Data Collection

Rationale for Data Instruments

Quantitative research methods were utilized to gather initial data about all participants. Surveys were mailed and were therefore less expensive than qualitative methods of data collection, which involved travel for face-to-face interactions. Use of

quantitative data "defines relationships and parameters in a most valuable way that helps define what must be explored with direct observation and interviewing and, conversely, makes possible the extension of generalizations initially derived idiographically" (Spindler & Spindler, 1985, p. 157).

Qualitative research methods were utilized in this study to gain further insight into the administrative and educational practices of shared governance in nursing education in the state of Tennessee. Qualitative research methods enabled the researcher to describe and delineate patterns of leadership behavior rather than merely quantify them and added another dimension for understanding perceptions and practices. Qualitative research is expensive and time consuming; therefore, smaller sample sizes were utilized. Qualitative research is an inductive process and Taylor and Bogdan (1984) described this type of research as: "Researchers develop concepts, insights, and understanding from patterns in the data, rather than collecting data to assess preconceived models, hypothesis, or theories" (p. 5).

Qualitative researchers attempt to understand individuals from their own frame of reference. Taylor and Bogdan (1984) remark: "Central to the phenomenological perspective and hence qualitative research, is experiencing reality as others experience it. Qualitative researchers empathize and identify with the people they study in order to understand how they see things" (p. 6). An interviewer must first build rapport with the respondent (Whyte, 1980).

The research instrument in qualitative research is the researcher. LeCompte (1987) wrote on the bias and subjectivity of the human researcher: "Identifying the

sources of bias and subjectivity in the researcher's own make-up is critical to the quality of the work done" (p. 43). Qualitative researchers, consequently, must be aware of their own beliefs, values, and perspectives in order to have a "clearer" view of the things happening and include observation of and sensitivity to research participants. The relationship between the researcher and participant is more complex in qualitative research (McCracken, 1988).

In comparing qualitative and quantitative research, Taylor and Bogdan (1984) state: "Whereas qualitative researchers emphasize validity, quantitative researchers emphasize reliability and replicability in research" (p. 7). Qualitative and quantitative methodologies lend themselves to different techniques, presentations, and divergent assumptions. Firestone (1987) remarks "They are not antithetical" for "they present the reader with different kinds of information and can be used to triangulate to gain greater confidence in one's conclusions" (p. 16). Quantitative research strives to answer research questions through objective measurement and analysis. Qualitative research is "more concerned with understanding the social phenomenon from the actors perspectives," states Firestone (1987, p. 17).

Separately, quantitative and qualitative data collection methods provided different kinds of information. Quantitative data in the form of a survey provided objective data by asking participants to read a statement then select an answer from a series of responses. Thus quantitative data could be efficiently and objectively analyzed on a large scale.

Qualitative data in the form of semi-structured face-to-face interviews provided

in-depth responses of participants' perceptions, beliefs, and practices relating to questions guiding the research. However, when quantitative and qualitative data strive to answer the same research questions, they triangulate and attach stability and validity to findings (Firestone, 1987).

Development of Quantitative Data Instruments

Three instruments were developed for data collection. Demographic data were collected on age, sex, race, initial nursing education, highest degree held, academic rank, administrative title, years in present position, tenure, and employment status. Demographic data provided valuable information on the profile of the participants and were useful for comparison of groups. A copy of the Demographic Data Instrument can be found in Appendix C.

A Leadership Survey instrument was developed from a review of literature about leadership dimensions and characteristics. The purpose of the survey instrument was to collect quantitative data to identify leadership variables relating to the shared governance model of leadership as demonstrated by administrators, faculty, and nursing students in a baccalaureate nursing program.

Part One of the Leadership Survey instrument consisted of a series of 48 statements that summarized functions and responsibilities of various members of a nursing education program. Part Two of the Leadership Survey listed five statements, each followed by an open-ended question. The purpose of Part Two was to identify what nursing students learned and experienced relating to the shared governance

model of leadership in classroom and clinical areas. A copy of the Leadership Survey can be found in Appendix D.

Before demographic and leadership surveys were distributed, they were reviewed by a panel of ten experts. Experts included nursing administrators at a nursing program and medical centers and several nurse educators. Changes were made based on reviewers' comments and suggestions.

Development of an Interview Guide

An interview schedule was designed to assess participants' perceptions and practices of shared governance. Interviews have unique advantages and disadvantages for the researcher. Data collected from a personal interview can yield in-depth information. Gay (1987) remarks: "By establishing rapport and a trusting relationship, the interviewer can often obtain data that subjects would not give on a questionnaire" (p. 203). Interview responses may be more accurate and honest since the interviewer can explain and clarify the purpose of the research or follow up on incomplete or unclear responses.

Interviews also had limitations because they were time-consuming and expensive, resulting in smaller sample sizes. Gay (1987) stated another disadvantage as: "The responses given by a subject may be biased and affected by her or his reaction to the interviewer, either positive or negative" (p. 203).

Interview questions were based on information delineated from dimensions of leadership and concepts of shared governance described in the literature review.

Research questions guiding the study were also utilized to design interview questions. A semi-structured interview technique was used. The interview questions were submitted to the researcher's dissertation committee and a panel of experts for comments and suggestions. The same panel of experts that reviewed quantitative data instruments, reviewed interview questions. A revision of interview questions were made based on comments and suggestions received from the dissertation committee and panel of experts.

The interview instrument was then field tested by interviewing a nursing administrator and nursing educator. Field testing determined the effectiveness of providing appropriate responses, determined the length of time needed for the interview, suggested additional questions, or eliminated questions from the interview guide.

The Interview Guide

The interview guide was designed to answer the following research questions:

1. What practices of shared governance are being implemented by nursing administrators and faculty in approved baccalaureate nursing programs in the state of Tennessee?
2. What practices of shared governance are being implemented by nursing faculty in classrooms?
3. What practices of shared governance are being implemented by nursing faculty in clinical areas?

4. What educational experiences do nursing students need to prepare them to function as graduates employed in shared governance organizations?

The interview guide comprised the following questions; the purpose and intent for each question is provided.

Question 1: *How long have you been in your present position?*

Question 2: *What do you like most about nursing education?*

These questions were intended as warm-up questions. In addition, the interview began on a positive note by asking what participants liked most about nursing education.

Question 3: *How would you describe the nursing leadership practiced at your nursing school?*

This question was intended to get participants thinking about the broad topic of leadership. This question further provided the researcher with an indication of the organizational environment of the school.

Question 4: *Explain the organizational structure of your nursing school and reflect on your role in that structure.*

This question addresses two issues. First, participants were asked to think about and delineate the organizational structure of their nursing school. Second, this question gave participants the opportunity to address issues regarding their role in the organizational structure. Role identification, furthermore, assisted the researcher in comparing responses of nursing administrators and faculty, some of whom held administrative responsibilities.

Question 5: *Describe typical decision-making processes at your nursing school.*

Question five gave participants an opportunity to discuss and explain vital processes in an organization. Furthermore, decision-making processes are a key component of shared governance models.

Question 6: *What is your role in the decision-making process?*

This question was intended to provide another opportunity for participants to reflect on aspects of decision-making, this time by examining their personal roles in the process.

Question 7: *How satisfied are you with your decision-making role in your nursing school? Explain.*

This question asked participants to evaluate their role in decision-making and then give a rationale for their evaluation.

Question 8: *Describe how information is communicated at your nursing school between administration, faculty, and students.*

This question provided participants the opportunity to consider another essential organizational process. Communication patterns are another crucial process in shared governance models and require participation of all members of a nursing program.

Question 9: *Describe your understanding of the term "professional autonomy".*

Question nine was asked to give participants the opportunity to discuss a primary goal of the shared governance model for the nursing profession.

Question 10: *To what extent do you believe you have professional autonomy in*

your position at this nursing school? Explain.

This question encouraged participants to further consider the concept of professional autonomy on a personal level. Professional autonomy is a critical element of the shared governance model.

Question 11: *Describe your understanding of the term "shared governance".*

Previous interview questions have delineated important components of the shared governance model. This question was intended to discover participants' knowledge and understanding of shared governance.

Question 12: *Describe specific applications of shared governance practiced at your nursing school.*

The purpose of this question was to determine if perceptions about shared governance were implemented into action.

Question 13: *What specific practices of shared governance would you like to see implemented at your nursing school? Why?*

This question gave participants the opportunity to share their aspirations and goals for their nursing program. In addition, this question provided further insight into participants' understanding of shared governance by asking them to reflect on changes needed to move toward shared governance practices.

Question 14: *What educational experiences do nursing students need in classroom and clinical areas to prepare them to function as graduates employed in shared governance organizations?*

This question encouraged participants to reflect on what nursing students need to

experience to prepare them to function in shared governance organizations. This is important because medical centers and hospitals are increasingly developing and implementing the shared governance leadership model. A copy of the Interview Guide can be found in Appendix E.

Data Collection Strategies

The Tennessee Board of Nursing was contacted by phone and furnished the researcher with a list of approved baccalaureate nursing programs in the state of Tennessee. A letter of intent was sent to the dean or director of all approved baccalaureate programs in the state of Tennessee. This letter described the purpose of the research and data collection strategies, and requested written permission to send quantitative data collection instruments to all nursing administrators and faculty at their school. A copy of the letter sent to the dean or director can be found in Appendix A.

After permission was received for participation, a letter of intent presenting an overview of the research project was mailed to nursing administrators and faculty. Included with the letter were two data collection instruments with a stamped, addressed envelope for return. There were no identifiers on these instruments, so anonymity was maintained. The first instrument collected general demographic data. The second, the Leadership Survey, had two parts. Part One listed statements with Likert scale responses. Part Two listed a few statements with Likert scale responses then asked participants to respond to a few open-ended questions, enabling

participants to provide more detailed responses. A copy of the letter sent to nursing administrators and faculty regarding survey data can be found in Appendix A.

Anonymity was maintained during quantitative data collection. In order to collect qualitative data, participants were asked at the end of the quantitative instrument if they would be willing to be interviewed. Participants willing to be interviewed were asked to provide their name and the name of their school so an interview time could be arranged. A stamped, addressed envelope was provided for separate return of this page so anonymity of quantitative data collection instruments were maintained.

Thirty-four survey participants expressed interest in participating in the interview phase of the study. The nine potential interview participants in West Tennessee nursing schools were excluded due to travel distance and time constraints of the research project. The 25 participants willing to be interviewed at nursing schools in Middle and East Tennessee were contacted by phone or letter in an attempt to arrange an interview time. Most participants were contacted several times by phone before an interview time was arranged, and 18 interviews were scheduled. A confirmation letter with a copy of the consent form for audiotaping was mailed to each participant. A copy of the letter sent to nursing administrators and faculty regarding interview data and the consent form for audiotaping can be found in Appendix B.

Interviews were conducted at schools of nursing or clinical sites where participants were affiliated. Participants were required to sign a written consent to be

audiotaped. The consent form stated the purpose of the study, reasons for audiotaping, and guarantee of confidentiality. Participants were reassured that audiotapes did not have any identifiers such as date, place, or time. Audiotapes would be the property of the researcher only and would be erased after transcription. Each interview lasted approximately 30 minutes and all 18 participants agreed to be audiotaped.

Utilization of a tape recorder had many advantages. It eliminated the tendency of the interviewer to favor data. Data was played over again to be studied more thoroughly. Furthermore, the interviewer listened more intently when a tape recorder was recording the data. Non-verbal behaviors such as physical movements, gestures, and facial expressions were noted by the researcher when listening rather than writing (Whyte, 1980). A good interviewer, Whyte (1980) believes "must reflect upon what is being said, ask ourselves what each statement means and how best to encourage the informant to clarify a point or give detail on an item only hinted at" (p. 114).

Audiotaping had disadvantages because participants were not anonymous, since researcher and participants were face-to-face and participants' voices being recorded. The researcher likewise knew where participants were employed. Participants and researcher had never meet before and participants may feel uneasy and not trust that confidentiality will be maintained.

Techniques for Data Analysis

Three data instruments required analysis: the Demographic Data Instrument, the Leadership Survey, and the Interview Guide. Each item of demographic data was analyzed for frequency distribution. Commonalities and differences were tabulated and presented in graph format.

The Leadership Survey Instrument was analyzed using frequency distribution and Chi square. Chi square enabled the researcher "to compare a set of observed frequencies with a set of theoretical frequencies" (Ferguson, 1981, p. 199). The observed frequencies were empirically obtained by having participants answer a Leadership Survey Instrument. A series of statements was followed by a Likert scale requiring participants to circle an answer based on their perceptions. Theoretical frequencies were based on speculation independent of the observed data. The researcher determined whether the differences between the observed and theoretical frequencies were significant (Ferguson, 1981).

Ammon-Gaberson and Piantanida (1988) say that "Clearly conceptualized and articulated research questions provide an essential structure for guiding (qualitative) data analysis and interpretation" (p. 159). A primary function of qualitative analysis is searching for patterns. According to Spradley (1980), analysis refers "to the systematic examination of something to determine its parts, the relationship among parts, and their relationships to the whole" (p. 85).

Content analysis was utilized for analysis of written answers to open-ended

questions in Part Two of the Leadership Survey and for qualitative data collected from transcribed audiotaped interviews. Content analysis, as defined by Weber (1990), "classifies textual material reducing it to more relevant, manageable bits of data" (p. 5). Content analysis enables the researcher to make "replicable and valid inferences from data to their context" states Krippendorff (1980, p. 21). According to Holsti (1969), content analysis is a multipurpose research method. He further states, "Content analysis was developed specifically for investigating any problem in which the content of communication serves as the basis of inference" (p. 2). Inferences are made by objectively and systematically identifying specific characteristics of messages. The primary purpose of content analysis is to take the words of the text and classify them into content (Weber, 1990). Holsti (1969) believed that "content analysis should use qualitative and quantitative methods to supplement each other" (p. 11).

Content analysis was a multi step process and was guided by the study's purpose and research questions. The following steps were outlined by Waltz, Strickland, and Lenz (1984, p. 258-261).

Step 1. *Define the universe of content to be examined.* The content to be examined included all written answers to Part Two of the Leadership Survey and transcribed audiotaped interview data.

Step 2. *Identify the characteristics or concepts to be measured.* The concepts to be measured from transcribed written answers to Part Two of the Leadership Survey included leadership models and shared governance concepts and experiences in

classroom and clinical areas. The concepts to be measured from transcribed audiotapes were leadership styles, organizational structures, decision-making, communication, professional autonomy, shared governance, and educational experiences for nursing students. Subject matter categories were most frequently used. (Holsti, 1969).

Step 3. *Select the unit of analysis to be employed.* The primary unit of analysis used in this research was themes. Themes were assertions about some subject or sentences or propositions (Holsti, 1969; Waltz, Strickland, & Lenz, 1984).

Step 4. *Develop a sampling plan.* Sampling included all written answers to open-ended questions from Part Two of the Leadership Survey and transcribed responses to audiotaped interview questions.

Step 5. *Develop a scheme for categorizing the content.* Content was categorized inductively. Inductive reasoning summarizes a series of observations so that the observations form a pattern. Categories were used to group material and describe objectively the contents of the written answers and transcribed audiotaped interviews (Budd & Thorp, 1963).

Step 6. *Develop explicit coding and scoring instructions.* Transcriptions were coded and scored more than once by the researcher. According to Weber (1990), coding involves the following: define the recording unit, define categories, test coding on sample text, code all written answers and transcribed texts, and assess for accuracy and reliability.

Step 7. *Establish an acceptable level of reliability.* Some duplication of

effects was essential. Multiple coders permit quantitative assessment of reliability (Weber, 1990). Krippendorff (1980) defines the reliability procedure as "yielding the same results from the same set of phenomena" (p. 129). Krippendorff (1980) adds that the ultimate aim of testing reliability, "is to establish whether data obtained in the course of research can provide a trustworthy basis for drawing inferences, making recommendations, supporting decisions, or accepting something as fact" (p. 146). Due to the confidential nature of interview data, the researcher was the only one who completed steps for content analysis.

Step 8. *Perform the analysis.* The final step in the data collection process was performing the analysis on data which was coded according to previous steps.

This chapter outlined the methods and procedures for data collection and presented rationale for utilization of quantitative and qualitative data. Development of three data collection instruments which included instruments to collect demographic data, a Leadership Survey, and an Interview Guide, was explained. Strategies for data collection provided a step-by-step examination of the procedures utilized for data collection. The chapter concluded with a discussion of most frequently used techniques for data analysis.

CHAPTER IV

ANALYSIS AND PRESENTATION OF DATA

Introduction

This study was designed to determine the administrative and educational practices of shared governance in baccalaureate nursing programs in the state of Tennessee by collecting data from quantitative and qualitative sources. Eighty-nine (53%) faculty and nursing administrators representing eight nursing schools participated in the study. Participants completed a demographic data sheet and Leadership Survey. The Leadership Survey was developed from a review of literature on leadership dimensions and characteristics.

At the end of the Leadership Survey, participants were asked if they would be willing to be personally interviewed. Thirty-four participants expressed willingness to be interviewed and 18 (53%) nursing administrators and faculty representing five of the eight schools were interviewed. All participants were willing to be audiotaped during the interview and consent forms for audiotaping were signed before interviews began. Three participants during the interview wanted reassurance that confidentiality would be maintained before they shared examples. The interview guide was developed from the literature and guided by the research questions.

Several interview participants remarked about the ease of answering interview

questions and all participants readily gave answers with minimal probing needed. Participants who felt they had minimal knowledge of shared governance expressed concerns about being able to answer interview questions appropriately. All participants were reassured that there were no right or wrong answers and they were requested only to share their perceptions and opinions in responding to the issues presented to the interview questions.

Presentation of data will include responses from four data sources: the Demographic Data Instrument, the Leadership Survey with Likert statements and open-ended questions, and the Interview Guide. A computer program was used to analyze the Demographic Data Instrument and the Likert statement responses from the Leadership Survey. Content analysis was utilized for analysis of open-ended questions and interview responses. Triangulation of data was possible because several sources of data were analyzed. All data entered into the computer were verified twice for accuracy by the researcher and another person familiar with the project. A few entry errors were detected and corrected.

Demographic Profiles

Survey Participants

Each participant completed a demographic data sheet. Eighty-nine (53%) demographic data sheets were returned, with 87 participants answering all demographic items. Two participants did not answer the item asking their sex but

answered other items.

The first demographic item asked participants their age according to groupings on the profile. Half of the participants were in the 41-45 (29.2%) or 51-55 (21.3%) age groups. The youngest participant was in the 26-30 age group and the oldest was more than 65. Refer to Figure 1 for distribution of age groups.

The second item of demographic data asked the sex of participants. Two participants did not answer this item. Of the participants who answered this item, 81 (91%) were female and six (6.7%) were males.

Race was the third item included in the demographic profile. The majority of participants were Caucasian (94.4%). Other participants included three African Americans (3.4%), one Native American (1.1%) and one Asian (1.1%).

Forty-seven (52.8%) participants received their initial nursing education from baccalaureate nursing programs. Diploma nursing programs represented the next highest initial nursing education level, with 23 (25.8%) participants. Refer to Figure 2 for distribution of initial nursing education.

The highest degree held by the majority of participants (52.8%) was a Master of Science Degree in Nursing. Doctor of Philosophy degrees in fields other than nursing represented the next highest group of participants, with thirteen (14.6%). Doctoral degrees represented by Ed.D., D.S.N., and Ph.D. in nursing and other fields cumulatively represented 36 (40.4%) participants. Refer to Figure 3 for distribution of highest degree held.

The majority of participants were represented by two academic categories.

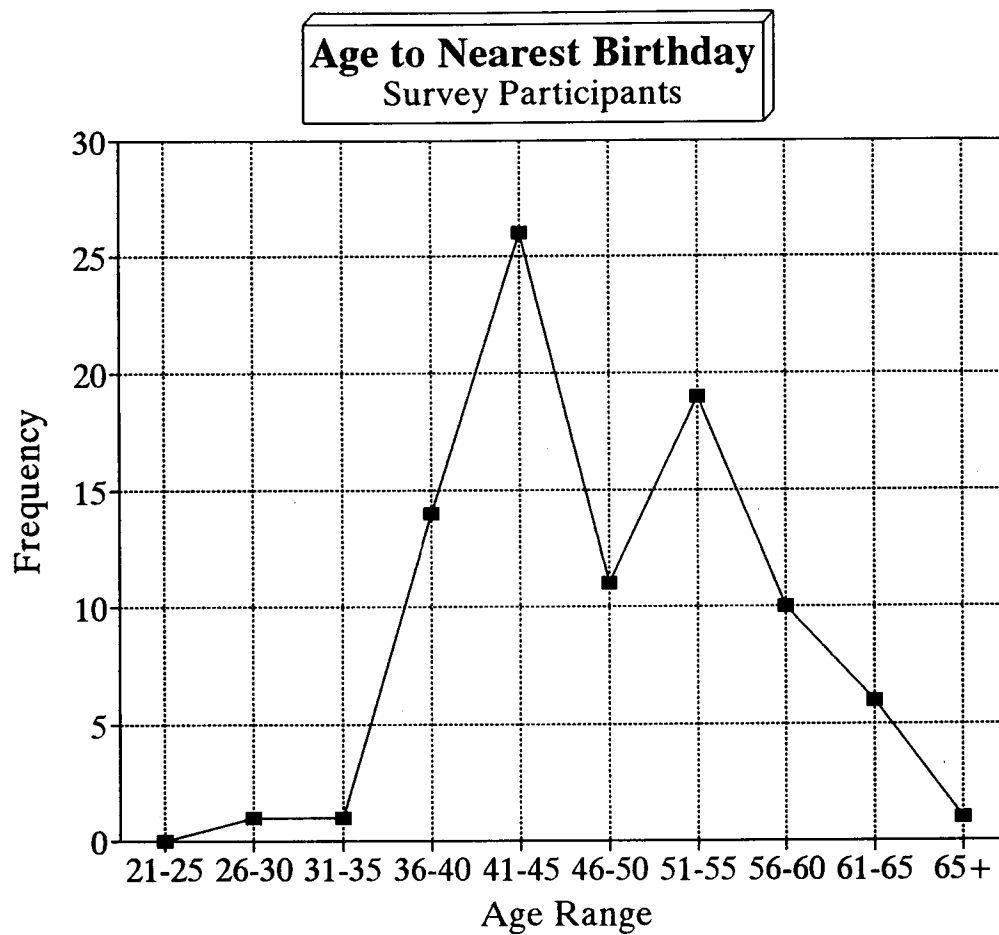


FIGURE 1. Age to Nearest Birthday - Survey Participants.

Graph of age to nearest birthday showing frequency of age ranges for survey participants.

Initial Nursing Education Survey Participants

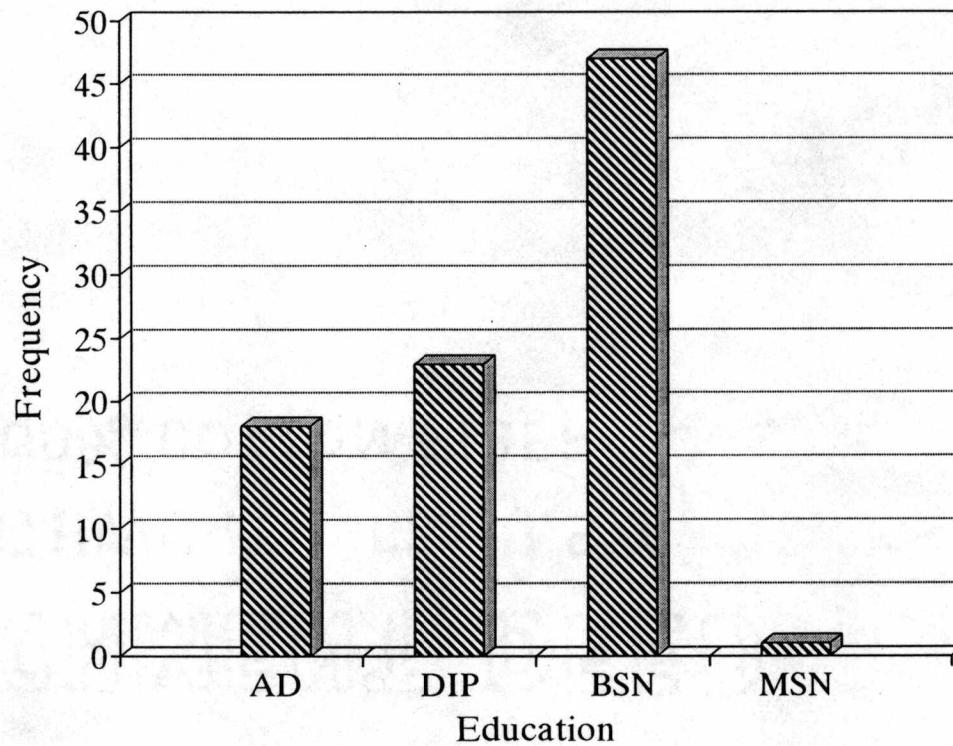


FIGURE 2. Initial Nursing Education - Survey Participants.

Bar graph portraying frequency of survey participants' initial nursing education represented by Associate Degree in Nursing (AD), Diploma (DIP), Baccalaureate Degree in Nursing (BSN), and Master of Science Degree in Nursing (MSN).

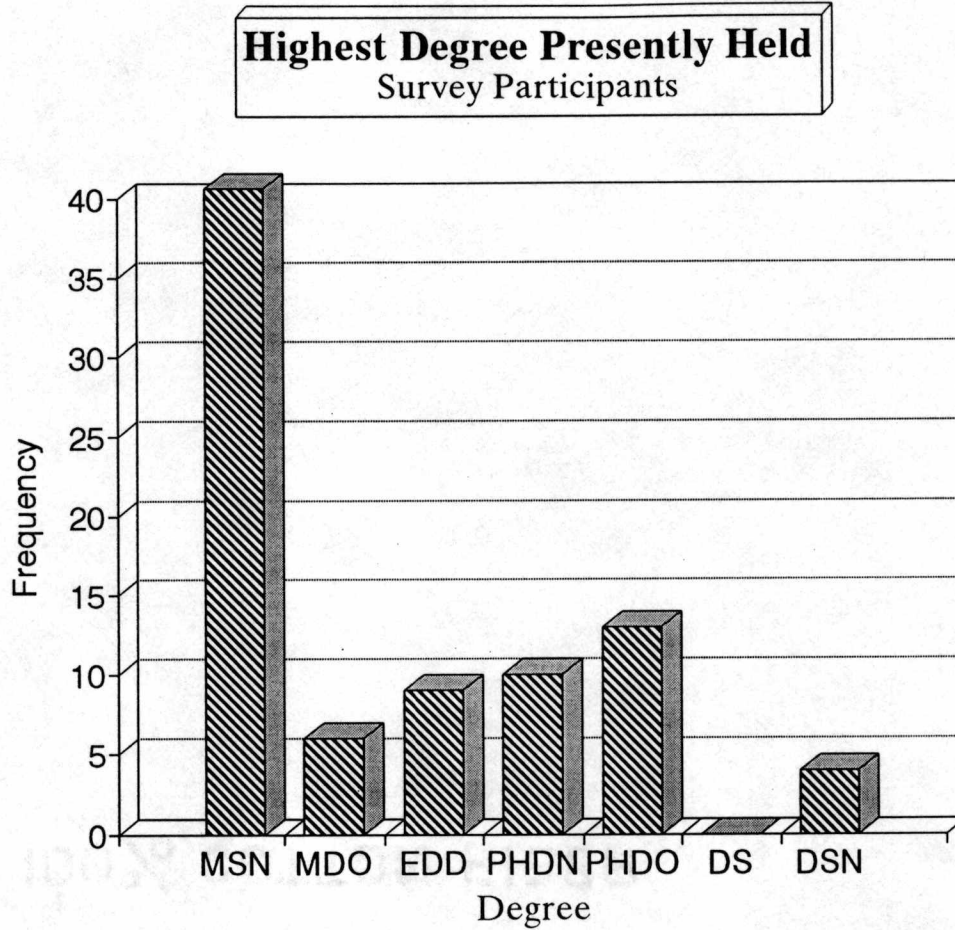


FIGURE 3. Highest Degree Presently Held - Survey

Participants. Bar graph illustrating frequency of survey participants' highest degree presently held: Master's degree in Nursing (MSN), Master's Degree in other field (MDO), Ed.D. (EDD), Ph.D. in Nursing (PHDN), Ph.D. in other field (PHDO), Doctor of Science (DS), and Doctor of Science in Nursing (DSN).

Forty-one (46.1 %) participants were assistant professors and 24 (27 %) were associate professors. A small number, eight participants (15.7 %) had the title clinical instructor or instructor. Refer to Figure 4 for distribution of participants by academic rank.

The majority of participants (78) did not hold administrative titles. Four (4.5 %) participants had the title of dean. Two (2.2 %) participants held the title director and two (2.2 %) participants were associate deans. The remaining two (2.2 %) participants held the administrative title of department chair.

Twenty-five (28.1 %) participants had been employed two to three years in their present positions. Fifty-five (61.9 %) of the participants had been employed one through five years. All categories of years employed were represented by at least one participant. Refer to Figure 5 for distribution of survey participants according to years employed in present position.

Three categories of tenure status were identified: tenured, not having tenure, or on tenure track. Each category was represented by at least 31 % of the participants. Refer to Figure 6 for distribution of participants according to tenure status. The final category on the demographic data sheet was employment status. The majority of participants were employed full time, representing 85 (95.5 %) participants.

The majority of survey participants were in the 41-45 or 51-55 age group, and were female, Caucasian, BSN graduates whose highest degree was a Master of Science Degree in Nursing. In addition, the majority of participants were employed

Academic Rank Survey Participants

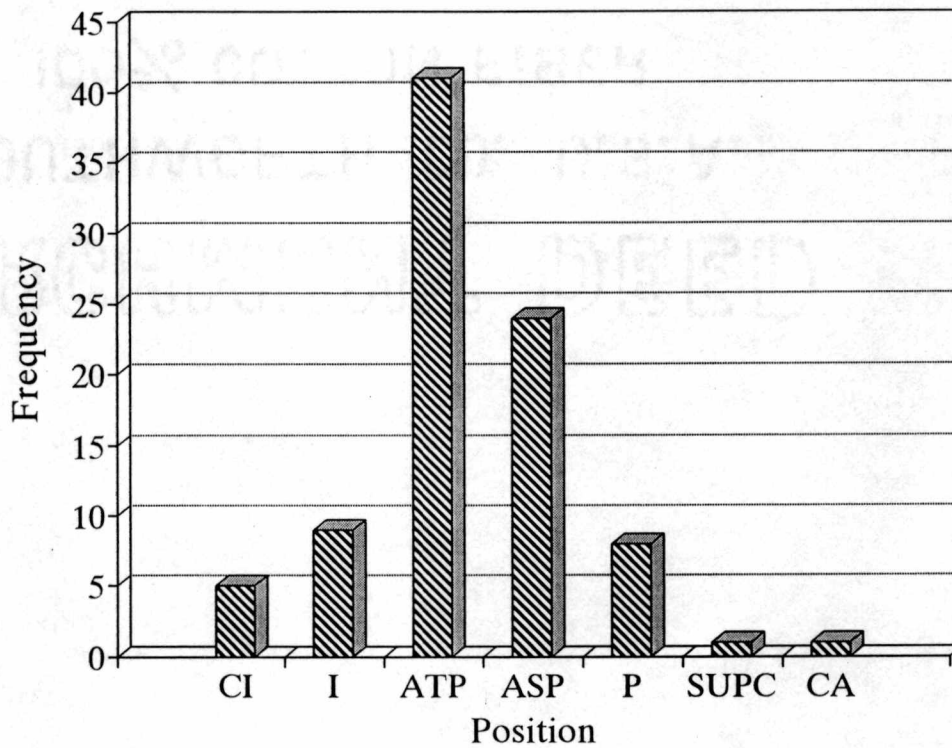


FIGURE 4. Academic Rank - Survey Participants. Bar graph portraying frequency of survey participants' academic rank represented by Clinical Instructor (CI), Instructor (I), Assistant Professor (ATP), Associate Professor (ASP), Professor (P), Supervising Clinician (SUPC), and Clinical Associate (CA).

Years Employed in Present Position Survey Participants

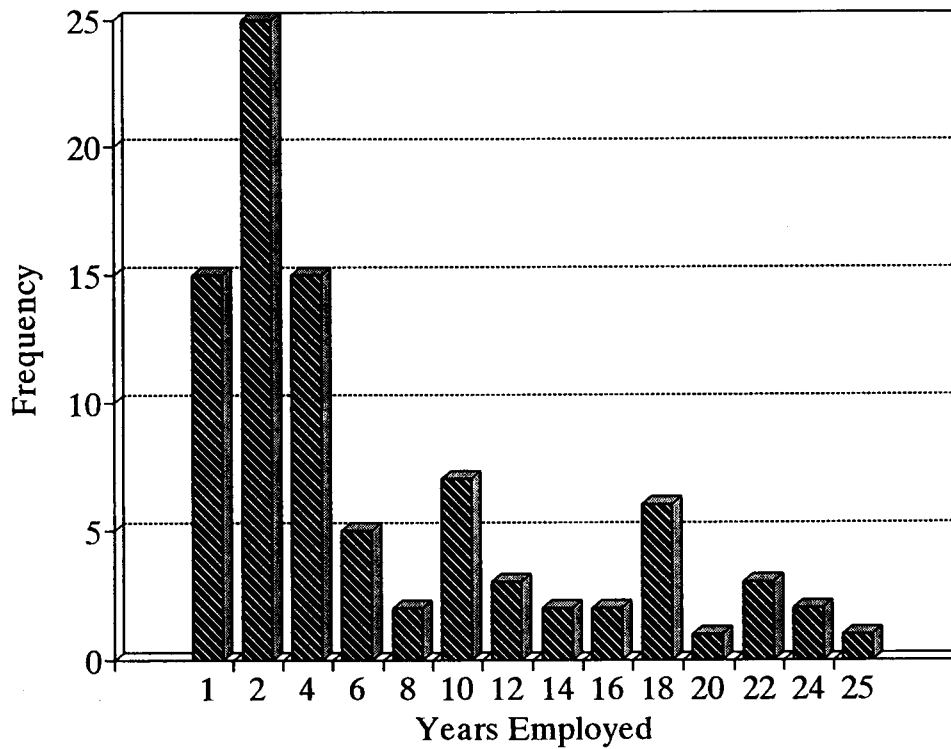


FIGURE 5. Years Employed in Present Position - Survey Participants. Bar graph showing frequency of survey participants' years employed in present position, including present year.

Tenure Status
Survey Participants

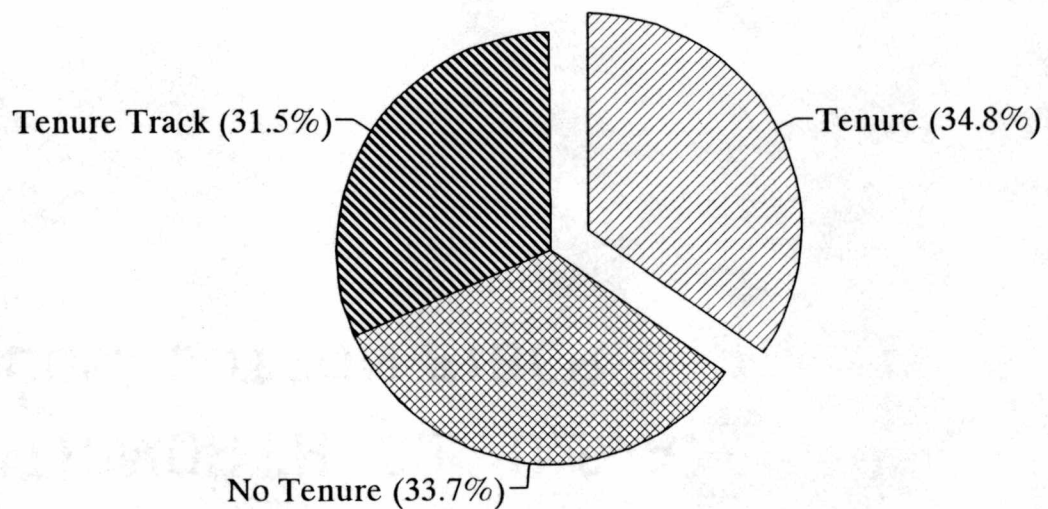


FIGURE 6. Tenure Status - Survey Participants. Pie chart depicting frequency of tenure status for survey participants.

full time as assistant professors but did not hold administrative titles.

Interview Participants

Eighteen participants representing five of the eight nursing schools participated in the interview phase of the study. Seventeen (94.4%) participants were female and one participant was male.

In the first interview question, participants were asked how long they had been in their present position. The number of years employed was tabulated utilizing the groupings from the Demographic Data Instrument. The largest number of participants (38.9%) had been employed two to three years. This was the first year teaching at their nursing school for four (22.2%) participants. Refer to Figure 7 for distribution of interview participants according to years employed in present position.

In the second interview question, participants were asked what they like most about nursing education. Three major themes emerged from content analysis of responses to this question. They were interaction with and growth of nursing students, role diversity with flexibility, and professional learning.

Contact with nursing students emerged as the primary theme. Faculty to student contact involved student interactions and learning experiences. A new faculty member shared her experiences with nursing students and commented:

I love the students. I enjoy helping the students to process and develop thinking skills. And I enjoy listening to their perspectives. And I enjoy being able to have both the clinical component to my life and the classroom component. I would not want to give up either one.

Role diversity with flexibility was another emerging theme. Several

Years Employed in Present Position Interview Participants

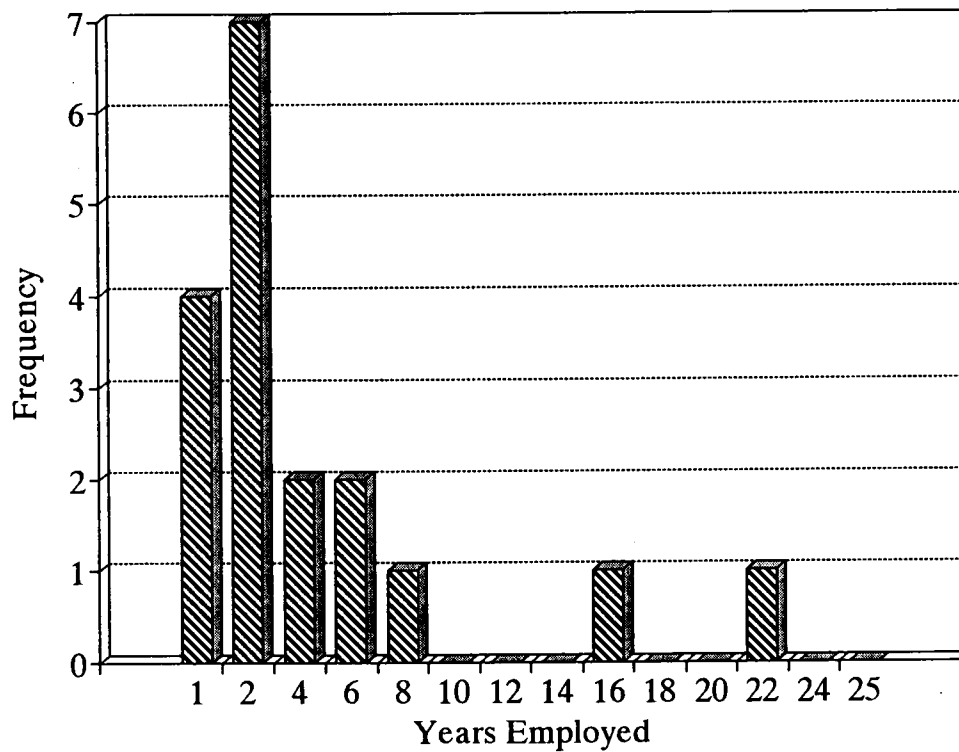


FIGURE 7. Years Employed in Present Position - Interview Participants. Bar graph illustrating frequency of interview participants' years employed in present position, including present year.

participants shared the diversity of roles presented by education, practice, and research. "Flexibility" was defined by participants as having non-rigid schedules and having time off in summer months and during holidays. A faculty member shared her experiences with role diversity:

The diversity of roles. I spent a lot of time...I continued my nursing roles before like being a clinician and a patient educator and then I get to be an educator of students one on one and to share their experiences. Their initial experiences in nursing.

A committee chair shared her love of role diversity and stated:

In an instant I can be talking with people from the sciences, history, the arts. I can in one minute be teaching, the next minute be practicing as a manager in a setting. I can be practicing as a leader among the rest of the faculty. I can be at tiny committee meetings. I can be doing research. I can be doing service. And they all relate to my job and I can have fun with everyone of them.

Professional learning of faculty in their various roles was the third emerging theme. Nursing educators were constantly challenged by students to display their expertise. A faculty member shared this about her learning:

I like the fact that its always new. It's never the same cause every new class of students brings a whole different dimension to it and they are always asking questions that I don't have the answers for and that keeps me on my toes.

The fourth interview question asked participants to explain the organizational structure of their nursing school and their role in that structure. Demographic data were obtained from participant responses to the second part of the question regarding organizational roles. Two (11.1%) participants held the administrative title of director of their nursing programs. Eight (44.4%) participants held faculty positions without any additional titles. Six participants (33.3%) were course coordinators. One

participant was a nursing site leader and another was chairman of the curriculum committee. Refer to Figure 8 for frequency distribution of organizational roles.

Based on the analysis of responses to interview questions one, two, and four, the majority of interview participants were female and had been employed two to three years in their position as a faculty member or course coordinator. The majority of participants appreciated nursing education because of interaction with nursing students and role diversity.

Shared Governance in Schools of Nursing

This section presents data related to research question one: *What practices of shared governance are being implemented by nursing administrators and faculty in approved baccalaureate nursing programs in the state of Tennessee?* Two major areas of an organization were examined. Organizational structure and processes in a nursing school were explored first, followed by shared governance practices and principles. Finally, the roles of the chief nursing administrator, faculty, and nursing students were identified and discussed.

Relating to Nursing Schools

Interview questions three through eight identified and discussed leadership characteristics and organizational processes in schools of nursing. Participants were asked about the leadership practices and organizational structures of their schools and

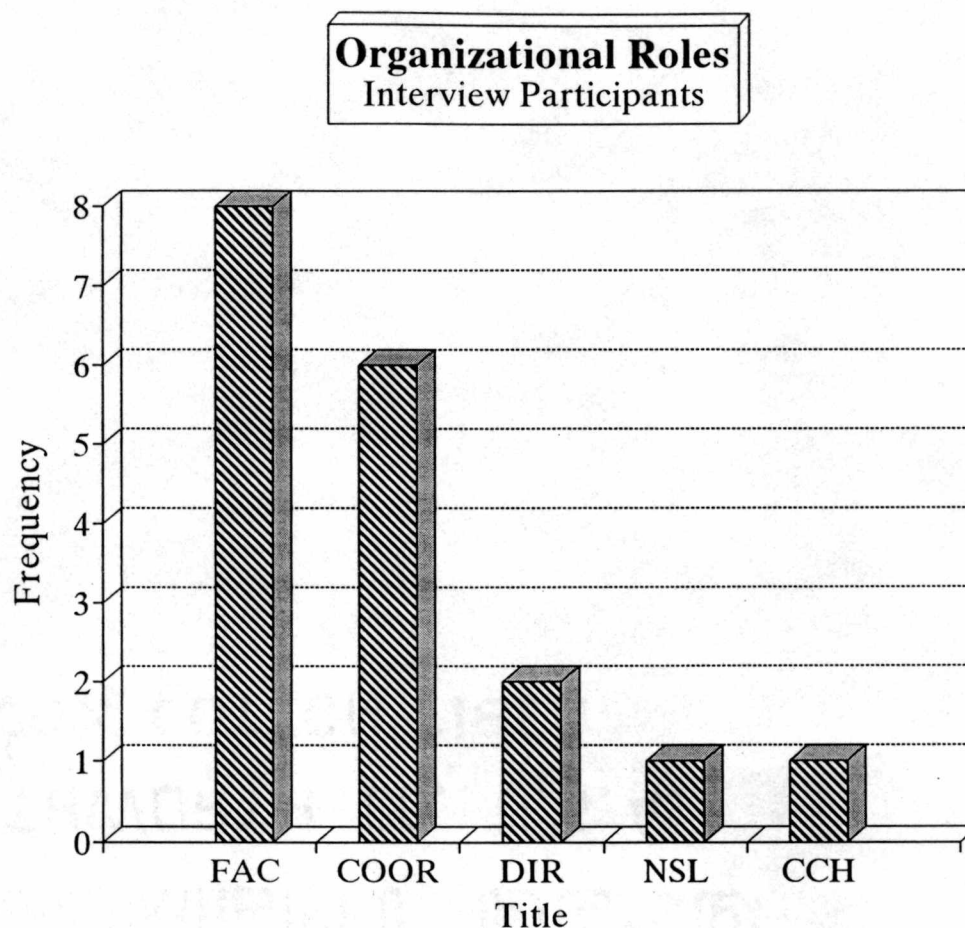


FIGURE 8. Organizational Roles - Interview Participants. Bar graph depicting organizational roles of interview participants: Faculty (FAC), Course Coordinators (COOR), Directors (DIR), Nursing Site Leader (NSL), and Committee Chair (CCH).

their role in that structure. Their answers gave insights into the leadership environment of their schools.

Organizational Leadership and Structure

Interview question three asked participants to describe the nursing leadership practiced at their schools. Each nursing school had a minimum of three interview participants. Participants from the same school of nursing often described their nursing leadership from different perspectives. Examples of different leadership styles follow.

Both directors described their leadership style as participative. One director described her leadership as:

I see myself as a democratic leader, as a facilitator, as a visionary working to get the faculty to buy into the vision and make them happen and they do.

Two faculty members from different nursing schools described their nursing leaders as micro managers. One of the faculty members described leadership behavior at her nursing school this way:

It has a tendency to be micro management. In other words people are given responsibility to do, that whether it be, as an individual faculty or as part of a committee. However, even though the responsibility is delegated to this individual or the committee, the administrator has a hands-on approach to everything.

Another faculty member characterized her nursing leadership as "hidden". She explained:

We have a lot of people not necessarily in administrative positions who exert a great deal of leadership.

Several faculty members from other schools described their nursing leadership

as democratic, participative, and decentralized. A new faculty member shared her perceptions of democratic leadership:

The nursing leadership practices are democratic and I would consider it shared governance. Everybody has an important role in the school and we all have certain expectations in terms of meeting deadlines, producing information for meetings, sharing in decisions.

Participation does not necessarily occur throughout the organization but may be more characteristic at the faculty level of the program. A new faculty member was most impressed with her department and commented:

I have found that personally the leadership in the department of adult nursing is fabulous...I've sensed a tremendous amount of support, encouragement, and assistance when I've needed it.

A faculty member chairing a major committee characterized nursing leadership in her program as "hands-off". She remarked:

I'd say its essentially hands-off, let people do their jobs, get out of their way. Then participate in what they want to do and then get out of their way and let them do it.

The first part of interview question four examined the organizational structure of the nursing schools. Interview participants came from five nursing programs. All programs were state institutions and influenced by the Tennessee Board of Regents. Three nursing programs had a multi-layered organization with a dean or director, followed by associate deans, program chairs, directors or coordinators of programs, and then course coordinators and faculty. The remaining nursing schools had fewer layers in their organizational structure with a director, program coordinators, and course coordinators. A director described the organizational structure of her nursing

program as "flat" and stated:

Flat organization. One person, the director, then the rest are all faculty. I do have coordinators at the junior level and there's one at senior level. And there's one person who's responsible for the RN BSN program. So the coordinators are more liaison links to me so that I can get a message to the teams.

Participants shared a variety of perceptions regarding leadership styles of nursing administrators in their schools of nursing. Organizational structure, however, was reported in a similar manner by all interview participants from a particular school of nursing.

Organizational Processes

The next four interview questions (5,6,7,8) identified organizational processes involved with decision-making and communication. Organizational processes are a critical dimension of leadership and it is essential that these processes be examined and discussed.

In interview question five, participants were asked to describe typical decision-making processes at their nursing school. Committees, task forces, and course level meetings were the primary means for decision-making. The overwhelming majority of participants discussed committee structures and meetings as the primary formal methods of decision-making.

A director described the committee work at her school as:

Most all, most everything that comes to faculty organization is... to be recommended by a committee...If there's any changes in the objectives in any course the level people make the decision. That's recommended to the curriculum committee. So everyone is involved in the decision-making at the local level.

Numerous committee meetings were the norm for many faculty as they shared the number of meetings they attended. One faculty member felt "an enormous amount of redundancy" in the number of committee meetings she attended. Many participants believed meetings were the main decision-making structure. A new faculty member shared her views on committees and commented:

Typically decisions are made in committee fashion. We spend a long time forming committees and having committees address specific issues. And then making their recommendations to the faculty and then the faculty vote, approve, or reject these recommendations. Then sometimes committees are dissolved. We have a lot of committees that just gather to make a single decision, then their work is done.

Use of task force groups was the second major theme that emerged. Task forces usually were instituted to manage special concerns and after research and recommendations on issues were made, the task forces were dissolved. A nursing site leader stated this about the task force structure:

And lots of things are done by task force that comes back with recommendations either to a standing committee like curriculum or to faculty as a whole.

A third theme was the importance of decision-making at the course level. Most faculty teach with others in courses facilitated by course coordinators. This faculty member explained:

Well as it gets down the chain...it's an easier working relationship. And I really enjoy a very positive relationship with a woman who's my immediate supervisor, who's the course coordinator and director of the undergraduate program.

Participants were asked to explain their decision-making role in interview question six. The majority of faculty believed that the primary role of decision-

making, was voicing their opinions and giving input on issues. Faculty members who held their positions one to two years were more reserved about sharing in the decision-making process. A new faculty member stated the following:

As a new faculty member I'm somewhat, I guess more of a listener right now than an active participant. I try to listen to other people and understand what the dynamics of past decisions were. Because I know that influences greatly here because they have a history here. I haven't lived that history so I have to kind of understand what the history is and why decisions are made. But usually once I understand that and also from my experience as a nurse educator...I will give my input at that point.

Another new faculty member concurred:

Oh, I think I have a very small role in decision-making. I mean I feel like I have the opportunity to voice my opinion and it generally is considered but I don't feel like I have. I don't have more. I don't have a greater authority in decision-making then my...you know, percentage.

The seventh interview question asked participants about their satisfaction with decision-making. Most faculty members were satisfied; however, their degree of satisfaction varied. Newer faculty had some reservations about their level of satisfaction. These faculty presumed their satisfaction level would increase with time.

A new faculty member shared this:

I'm not terribly satisfied, but again I'm not sure if it isn't because that I'm new or if it's in fact faculty don't have that much say. I know we're talking about changing the curriculum. And I do anticipate being very involved if that happens. I think that to a certain extent new faculty have to be pretty assertive to get in on the issues.

Another new faculty member was very satisfied with her decision-making role and commented:

Extremely satisfied. I can influence. I can have the opportunity to

influence any decision that gets made by the College of Nursing. You can't ask for more than that.

Communication is a vital organizational process and interview question eight asked participants to describe how information is communicated between individuals at their nursing schools. Two major vehicles of communication between administration and faculty emerged. Memos and meetings were the most common forms of dispensing information. A new faculty member had this to say about memos:

Memos, paper, a lot of memos. I mean I'm memoed to death. I mean all the trees that die for the memos on my desk...I'm not sure how we could do it differently. I think that the goal is for everyone to internet and be on E-Mail.

E-Mail was utilized by faculty and administrators if available. Only one school had all office computers on the E-Mail System. Another school had part of their offices on E-Mail, others relied on memos. A faculty member shared the advantages and disadvantages of using E-Mail and remarked:

E-Mail is probably the main way and that's good and bad. I mean you get quick information but you can't see the smile or you can't hear...they take offense to it. And like you know that was a joke. They missed the innuendo in it. But it certainly that's I mean an easy way to communicate. The main way things are communicated around here. And I think inappropriately in terms of like job assignments.

Newsletters, written policies, and bylaws were other means of formal communication. All nursing schools had some form of formal written communication. Two schools had regularly published newsletters. Informal communication was also a vital means of communication between faculty. Faculty frequently met in offices to discuss issues and solve problems.

Determination of communication with students was based on nursing administrators' and faculty perceptions since nursing students were not participants in this study. Communication with students was primarily through the use of bulletin boards at each school. One school of nursing had bulletin boards for each class and each course. Student nurses associations were also important means of communication and information. Class officers played an essential role as well. One director shared this about the vital role played by interaction with class officers.

We did have a situation with our students last fall where an entire class was very unhappy with what was going on. They had a good class president who had them write out their problems and needs and a group that he organized went through and looked at those and then presented them to me. That's really was as far as it went because they felt that they had been heard.

Four nursing schools had student representatives on faculty committees or subcommittees and their input was solicited. A faculty member shared the following about student involvement on faculty committees. She stated:

And we have students sitting on most of our school of nursing committees. So there's student representation and they really enjoy that.

A committee chair commented on student involvement at her school.

We have students on all of our committees, curriculum and student affairs and all those committees. And since we have associate degree, baccalaureate, and graduate students we have all three levels represented on committees. So I think that's real important.

The principal methods of decision-making reported by interview participants were committees and task forces groups. Most participants perceived their decision-making roles as giving input on issues. New faculty members were more reserved on

sharing opinions but believed their role would change with time. Although most participants were satisfied with their decision-making roles, the degree of satisfaction varied from somewhat satisfied to very satisfied. Communication of information was primarily achieved through memos and meetings between nursing administration and faculty. Nursing students utilized information on bulletin boards as their chief means of receiving information but in some schools of nursing were also involved as student representatives on faculty committees.

Relating to Shared Governance

This section presents data related to research question one on the practices of shared governance in nursing schools. Several interview questions relating to shared governance were asked of participants. Interview questions nine and ten asked participants to define professional autonomy and assess the degree of professional autonomy in their roles. Interview questions 11 through 13 asked participants to define shared governance and give specific practices of shared governance in their school of nursing.

Professional Autonomy

Each interview participant was asked to describe what the term "professional autonomy" meant to them. Independence, accountability, and empowerment were three major themes that emerged from content analysis. A major theme expressed by participants was independence. A variety of definitions for professional autonomy

follows. A faculty member defined professional autonomy as:

It means that you're intelligent. You're capable of making independent decisions. You're capable of interacting with other professionals who make independent decisions.

A new faculty member shared her definition as:

Professional autonomy means I have the education, the experience and I'm empowered to make decisions in certain areas with out permission of my supervisor.

A second theme was accountability. When professionals function as "disciplinary experts" they must be accountable. A director of a nursing program stated:

That means that I have responsibility and accountability as a professional for all of my behavior and to facilitate professionalism for the program, to be an exemplar of professionalism with students and faculty, to be actively involved professionally in the organizations and legislatively, and to uphold the Nurses Code of Ethics.

Decision-making through empowerment emerged as the third theme. As "disciplinary experts", professional nurses make many decisions. Professional autonomy means being empowered to make decisions independently. A faculty member, a course coordinator, remarked:

Professional autonomy to me is giving. It's a trust that I have the skills, the experience, and needed decision-making abilities to function in whatever role I'm in without a lot of bureaucracy.

A new faculty member concurred:

Professional autonomy to me means that I am able to do what I need to do to fulfill my professional role without getting hassled. That to me is autonomy. If I feel I need to change the direction of a research project or if I need to take a time out or if I need to make comments which I feel are part of the professional development for myself in my role I can do it without having to check with fifteen people.

Interview participants were then asked if they had professional autonomy in their roles. Both directors agreed that they had professional autonomy and were respected by university administrators. One director stated the expectations of the University President:

He really expects me to be responsible over here and to take care of the problems that arise and not take him problems. Take him solutions and so I really try to do that.

The majority of participants believed they had some degree of professional autonomy in their roles. Some participants believed professional autonomy was more common in their clinical practice roles with nursing students. Other participants concluded that they had professional autonomy in both classroom and clinical roles. Many interview participants had very positive experiences to share. A faculty member described professional autonomy in her role as a nurse educator.

I think that as an educator I can conduct my class using creative experiential learning techniques if I choose, using standard lecture if I choose. My assignments are never second guessed in the clinical. I don't have to show them to anybody else. My students and I are able to negotiate. So I feel comfortable in it.

Another faculty member found he had a lot of professional autonomy when he redesigned a course during his first year on the faculty. He shared the following:

And so I designed the course the way I thought the course should be and it changed the culture of what the previous course was.

Professional autonomy was defined as having the independence and power to make decisions and be accountable for decisions made. Participants assumed various roles in the organization of a nursing school and most participants believed they had professional autonomy in some of their roles.

Shared Governance

Three interview questions (11,12,13) asked participants about the status of shared governance at their nursing school. Interview question 11 asked participants to describe their understanding of the term "shared governance". Input in decision-making, multidirectional interactions, and partnership were major themes that emerged.

A majority of participants reported that decentralized decision-making was a vital component of shared governance, and it emerged as a major theme. A selection of shared governance definitions that express the first theme follows.

A new faculty member who helped implement and develop shared governance on a nursing unit in another state described shared governance this way:

Shared governance to me is a philosophy of government, in other words a philosophy about decision-making where the persons who are most involved, who have the most stake in the outcome of that decision are the ones who are very involved in researching and input for that decision.

Another faculty member stated the following:

My understanding of it is that everybody has a voice, so to speak. An everybody contributes and everybody benefits out of the decision-making process.

A new faculty member shared this definition.

Shared governance to me would be that I have not only the right expressing my opinion and having my opinion weighed, considered, and just not listened to but have to be listened to. And also I have the responsibility then to be prepared, and do the background for the decision that I make. So that my decisions are respected...

A course coordinator talked about why shared governance fails in spite of

decentralized decision-making. She stated:

To me, shared governance is when the group that is participating, you define the group, participates in decision-making and helps to carry it out which many times is where shared governance fails. And that's the faculty's fault-they are willing to make decisions but not willing to put forth the effort to carry out those decisions.

Another emerging theme was multidirectional interaction between members of the organization. Autocratic bureaucratic organizations are unidirectional, with decisions going from the top down. However, shared governance models, advocate interaction in many directions. A committee chair explained her views:

But shared governance just means to me a very participatory governing system where things go up and down. It's really not an up and down. It's kind of a vague up and down you know it's there but as much goes up as comes down. And goes across and that brings responsibility.

Another faculty member concurred:

I think of shared governance as being very team oriented. I think of it as being each player has a responsibility to the organization and has the responsibility into the success or failure of the team in achieving the goals.

Partnership and ownership in an organization were other emerging themes.

A faculty member explained the meaning of partnership this way:

It means a partnership in a sense in that there is equal opportunity as well as equal responsibility in making sure that decisions are made that everyone. If the governance is shared, then people have the opportunity to express their views vote on the issue or topic whatever it is and also by doing that would also take ownership of the responsibility in those decisions.

Shared governance was defined by participants as decentralized decision-making flowing in many directions. In addition, shared governance gave participants the opportunity to have a voice, but required responsibility and accountability in

implementation of decisions. Sharing governance in an organization fostered a feeling of ownership.

Interview question twelve asked participants to describe specific applications of shared governance. The majority of application examples related to being a part of the decision-making process. A faculty member shared a college's work on the philosophy and mission statement for their nursing program. By the time the process was over she believed:

I think shared governance was very evident in our work on the philosophy and missions statement...It was not an identical group from which people could come. But by the time it was over every single faculty person had participated in that process.

A course coordinator shared the process her school went through with curriculum changes to reduce deficits discovered in students' NLN test scores through an enrichment program developed and implemented by faculty. The process included:

And we as a group formed a committee to define what needed to be done to enrich those areas. It was taken to the faculty organization; they gave input. We corrected those things. We voted on this as a whole. We were united. Everybody felt good about it. We started an enrichment program for students who did poorly on the ... And faculty were committed to serve as advisors to students. That was done as a group. It was not part of a job description but we wanted the students to do the best that they could. That's shared governance.

Faculty members believed shared governance concepts were frequently utilized with decision-making in groups of faculty who team teach. A faculty member explained:

I think we have shared governance when it comes to clinical decision-making. We have shared governance in all our academic areas where the team meets and makes the decision. As what is in the best interest of the student. What is the best approach to a certain problem. How the faculty can best meet the needs of the students in the time frame and what is required of us to do this.

A course coordinator stressed the importance of formal and informal decision-making and sharing and he believed this should occur between administration and faculty. A new faculty member believed shared governance was evident in the curriculum committee at her school of nursing, where all faculty are members of the curriculum committee. She shared the following:

I mean informally what happens is the faculty go along with what their (committee members) recommendations are to the faculty, and essentially the faculty go along with what their recommendations are. So really they have more informal power than they have formal power. Informally you have that power and that power is distributed to committees and that's a shared power.

Applications of shared governance occurred in situations where participants had an active role in decision-making. Decisions were made throughout various levels in the school of nursing organization. The majority of participants believed they had an active decision-making role at the course level but not always within upper levels of administration.

Interview question 13 asked participants to share specific practices of shared governance they would like to see implemented. It was readily noted that both directors of nursing schools and some faculty members felt shared governance was in place and offered no suggestions. Others, however, had differing points of view on this issue and a faculty member shared this view:

And in other words committees should be appointed by faculty, selected by faculty. The curriculum belongs to the faculty. Those kinds of things that whereas administrators really take a less heavy handed role.

A course coordinator believed that although shared governance is in place in

her nursing program, more work needs to be done. She stated:

If anything what we're having problems with is educating some of the faculty and administrators to what it is. What the values are. As far as when it's working here it works very, very well. But a lot of people do not see the value in shared governance and there lies the problem and a lot of that I think is because they don't...It's complicated and it requires work and some people would rather be told what to do and do it and not be part of the decision-making because it's easy.

Another faculty member believed shared governance was in place in the lower levels of the organization but believed program directors were not empowered and should be involved in hiring, firing, and faculty job assignments. Another faculty member would like to see nursing administrators relinquish authority and develop trust in faculty. She commented:

If a committee or an individual is given responsibility to do a task. I would like to see that they're left alone to do that task. And not having someone hover over them to make sure. In other words if you feel I'm responsible enough to do it or a committee is a responsible enough body to do it. Let us do it.

Decision-making roles and professional autonomy influenced participants' responses to what practices of shared governance they would like to see implemented. The remaining sections under leadership characteristics and concepts address the roles of the chief nursing administrator, faculty, and nursing students. This section answers research question one on practices of shared governance in nursing schools.

Relating to the Dean/Chair

The first twelve statements of the Leadership Survey asked participants to evaluate leadership behaviors of the Dean/Chair of their nursing programs.

Participants were asked to evaluate each statement by circling one choice ranking from "strongly agree" to "strongly disagree" with the statement. The "strongly agree" and "agree" categories suggest implementation of shared governance leadership behaviors.

The majority of participants agreed or strongly agreed with the statement that the Dean/Chair delegates authority. The statement that the Dean/Chair empowers faculty to make decisions also received a majority of responses in the "agree" or "strongly agree" categories.

Statement three related to the Dean/Chair empowering nursing students to make decisions. While the most frequent response was agreement, 20 participants were "undecided". The next two statements assessed communication of the Dean/Chair with faculty and nursing students. Both statements received a majority of responses in "agree" or "strongly agree" categories.

Statements six and seven related to the Dean/Chair sharing governance with faculty and nursing students. Again, the majority of responses were in the "agree" or "strongly agree" categories. Statement eight evaluated the extent to which faculty were encouraged by the Dean/Chair to make decisions. The majority of participants responded in the "agree" or "strongly agree" categories. Statements nine and ten concerned the level of trust between Dean/Chair and faculty and nursing students. The majority of responses continued to be in the "agree" or "strongly agree" categories.

The final two statements concerning the Dean/Chair were unrelated to each

other. Statement eleven assessed management of conflict by interaction and resolution, with the majority of responses being in the "agree" or "strongly agree" categories. The final statement dealt with the Dean/Chair promoting attendance at professional meetings and conferences. The majority of participants responded "agree" or "strongly agree". Table 1 summarizes participants' responses regarding the Dean/Chair.

An analysis of statements relating to leadership behaviors of the Dean/Chair in various leadership roles were reported in "agree" or "strongly agree" categories. The "agree" and "strongly agree" categories reflected shared governance leadership behaviors by the Dean/Chair. The following behaviors of the Dean/Chair were evaluated: delegation of authority, empowering others, communication, need to share in governance, decision-making, trust, accountability, and conflict management.

A Chi Square Test was completed for each statement. Expected frequencies for each statement were 17.8 (20%). Differences existed between observed and expected frequencies. Chi Square results for four degrees of freedom were greater than 13.28 for .01 statistical significance and greater than 18.46 for .001 statistical significance. "The Dean/Chair delegates authority" received the highest Chi Square value of 94.91. Table 2 summarizes the Chi Square results for Dean/Chair statements.

Relating to Faculty

Twenty-two statements related to the leadership behaviors of faculty. Eight

TABLE 1. PARTICIPANTS' RESPONSES REGARDING DEAN/CHAIR

Leadership Variables Dean/Chair	%SA	%A	%U	%D	%SD
1. The Dean/Chair delegates authority. *	33.7	53.9	3.4	4.5	3.4
2. The Dean/Chair empowers faculty to make decisions.	33.7	47.2	9.0	4.5	5.6
3. The Dean/Chair empowers nursing students to make decisions.	14.6	47.2	22.5	13.5	2.2
4. The Dean/Chair communicates clearly with faculty.	28.1	48.3	10.1	7.9	5.6
5. The Dean/Chair communicates clearly with nursing students.	25.8	42.7	18.0	10.1	3.4
6. The Dean/Chair understands the needs of faculty members to share governance in the organization.	40.4	39.3	9.0	5.6	5.6
7. The Dean/Chair understands the needs of nursing students to share governance in the organization. *	30.3	39.3	18.0	7.9	3.4
8. The Dean/Chair encourages faculty to make decisions and act on them. **	34.8	40.4	10.1	5.6	5.6
9. The Dean/Chair trusts faculty to be responsible and accountable.	50.6	36.0	5.6	3.4	4.5
10. The Dean/Chair trusts nursing students to be responsible and accountable.	27.0	44.9	19.1	6.7	2.2
11. The Dean/Chair manages conflict by interaction and resolution. *	27.0	42.7	6.7	12.4	10.1
12. The Dean/Chair encourages and promotes attendance at professional meetings and conferences. *	47.2	38.2	6.7	5.6	1.1

*One participant (1.1%) did not respond to this statement.

**Three participants (3.4%) did not respond to this statement.

TABLE 2. CHI SQUARE RESULTS FOR DEAN/CHAIR STATEMENTS

Leadership Variables Dean/Chair	X ²	.01	.001
1. The Dean/Chair delegates authority.	94.91	13.28	18.46
2. The Dean/Chair empowers faculty to make decisions.	66.56	13.28	18.46
3. The Dean/Chair empowers nursing students to make decisions.	50.38	13.28	18.46
4. The Dean/Chair communicates clearly with faculty.	58.70	13.28	18.46
5. The Dean/Chair communicates clearly with nursing students.	41.28	13.28	18.46
6. The Dean/Chair understands the needs of faculty members to share governance in the organization.	59.03	13.28	18.46
7. The Dean/Chair understands the needs of nursing students to share governance in the organization.	40.42	13.28	18.46
8. The Dean/Chair encourages faculty to make decisions and act on them.	51.16	13.28	18.46
9. The Dean/Chair trusts faculty to be responsible and accountable.	85.10	13.28	18.46
10. The Dean/Chair trusts nursing students to be responsible and accountable.	51.73	13.28	18.46
11. The Dean/Chair manages conflict by interaction and resolution.	39.85	13.28	18.46
12. The Dean/Chair encourages and promotes attendance at professional meetings and conferences.	80.53	13.28	18.46

statements (13,14,17,26,27,28,29,30) were used to assess planning and development of curriculum, curriculum changes, academic policies, short and long term goals, philosophy, objectives, and nursing courses. The majority of responses were in the "agree" or "strongly agree" categories. Table 3 summarizes participants' responses regarding planning and development by faculty.

Statements 16,18,19,20, and 22 described evaluation of various aspects of a nursing program, including curriculum, Dean/Chair, faculty, and nursing students. There was strong agreement that faculty were involved with curriculum evaluation. Participants agreed or strongly agreed that faculty were involved in identifying the strengths and weaknesses of their nursing program and that nursing students participated in the evaluation of their own strength and weakness. Statements that involved evaluating the Dean/Chair and other faculty members had a large number of "undecided" responses. Table 4 summarizes participants' responses regarding evaluation by faculty.

Several statements (23,24,25,31,34) described faculty involvement with the learning needs of nursing students. Participants agreed or strongly agreed that faculty have the autonomy to identify and implement meaningful learning activities both in the classroom and clinical areas and can make changes in curriculum and instruction according to the needs of their students. That faculty were involved in identifying the competencies for nursing students entry into the nursing profession and that nursing students were responsible and accountable, also received "agree" or "strongly agree" responses from participants. Table 5 summarizes participants' responses regarding

**TABLE 3. PARTICIPANTS' RESPONSES REGARDING
PLANNING AND DEVELOPMENT BY FACULTY**

Leadership Variables Faculty	%SA	%A	%U	%D	%SD
13. Faculty assist in curriculum planning and development.	67.4	29.2	0.0	2.2	1.1
14. Faculty are encouraged to explore and initiate curriculum changes.	53.9	41.6	0.0	3.4	1.1
17. Faculty are encouraged to plan and develop academic policies.	36.0	49.4	7.9	3.4	3.4
26. Faculty are involved in the preparation of <u>short</u> term goals for their nursing program.	32.6	60.7	4.5	1.1	1.1
27. Faculty are involved in the preparation of <u>long</u> term goals for their nursing program.	38.2	52.8	5.6	2.2	1.1
28. Faculty are involved in the planning and development of the philosophy for their nursing program.	53.9	37.1	5.6	2.2	1.1
29. Faculty are involved in the planning and development of objectives for their nursing program.	47.2	46.1	3.4	2.2	1.1
30. Faculty are involved in the planning and development of the nursing courses they teach.	70.8	25.8	1.1	1.1	1.1

**TABLE 4. PARTICIPANTS' RESPONSES REGARDING
EVALUATION BY FACULTY**

Leadership Variables Faculty	%SA	%A	%U	%D	%SD
16. Faculty are involved with curriculum evaluation.	62.9	31.5	2.2	1.1	2.2
18. Faculty are involved with evaluating the Dean/Chair.	30.3	39.3	23.6	4.5	2.2
19. Faculty are involved with the evaluation of other faculty members.	18.0	42.7	22.5	13.5	3.4
20. Faculty are involved in identifying the strengths and weaknesses of the nursing program.	40.4	55.1	2.2	0.0	2.2
22. Faculty encourage nursing students to participate in the evaluation of their strengths and weaknesses.	30.3	57.3	10.1	2.2	0.0

**TABLE 5. PARTICIPANTS' RESPONSES
REGARDING ASSESSMENT OF NURSING STUDENTS'
LEARNING ACTIVITIES BY FACULTY**

Leadership Variables Faculty	%SA	%A	%U	%D	%SD
23. Faculty have the autonomy to identify and implement meaningful learning activities for their nursing students in the <u>classroom</u> .	64.0	33.7	1.1	1.1	0.0
24. Faculty have the autonomy to identify and implement meaningful learning activities for their nursing students in <u>clinical areas</u> .	62.9	32.6	3.4	1.1	0.0
25. Faculty are involved in identifying the competencies nursing students from their program need for entry into the nursing profession.	49.4	46.1	2.2	2.2	0.0
31. Faculty make changes in curriculum and instruction according to the needs of nursing students.	40.4	46.1	10.1	1.1	2.2
34. Faculty trust nursing students to be responsible and accountable.	16.9	57.3	19.1	6.7	0.0

assessment of nursing students learning needs by faculty.

The decision-making role of faculty was the focus of statements 15 and 21. Participants agreed or strongly agreed that faculty were given the opportunity to share in decision-making. The majority of participants agreed or strongly agreed that faculty were consulted prior to the Dean/Chair making major decisions. Statements 32 and 33 examined the issue of faculty feeling part of the academic team and management of conflict. The statement on management of conflict by interaction and resolution received the largest response in the "agree" category; however, 12 to 20 participants chose "strongly agree", "undecided" or "strongly disagree" categories. The majority of participants agreed that faculty were an important part of the academic team. Table 6 summarizes participants' responses regarding organizational processes by faculty.

Analysis of statements relating to leadership behaviors of faculty were reported in the "agree" or "strongly agree" categories. The following behaviors of faculty were evaluated: planning and development, evaluation, learning activities, and organizational processes. The "agree" and "strongly agree" categories reflected shared governance leadership behaviors by faculty.

A Chi Square Test was also completed for each statement about faculty. Expected frequencies for each statement were 17.8 (20%). Differences existed between observed and expected frequencies. Chi Square results for four degrees of freedom were greater than 13.28 for .01 statistical significance and greater than 18.46 for .001 statistical significance. Twelve out of 22 statements relating to faculty

**TABLE 6. PARTICIPANTS' RESPONSES
REGARDING ASSESSMENT OF ORGANIZATIONAL
PROCESSES BY FACULTY**

Leadership Variables Faculty	%SA	%A	%U	%D	%SD
15. Faculty are consulted prior to the Dean/Chair making major decisions.	29.2	44.9	9.0	11.2	5.6
21. Faculty are given the opportunity to share in decision-making.	36.0	49.4	6.7	4.5	3.4
32. Faculty feel they are an important part of the academic team.	41.6	43.8	11.2	2.2	1.1
33. Faculty manage conflict by interaction and resolution.	20.2	46.1	19.1	12.4	2.2

behaviors had Chi Square values over 100, indicating very significant behaviors relating to shared governance. Table 7 summarizes Chi Square results for faculty statements.

Relating to Nursing Students

Fourteen statements related specifically to nursing students. Nursing students did not participate in the study; therefore, statements relating to nursing students were answered by nursing administrators and faculty. Four statements (35,36,39,45) described nursing students' involvement in their educational process. That nursing students had input in curriculum planning and development and that nursing students were involved in development of academic policies received the majority of responses in the "agree" category. Statements 36 and 45 focused on nursing students being encouraged to explore and be self directed in achieving their goals and objectives, and on, nursing students as active participants in their educational process. Both received a majority of responses in "agree" or "strongly agree" categories. Table 8 summarizes participants' responses regarding assessment of nursing students' involvement in their education.

Several statements (37,38,40,42,43) addressed issues relating to evaluation. Evaluation of faculty by nursing students received "agree" or "strongly agree" responses by participants. Nursing students' participation in evaluation of the Dean/Chair received very different responses, with 45 participants "undecided" and 21 participants disagreeing with the statement.

**TABLE 7. CHI SQUARE RESULTS
FOR FACULTY STATEMENTS**

Leadership Variables Faculty	X ²	.01	.001
13. Faculty assist in curriculum planning and development.	151.51	13.28	18.46
14. Faculty are encouraged to explore and initiate curriculum changes.	117.91	13.28	18.46
15. Faculty are consulted prior to the Dean/Chair making major decisions.	49.48	13.28	18.46
16. Faculty are involved with curriculum evaluation.	131.73	13.28	18.46
17. Faculty are encouraged to plan and develop academic policies.	81.06	13.28	18.46
18. Faculty are involved with evaluating the Dean/Chair.	46.67	13.28	18.46
19. Faculty are involved with the evaluation of other faculty members.	37.57	13.28	18.46
20. Faculty are involved in identifying the strengths and weaknesses of the nursing program.	119.15	13.28	18.46
21. Faculty are given the opportunity to share in decision-making.	80.72	13.28	18.46
22. Faculty encourage nursing students to participate in the evaluation of their strengths and weaknesses.	102.85	13.28	18.46
23. Faculty have the autonomy to identify and implement meaningful learning activities for their nursing students in the <u>classroom</u> .	144.20	13.28	18.46

**TABLE 7. CHI SQUARE RESULTS
FOR FACULTY STATEMENTS (Cont'd)**

Leadership Variables Faculty	X ²	.01	.001
24. Faculty have the autonomy to identify and implement meaningful learning activities for their nursing students in <u>clinical areas</u> .	134.99	13.28	18.46
25. Faculty are involved in identifying the competencies nursing students from their program need for entry into the nursing profession.	32.0	13.28	18.46
26. Faculty are involved in the preparation of <u>short</u> term goals for their nursing program.	123.08	13.28	18.46
27. Faculty are involved in the preparation of <u>long</u> term goals for their nursing program.	101.73	13.28	18.46
28. Faculty are involved in the planning and development of the philosophy of their nursing program.	103.30	13.28	18.46
29. Faculty are involved in the planning and development of objectives for their nursing program.	105.33	13.28	18.46
30. Faculty are involved in the planning and development of the nursing courses they teach	163.87	13.28	18.46
31. Faculty make changes in curriculum and instruction according to the needs of nursing students.	83.08	13.28	18.46
32. Faculty feel they are an important part of the academic team.	79.26	13.28	18.46
33. Faculty manage conflict by interaction and resolution.	46.90	13.28	18.46
34. Faculty trust nursing students to be responsible and accountable.	88.02	13.28	18.46

**TABLE 8. PARTICIPANTS' RESPONSES REGARDING
ASSESSMENT OF NURSING STUDENTS' INVOLVEMENT
IN THEIR EDUCATION**

Leadership Variables Nursing Students	%SA	%A	%U	%D	%SD
35. Nursing students have input in curriculum planning and development.	13.5	50.6	22.5	12.4	1.1
36. Nursing students are encouraged to explore and be self directed in achieving their goals and objectives.	18.0	58.4	15.7	6.7	1.1
39. Nursing students are encouraged to be involved in development of academic policies. *	12.4	44.9	25.8	15.7	0.0
45. Nursing students are active participants in their educational process.	23.6	52.8	15.7	7.9	0.0

*One participant (1.1%) did not respond to this statement.

Three statements (37,38,43) described the nursing students' evaluation of curriculum, clinical experiences, and the strengths and weaknesses of the nursing program. Nursing students' evaluation of curriculum and clinical experiences received a majority in "agree" or "strongly agree" categories. That nursing students participated in evaluation of their nursing program had the majority of responses in the "agree" category; however, "strongly agree" and "undecided" categories received almost equal responses. Table 9 summarizes participants' responses regarding assessment of nursing students' involvement in evaluation.

Statements 41, 44, and 48 described additional nursing student behaviors. That nursing students are prepared as autonomous professionals received a variety of responses. Although the primary response was "agree", "strongly agree" and "undecided" received an equal number of responses. A similar breakdown of responses was noted for nursing students participating in management of conflict and nursing students having the opportunity to share in decision-making. The majority of responses were in the "agree" category; "undecided" was the second choice.

Statements 46 and 47 described nursing students' participation in collaboration with faculty and the Dean/Chair. The majority of participants agreed or strongly agreed that nursing students collaborated with faculty. That nursing students collaborate with the Dean/Chair had a wide variety of responses, with some participants agreeing, "undecided", and disagreeing. Table 10 summarizes participants' responses regarding assessment of nursing students involvement in organizational processes.

**TABLE 9. PARTICIPANTS' RESPONSES REGARDING
ASSESSMENT OF NURSING STUDENTS' INVOLVEMENT
IN EVALUATION**

Leadership Variables Nursing Students	%SA	%A	%U	%D	%SD
37. Nursing students are encouraged to evaluate their curriculum.	31.5	47.2	16.9	4.5	0.0
38. Nursing students are encouraged to evaluate their clinical experiences.	41.6	52.8	4.5	1.1	0.0
40. Nursing students participate in evaluation of faculty members.	62.9	34.8	1.1	1.1	0.0
42. Nursing students participate in evaluation of the Dean/Chair.	1.1	13.5	50.6	23.6	11.2
43. Nursing students participate in identifying the strengths and weaknesses of their nursing program. *	24.7	44.9	21.3	6.7	0.0

*Two participants (2.2%) did not respond to this statement.

**TABLE 10. PARTICIPANTS' RESPONSES REGARDING
ASSESSMENT OF NURSING STUDENTS' INVOLVEMENT
IN ORGANIZATIONAL PROCESSES**

Leadership Variables Nursing Students	%SA	%A	%U	%D	%SD
41. Nursing students are prepared to function as autonomous professionals.	18.0	57.3	19.1	5.6	0.0
44. Nursing students learn to manage conflict by interaction and resolution.	7.9	50.6	28.1	10.1	3.4
46. Nursing students collaborate with faculty.	18.0	52.0	13.0	6.0	0.0
47. Nursing students collaborate with the Dean/Chair.	11.2	36.0	31.5	18.0	3.4
48. Nursing students are given the opportunity to share in decision-making.	9.0	57.3	24.7	9.0	0.0

Analysis of statements relating to nursing students presented a different picture than statements relating to the Dean/Chair or faculty. Analysis of statements relating to nursing students expressed the perceptions of nursing administrators and faculty since nursing students were not participants in this study. Participation of nursing students may have presented an entirely different assessment of shared governance behaviors. Only half of the fourteen statements had 75% or above in the "agree" or "strongly agree" categories. The nursing students' behaviors assessed were achievement of goals and objectives, evaluation of curriculum, clinical experiences, the nursing program, clinical areas, and faculty.

Seven statements (35,39,42,44,47,48) had a significant number of participants selecting the "undecided" category. The nursing students' behaviors assessed by these statements were planning and development of curriculum, development of academic policies, evaluation of the Dean/Chair, participation in conflict management, and sharing in decision-making. Refer to Tables 8 through 10 for review of findings.

A Chi Square Test was completed for this section of statements about nursing students behaviors as evaluated by nursing administrators and faculty. Expected frequencies for each statement were 17.8 (20%). Differences existed between observed and expected frequencies. Chi Square results for four degrees of freedom were greater than 13.28 for .01 statistical significance and greater than 18.46 for .001 statistical significance. Chi Square results regarding nursing students' evaluating faculty and clinical experiences received Chi Square values over 100. Table 11 summarizes results of Chi Square Test for statements about nursing students.

**TABLE 11. CHI SQUARE RESULTS FOR
NURSING STUDENTS' STATEMENTS**

Leadership Variables Nursing Students	X ²	.01	.001
35. Nursing students have input in curriculum planning and development.	62.18	13.28	18.46
36. Nursing students are encouraged to explore and be self directed in achieving their goals and objectives.	90.38	13.28	18.46
37. Nursing students are encouraged to evaluate their curriculum.	67.69	13.28	18.46
38. Nursing students are encouraged to evaluate their clinical experiences.	112.97	13.28	18.46
39. Nursing students are encouraged to be involved in development of academic policies.	50.42	13.28	18.46
40. Nursing students participate in evaluation of faculty members.	141.28	13.28	18.46
41. Nursing students are prepared to function as autonomous professionals.	89.15	13.28	18.46
42. Nursing students participate in evaluation of the Dean/Chair.	63.30	13.28	18.46
43. Nursing students participate in identifying the strengths and weaknesses of their nursing program.	54.38	13.28	18.46
44. Nursing students learn to manage conflict by interaction and resolution.	67.69	13.28	18.46
45. Nursing students are active participants in their educational process.	73.64	13.28	18.46
46. Nursing students collaborate with faculty.	92.63	13.28	18.46
47. Nursing students collaborate with the Dean/Chair.	33.08	13.28	18.46
48. Nursing students are given the opportunity to share in decision-making.	91.51	13.28	18.46

Shared Governance in the Classroom

This section presents data related to research question two: *What practices of shared governance are being implemented by nursing faculty in classrooms?* Shared governance in classrooms was evaluated utilizing Likert responses and written responses to open-ended questions in Part Two of the Leadership Survey. Eighty-nine surveys were returned. Two statements on the survey addressed the issue of shared governance in classrooms. The first statement (Part II,3) focused on learning concepts of shared governance in the classroom. The second statement (Part II,7) focused on experiencing shared governance concepts in the classroom. The primary response for statement three was agreement with classroom learning of shared governance concepts. That nursing students experience shared governance in the classroom received mixed responses, with "agree" and "undecided" the major choices by participants. Table 12 summarizes participants' responses regarding shared governance in classroom and clinical areas.

Two open-ended questions in Part Two of the Leadership Survey related to shared governance in the classroom. The first question (Part II, 4) asked participants to specify and describe concepts of shared governance presented in the classroom. Parenthetical suggestions given were empowerment, decision-making, communication, trust, professional autonomy, and accountability.

Some participants did not answer the question but wrote an explanation why

**TABLE 12. PARTICIPANTS' RESPONSES REGARDING
SHARED GOVERNANCE IN CLASSROOM
AND CLINICAL AREAS**

Variables for Classroom and Clinical Areas	%SA	%A	%U	%D	%SD
1. Nursing students are prepared to function within various leadership models upon graduation.	10.1	57.3	25.8	6.7	0.0
3. Nursing students learn about concepts of shared governance within the <u>classroom</u> .	6.7	62.9	22.5	7.9	0.0
5. Nursing students learn about concepts of shared governance while in <u>clinical</u> areas. *	6.7	55.1	27.0	9.0	1.1
7. Nursing students experience the shared governance model of leadership within the <u>classroom</u> . **	9.0	39.3	32.6	13.5	2.2
9. Nursing students experience the shared governance model of leadership in <u>clinical</u> areas. **	7.9	56.2	22.5	9.0	1.1

*One participant (1.1%) did not respond to this statement.

**Three participants (3.4%) did not respond to this statement.

they could not answer. Some responses were "I only teach clinical." "This is currently not being implemented." "Unknown; what do you mean by shared governance?" "I teach no undergraduate classroom courses."

A faculty member wrote about the process of teaching shared governance concepts and explained:

These concepts are presented in a variety of ways depending on the level of the course and its purpose. Mutual goal setting in community is a good example of shared governance being taught, most, if not all, of these concepts are discussed in professional seminar.

Sixty-five participants responded to the question asking them to specify and describe concepts of shared governance presented in the classroom. Decision-making, communication, and accountability emerged as the principal concepts of shared governance presented in classrooms. Empowerment, trust, and professional autonomy were additional concepts used by participants. Sometimes these concepts were taught in leadership or management courses. Group activities were also important for teaching shared governance concepts. A faculty member wrote:

All of these are learned and shared in the classroom especially when working as a group for presentations.

An associate dean concurred:

Students have opportunities to work in groups, govern group activities, negotiate ways to meet course outcomes, engage in peer evaluation, work out own group/class conflicts, and are encouraged to monitor peer professional behavior in classroom.

The second question (Part II, 8) asked participants to describe classroom experiences that model or reinforce principles of shared governance. Twelve participants responded by writing why they could not answer the question. Some

responses were: "No basis on which to judge." "More at senior level." "Can't answer." "Unsure of specifics." "Don't know." Three participants mentioned that there was no shared governance in classrooms. These participants stated the following: "I have not heard of shared governance in class. I hear autocracy reigns." "Some classroom learning experiences are autocratic."

Forty-six responses were analyzed for themes. Several participants gave one-word answers without descriptions of specific experiences. Themes emerged from content analysis of written responses and a predominant theme was learning through inquiry. This involved active participation in planning and collaboration by students with faculty as facilitators. A faculty member wrote:

In student classroom presentations, students are expected to make decisions about priorities; they are expected to evaluate the material presented for accuracy and worth in the context of the presentations.

Several learning activities and projects were suggested by participants. Interactive learning activities suggested by participants included case study, computer-assisted instruction, interactive videos, presentations, and scenario analysis.

The second theme that emerged was developing the characteristics of a professional "disciplinary expert". This was demonstrated by autonomy, accountability, critical thinking, and responsibility. Two participants shared the following classroom activities:

Students are given choice in presentation topic - how the class should be conducted. Major decisions regarding exam date choices are voted by class.

Group activities to encourage deep, thinking on issues.

The third emerging theme involved active participation of faculty and students working as team members or in groups. Suggestions for group activities included seminars, debates, and interdisciplinary group projects. An associate dean wrote:

Assume leadership roles in group projects, even within interdisciplinary group learning experiences.

Another theme that emerged involved activities outside the classroom that involved class officers and student activities. A clinical instructor wrote:

Class officers taking information about likes and dislikes to meeting, and meeting with faculty, chair, and dean as needed.

Content analysis of statements four and eight in Part Two of the Leadership Survey indicated that nursing students were often taught about shared governance concepts in leadership management courses or issues courses. Group activities and learning through inquiry provided some shared governance experiences in the classroom. Extracurricular activities such as student nurses associations and interaction with class officers provided additional experiences with concepts in shared governance. Nursing students have some exposure to shared governance concepts in the classroom.

Shared Governance in Clinical Areas

This section presents data related to research question three: *What practices of shared governance are being implemented by nursing faculty in clinical areas?*

Shared governance in clinical areas was evaluated utilizing Likert responses and

written responses to open-ended questions in Part Two of the Leadership Survey.

Two statements addressed the issue of shared governance in clinical areas. The first statement (Part II, 5) focused on nursing students' learning shared governance concepts in clinical areas, with the majority of participants agreeing with the statement. The second statement (Part II, 9) focused on nursing students' experiencing shared governance in clinical areas. This statement received a majority of responses in agreement. Table 12 summarizes participants' responses regarding shared governance in classroom and clinical areas.

Two open-ended questions in Part Two of the Leadership Survey related to shared governance in clinical areas. The first question (Part II, 6) asked participants to specify and describe concepts of shared governance presented in clinical areas. Nine participants stated why they could not answer the question. Some responses included: "Only one institution used shared governance. Students too focused on clinical tasks to notice." "Varied, depending on philosophy of instructor/clinical setting." "Depends on agency. Most students do not as far as I know." "I do not teach it in a clinical area."

Fifty-six participants responded with brief answers. The predominant shared governance concepts presented were communication, accountability, and decision-making. Many of these concepts were presented in the leadership management clinical course. A clinical instructor wrote the following:

Students participate with instructor in selection of experiences for entire clinical group, plan, and present conferences related to clinical practice. Students interact with agency staffs who are participating in shared governance.

Other shared governance concepts presented were empowerment, trust, and professional autonomy. Team work on the clinical unit and interaction with agency staff were activities participants suggested that provided the opportunity for experiences in shared governance. A faculty member shared the following:

Concepts are discussed in relationship to interactions, conflicts, etc. on units where they are having clinical experience. Communication is always stressed, decision-making is guided rather than dictated, and accountability is a constant focus.

Interactions in clinical areas included goal setting, problem-solving, and collaboration.

A faculty member commented:

Essential nursing competencies are evaluated at the senior level (and elsewhere) and include communication, professional accountability. We also evaluate students on actions that empower patients, collaborate with others, and result in informed shared decisions.

Question ten in Part Two of the Leadership Survey asked participants to describe experiences in clinical areas that model or reinforce shared governance. Ten participants explained why they could not answer the question. Some responses included: "Dependent on instructor." "I cannot evaluate." "Depends on clinical site." "All of the above in numerous ways. I don't have time to give numerous experiences."

Forty-nine participants responded with brief answers. Professional autonomy, team interactions, and empowerment were the predominant themes representing shared governance experiences by nursing students in clinical areas. Professional autonomy emerged as a major theme as nursing students in their clinical roles were learning to make independent decisions and being accountable for those decisions. A

faculty member wrote:

Autonomy and accountability are experiences of each clinical day as students care for individual patients. This also involves decision-making, establishing trust and communication. They are often able to empower their patients' through health teaching.

A clinical instructor shared the following:

Again, students are responsible and autonomous. Community Health nursing students are assigned a family caseload and are independent in doing family assessment and planning.

Another emerging theme was a team approach to nursing care. Faculty or staff assist nursing students in caring for patients. Nursing students learn and practice nursing skills in an interactive learning environment where they may depend on assistance from others in their assessment, clinical judgment, and delivery of care. A faculty member emphasized:

Emphasis on students being jointly responsible for care with staff, reporting problems to faculty and staff; observing staff and faculty collaborate about assignments or care. Allowing students to select own learning experiences.

The third theme was empowerment. Nursing students need to be empowered to make decisions as they become ready to assume more responsibility and accountability in their nursing practice. A faculty member shared this:

Students are frequently encouraged and supported in discussing patient care with other health professionals and in health care planning as well as the actual intervention. They are empowered to take on as much responsibility as they are ready for.

Nursing students were taught and experienced some shared governance in clinical areas. Nursing students' experiences with shared governance depended on leadership modeled by faculty and the leadership model of the clinical site or agency.

Nursing students required some guidance when caring for patients in a clinical setting. The leadership style and professional experiences of faculty teaching nursing students in a clinical area affected shared governance experiences. Staff in clinical agencies, had an organizational structure and leadership style which influences the shared governance experiences of nursing students.

Preparation of Graduate Nurses in Shared Governance

This section presents data related to research question four: *What educational experiences do nursing students need to prepare them to function as graduates employed in shared governance organizations?* Data for this research question came from Leadership Survey responses and interviews.

Leadership Models

The first question of Part Two of the Leadership Survey asked participants if nursing students were prepared to function within various leadership models upon graduation. The majority of participants agreed or strongly agreed with the statement. Table 12 summarizes participants' responses regarding shared governance in classroom and clinical areas.

A Chi Square Test was completed for each Likert statement in Part Two of the Leadership Survey. Expected frequencies for each statement were 17.8 (20%). Differences existed between observed and expected frequencies. Chi Square results for four degrees of freedom were greater than 13.28 for .01 statistical significance

and greater than 18.46 for .001 statistical significance. The highest Chi Square values were noted for statements about nursing students being prepared to function in various leadership models after graduation and nursing students learning shared governance concepts in the classroom. Table 13 summarizes Chi Square results for shared governance in classroom and clinical areas statements.

An open-ended question (Part II, 2) asked participants to specify and describe leadership models that nursing students learn and experience. Suggestions of leadership models given in parentheses were autocratic, democratic, laissez faire, transformational, transactional, and shared governance.

Some participants did not answer the question but wrote an explanation for not answering, responses included: "I am not aware of what is taught on campus." "Can't specify because I don't teach these courses." "I do not know what our students are taught on this subject."

Sixty-five participants responded to the opened-ended question. Participants believed that leadership was taught in courses on leadership and management. Second, nursing students have a variety of experiences depending on the leadership modeled by faculty and their particular clinical rotation. A faculty member commented:

Introduced to different styles in nursing leadership and management class. Students see a variety of styles because of the diverse styles within the faculty. Could improve on amount of shared governance especially with curriculum development.

Another faculty member shared the following:

Students are exposed to all of these leadership models, but as I am not

**TABLE 13. CHI SQUARE RESULTS FOR
SHARED GOVERNANCE IN CLASSROOM
AND CLINICAL AREAS STATEMENTS**

Variables for Classroom and Clinical Areas	X ²	.01	.001
1. Nursing students are prepared to function within various leadership models upon graduation.	93.42	13.28	18.46
3. Nursing students learn about concepts of shared governance within the <u>classroom</u> .	114.43	13.28	18.46
5. Nursing students learn about concepts of shared governance while in <u>clinical</u> areas.	85.92	13.28	18.46
7. Nursing students experience the shared governance model of leadership within the <u>classroom</u> .	44.98	13.28	18.46
9. Nursing students experience the shared governance model of leadership in <u>clinical</u> areas.	86.33	13.28	18.46

currently teaching this content. I cannot be specific in how they are experiencing them.

The democratic leadership model was most frequently taught and experienced.

A faculty member stated this about the Democratic model:

Democratic - students have input as to experiences and requirements which are valid learning experiences.

Shared governance was the second most frequent leadership model experienced by nursing students and autocratic leadership models were participants' third choice. A faculty member wrote about experiences with several leadership styles:

In our program students are encouraged to participate in decision-making regarding the nursing program. In local hospitals much of leadership is autocratic. It's my perception that educational experiences are primarily democratic. Some courses do incorporate transactional leadership styles, especially BSN and MSN. Hospital experiences are a combination of autocratic and democratic.

Exposure to various leadership models was considered important. Nursing students learned leadership models and concepts through courses or seminars and they also learned about leadership through interactions with other students, faculty, and nursing staff at clinical facilities.

Educational Experiences

Data were collected about the educational experiences nursing students need to experience in classroom and clinical areas to prepare them to function as graduates in shared governance organizations. Data were obtained from Part Two, question 11 of the Leadership Survey and from the last question of the interview guide.

Some participants did not answer the question but stated why they could not answer. Some participants misread the question and answered the question "yes"

instead of providing an explanation. Fifty-seven participants answered the question with brief responses. Participants believed students should experience shared governance. A faculty member wrote:

The student should learn the model, the importance of staff nurse participation in clinical decision-making and their responsibility to be a part of the process after graduation in organizations that use the model.

Communication of information emerged as the skill nursing students most needed to learn and experience, with empowerment, participation, responsibility, and accountability frequently mentioned as additional concepts. A faculty member shared the following about educational experiences:

They must first develop a solid basis in their chosen major so that they are qualified to participate at a professional level. How to communicate with persons with different opinions and approaches. How to delegate responsibility to others. How to empower others. How to carry out their responsibility, AND share necessary aspects with others in the organization. Accountability and professional autonomy are taught and integrated throughout the curriculum.

Two participants gave specifics for classroom and clinical experiences and one wrote the following:

In the classroom: previously mentioned concepts, examples of shared governance, practice in experiencing the advantages and challenges. In clinical: faculty role modeling of concepts, student decision-making encouraged, role modeling of staff if in shared governance.

Students behaviors influenced their experience with shared governance. A faculty member shared this insight:

Students learn that respect is gained through knowledge and achievement of performance skills, and communication skills. Students who don't meet minimum expectations of performance are not given as many opportunities to practice shared governance as those who surpass expectations.

Interview participants were also asked about educational experiences that nursing students need in classroom and clinical areas. Face-to-face interviews elicited more detailed responses than written survey responses. A course coordinator shared her beliefs about the importance of experiences and remarked:

They do need to be involved in decision-making in the policies in the school of nursing. That's how they need the experience; they need to experience first hand shared governance because they already know what bureaucratic systems are. They understand that. They've got a lot that experience and you have to conform. But how much experience do they get being an active part of making decisions.

Students frequently were exposed to shared governance concepts in leadership management courses in senior year. Thinking critically was essential for nursing students in leadership courses, according to a faculty member who stated:

And I wanted them first of all to think, to be free to think, not to regurgitate but to think. And also to be able to express that in their own style...

A course coordinator shared his experience with teaching a leadership management course. He remarked:

They probably do need to experience that early in the curriculum. I just recently did a lecture on organizational culture for the leadership and management students. And we talked some about shared governance and what that is. I think we can do more when we talk about it, particularly the new organizational culture with decentralized decision-making, work groups, and CQI principles.

One school was making major curriculum changes to a student-centered classroom. The chair of the Curriculum Committee shared the following:

It's always been the teacher stand up and you lecture. Now it's student centered classrooms. The student is in charge of the learning that happens in there. Then the faculty being in charge of the teaching. We never were in charge of learning we just thought we were. Okay,

so now students are in charge of learning. If you put the student in charge of learning the faculty member can't stand up and lecture, discuss, and test. They have to come up with very creative interactive strategies that engage the student in the learning process.

Group processes both in the classroom and clinical areas were the major theme because group process taught collaboration and consultation with peer skills. A new faculty member shared her experiences with group process in classrooms.

We do several group projects. And I try to emphasize to students that group projects don't mean that one person does everything and eight people get all As. That group process is very important and that you don't all have to be best friends and you don't all have to like each other but you just do have to know how to work together. And that there's a difference. I think sometimes our students are very idealistic. They think everybody has to like each other an all that stuff. That's all nice. They think that's necessary for group process and when that's not really necessary for group process.

Decision-making and responsibility for decisions emerged as the second theme.

A faculty member gave some insights into decision-making in the clinical area.

But again I also think clinical faculty need to be demonstrating by acting and enacting the active participant role in shared governance and that actually came up in past conference with my junior students today...I think that's probably the most important thing to do as far as faculty as role model...involvement in that practice just don't sit back.

The majority of participants believed that learning and experiencing shared governance was important for the nursing graduate, requiring educational experiences with classroom and clinical components. Experiences were related to leadership modeled by the faculty and clinical agency. Group activities, participative decision-making, and collaboration in classrooms and clinical areas were essential for experiencing shared governance.

Extracurricular Activities

Activities outside of classroom and clinical areas surfaced as another means for experiencing shared governance. Class activities and membership in the student nurses associations provided opportunities for experiences in shared governance according to interview participants. Nursing students were involved with planning class activities, such as convocations and pinning ceremonies. One director shared her thoughts about nursing students being empowered outside educational experiences and stated:

The senior class has made all the decision about their convocation. That's really been that's theirs. They decide. It sure is a lot of struggles with making some of those decisions. But I think that the faculty have very much given up to students as much as they can for their decision-making.

A faculty advisor shared her experiences with a senior class.

For example, I'm senior class advisor this year. We are real hands off. We do not make decisions for them. If difficulties arise we'll sit and arbitrate but they are to work it out. The class itself, the senior class every year plans its own pinning ceremony.

Four schools had nursing student representatives on their faculty committees. Student representatives were vital members and their input was solicited and used in decision-making. A faculty member shared her experiences on a committee with students where a class was changed from optional to required because of the involvement of student representatives on the committee.

Summary

The analysis of data from the Leadership Survey and interview questions revealed a number of themes.

1. Leadership styles affected members of the nursing school differently depending on their role in the organizational structure.
2. Decision-making was accomplished through committee and task forces and most participants were satisfied with their decision-making role.
3. Communication for administrators and faculty was given in committee meetings or through memos, while some schools had E-Mail. Communication with students utilized bulletin boards, student nurses associations, and class officers.
4. Professional autonomy was an integral part of professional roles and involved decision-making through empowerment and accountability for practice.
5. Shared governance involved decentralized decision-making with multidirectional interaction. Partnership with the organization was a likely outcome.
6. Nursing administrators, faculty and nursing students demonstrated a variety of shared governance behaviors.
7. Classrooms were fundamental places to learn and experience shared governance. Student-centered learning with group process and learning through inquiry were vital components of classroom experiences.
8. Clinical experiences were essential for learning and experiencing shared governance. Communication, accountability, and empowerment to make decisions

were vital components of clinical experiences.

9. Extracurricular activities for nursing students provided many opportunities for students to be involved with shared governance through class activities, membership in student nurses associations, and serving as student representatives on faculty committees or task forces.

Triangulation of data were possible, with three sources of data to analyze relating to shared governance practices in nursing schools, classrooms, and clinical areas. Nursing administrators and faculty were participants in all phases of data collection.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS FOR FUTURE RESEARCH

Summary

During the past decade, as nurses have begun to seek greater professional autonomy, the leadership style of shared governance has become an important concept for the nursing profession. Shared governance is a radical departure from traditional management structures, the practice settings for many nursing professionals. However, this situation is changing as more and more health care organizations develop and implement shared governance models of leadership.

Since health care organizations have become more involved with shared governance models of leadership, the status of shared governance in nursing education requires exploration. Nursing students should be prepared to function in a variety of leadership models, including shared governance.

Shared governance is a model of leadership that provides an environment of trust and respect for autonomous decision-making and empowers nurses to be responsible and accountable for practice decisions. Nursing students need to learn and experience shared governance concepts and principles in classrooms and clinical areas during their educational program. Extracurricular activities such as planning

class activities and membership in student nurses associations may also provide opportunities for shared governance experiences.

Statement of the Problem

Nurses daily face complex ethical, legal, and professional issues. Practicing nurses need skills, which will enhance their ability to make autonomous decisions in practice settings including critical thinking, clinical judgment and assessment skills.

Traditionally, nursing education has involved the nursing educator as the prime source of knowledge and the nursing student as the passive recipient. Nursing education has been primarily content-oriented, for example nursing students have memorized facts and learned to perform skills. Nursing graduates of the 1990s must be prepared to function autonomously. The successful teaching of autonomy requires changes in nursing curricula to reflect process-oriented education.

Over the past 100 years, nursing has struggled to establish itself as an independent profession. Professional nurses are seeking increased autonomy, accountability, and responsibility in clinical practice. Shared governance is emerging as a leadership model that provides an environment for the professional standards nurses are seeking.

With the increasing development and implementation of shared governance models in clinical practice settings, the administrative and educational practices of nursing programs need to be re-evaluated. Since limited research is available on shared governance models in nursing education, the development and implementation

of shared governance in nursing education needs to be studied.

The following questions guided the research:

1. What practices of shared governance are being implemented by nursing administrators and faculty in approved baccalaureate nursing programs in the state of Tennessee?
2. What practices of shared governance are being implemented by nursing faculty in classrooms?
3. What practices of shared governance are being implemented by nursing faculty in clinical areas?
4. What educational experiences do nursing students need to prepare them to function as graduates employed in shared governance organizations?

Procedures

This study was conducted to describe the administrative and educational practices of shared governance in baccalaureate nursing programs in the state of Tennessee. Quantitative and qualitative research methods were utilized to collect data on practices of shared governance in baccalaureate nursing programs.

Descriptive methodology was utilized to determine and report nursing administrators' and faculty's attitudes, perceptions, and beliefs concerning shared governance. The status of shared governance was determined from responses to a Leadership Survey and semi-structured interview questions. Participants were asked to describe practices of shared governance leadership in their school of nursing and to

identify the skills and experiences graduate nurses need to function in practice settings having a shared governance model.

Senge's (1990) five disciplines of a learning organization, which states that how individuals think and interact affect the way organizations work, was the guiding philosophy for this study. By changing how individuals interact, organizational structures and processes can be redesigned. In nursing, the shared governance model of leadership is a fundamental change from traditional autocratic bureaucracies. Shifting from traditional, autocratic bureaucracies to participative, empowering, interactive organizations is a major challenge for nursing.

Gardner's (1991) characteristics of the learner influenced the study design. The third characteristic of the learner, to be a "disciplinary expert" was important to delineate. "Disciplinary experts" are individuals who have mastered the concepts and skills of a discipline. The purpose of a professional nursing program is to educate students to be "disciplinary experts" in the nursing profession.

Fourteen baccalaureate nursing programs are approved in the state of Tennessee and permission was received from eight of the chief nursing administrators to contact their administrators and faculty. Quantitative data collection instruments, which included a Demographic Data Sheet and Leadership Survey, were sent to 167 potential participants, with 89 instruments being returned. Thirty-four participants expressed interest in being interviewed and 18 interviews were subsequently completed at five of the eight nursing schools. Survey and interview participants included both nursing administrators and faculty, nursing students were not

participants in the study.

Demographic data were analyzed utilizing frequency distribution and the Leadership Survey was analyzed using frequency distribution and Chi Square. Content analysis was utilized for analysis of the written answers to open-ended questions in Part Two of the Leadership Survey. Written responses to each question were used to develop basic broad themes and reduce the data into manageable categories.

Content analysis was utilized for analysis of transcribed audiotaped interviews. Responses to interview questions were categorized into broad themes to reduce data to manageable divisions. Content analysis involved several steps: identification of concepts to be measured, a sampling plan, categorizing content, coding, and scoring. For survey data, findings were developed based on frequency distribution and a Chi Square Test. For interview data, findings were based on identified themes. Conclusions were then drawn from frequency distribution, Chi Square, and content analysis of the findings.

Findings

Research Question 1: What practices of shared governance are being implemented by nursing administrators and faculty in approved baccalaureate nursing programs in the state of Tennessee?

Practices of shared governance in baccalaureate nursing programs were

identified as professional autonomy in education and practice roles, empowerment in decision-making, interactive communication, trust, collaboration, and multidirectional leadership at the time of this study. Practices of shared governance were being implemented in varying degrees in schools of nursing in the state of Tennessee.

Interview participants defined "professional autonomy" as having the intelligence, independence, and power to make decisions relating to their various roles in an educational environment. Interview participants observed varying amounts of professional autonomy based on individual responsibilities. Survey participants strongly perceived that they had the autonomy to identify and implement meaningful learning activities in the classroom and clinical area. The majority of interview participants perceived they exercised the most autonomy in their clinical practice role. The perceptions of professional autonomy by interview participants depended on their years in a position and their role in the school of nursing. For example, course coordinators believed they had autonomy in the development and implementation of courses. Newer faculty were more reserved in giving input on issues. Professional autonomy was highly valued by all survey and interview participants.

In the participating nursing schools, empowerment in decision-making was achieved by committee structures. All nursing schools interviewed had faculty organizations or committees where all nursing administration and faculty were members with each member having the power to influence decisions. Decision-making occurred at all levels of each nursing program; interview participants were generally satisfied that they were empowered at some level. Many nursing schools

had course coordinators where a small group of faculty convened to develop and implement courses. Several interview participants believed interaction and decision-making often occurred during course development and implementation.

Survey participants strongly perceived that faculty were very involved in many aspects of planning, developing, and evaluation of the curriculum, goals, and objectives of their nursing program. Planning, development, and evaluation of various aspects of the nursing program required decision-making, collaboration, and communication skills. Survey participants perceived that the Dean/Chair empowered faculty more than nursing students to make decisions and that faculty were usually consulted prior to the Dean/Chair making major decisions. Survey participants also perceived that the Dean/Chair understood the needs of faculty to share in organizational governance more than nursing students and that faculty were given greater opportunity to participate in decision-making.

Interview participants shared their schools' methods of communicating information. Formal communication was achieved through meetings and memos. Interview participants had numerous opportunities to communicate ideas and opinions on issues through membership on committees.

Communication methods varied between administrators and faculty and between students. Faculty communicated frequently both formally and informally with other faculty, course coordinators, and program directors. Faculty to student communication was frequently accomplished through the posting of notices on bulletin boards or through interactions with class leaders.

Trust in the ability and capability of other professionals was identified as an important shared governance practice. Interview participants shared their desire to gather information on a project or issue and give recommendations without interference from a nursing administrator. Those interviewed felt that they were trusted by nursing administrators to be accountable for decisions. Survey participants believed that trusting faculty and nursing students to be accountable and responsible was highly valued by their school's administrators.

Survey and interview participants valued multidirectional leadership. Several interview participants said that their views were respected by course and program coordinators. The extent of communication between nursing administration and faculty varied at participating schools. Faculty described situations where they conferred with nursing administration influenced decisions, but said that in other situations important decisions were made without faculty input. The majority of survey participants perceived that they shared in the decision-making at course levels of the nursing program.

Perceptions of shared governance practices varied among groups depending on experience and education. Survey and interview participants holding nursing administrative titles believed that shared governance or a type of participative management was the primary leadership model at their school. The responses of survey participants with a master's degree and participants with doctoral degrees were compared. Survey participants with master's degrees identified shared governance behaviors between nursing administrators and faculty; however, they were often

undecided or disagreed that shared governance was practiced by or with nursing students. Survey participants with doctoral degrees perceived the use of shared governance at all levels more frequently than did participants with master's degrees.

Survey participants who had been employed at their nursing school for 14 years or more did not feel as strongly that shared governance behaviors were practiced at their school as did newer faculty. Survey participants with tenure perceived shared governance practices were more evident between faculty and nursing students than between the chief nursing administrator and faculty or nursing students.

Research Question 2: What practices of shared governance are being implemented by nursing faculty in classrooms?

Participants identified practices of shared governance implemented by faculty in classrooms. Nursing students were formally taught about shared governance through leadership management courses, professional role seminars, and issues courses. They experienced shared governance in classrooms through student-centered activities that involved learning through inquiry and group activities.

Traditional teacher-centered methods described by interview participants utilized lecture, discussion, and testing. The learning through inquiry methods required active participation by the learner, collaboration with other students and faculty, and decision-making. Student-centered learning required creative interactive strategies that engaged the learner. Nursing students had the opportunity to make decisions about learning activities by selecting, developing, implementing, and

evaluating individual and group projects. Survey and interview participants believed that student-centered learning was also a means of empowering students in decision-making and developing of critical thinking skills.

Survey participants perceived that nursing students usually learned about concepts of shared governance in classrooms through courses in leadership management or professional roles. Some survey participants perceived that nursing students were active participants in the educational process; others were undecided. Survey participants, however, were often uncertain how nursing students experienced shared governance in classrooms.

Survey and interview participants identified group activities as an essential means of exposing nursing students to shared governance concepts in classrooms. Group activities suggested by participants included presentations, scenario analysis, case study analysis, interactive videos, and projects. Survey and interview participants believed that group activities encouraged decision-making for project topics, responsibility and personal accountability, and conflict resolution during project development and implementation.

Research Question 3: What practices of shared governance are being implemented by nursing faculty in clinical areas?

Survey and interview participants stated that many shared governance concepts were presented to nursing students in leadership management and professional role courses, which frequently had a clinical as well as a classroom component. Some

leadership management students spent clinical time with nurse managers, learning about roles and responsibilities such as staffing their units, educating and evaluating their nursing staff. The leadership model nursing students experienced was determined by the nurse manager; therefore, shared governance practices were experienced only by those nursing students paired with nurse managers who understood and modeled shared governance.

Survey and interview participants indicated that accountability, decision-making, empowerment, and autonomy were the primary shared governance concepts experienced in clinical areas. Some survey participants perceived that nursing students learned about shared governance practices in clinical areas, but others were undecided about what nursing students experienced regarding shared governance in clinical areas.

In some nursing programs, nursing students had great autonomy and were expected to function independently, making decisions regarding selection of clinical sites, patient caseloads, or clinical groups. Survey participants believed that independent selection of clinical sites and patients encouraged accountability, responsibility, decision-making, and autonomy.

Survey participants stated that whether nursing students experienced shared governance in clinical areas was dependent on the clinical agency to which they were assigned or selected. Leadership behaviors modeled by the faculty played an important role in the nursing students experience or lack of experience with shared governance. Since nursing students were exposed to a wide variety of clinical

situations and faculty during the course of the educational program, survey and interview participants responded based on their personal leadership practices. According to the survey participants, nursing students experienced a wide variety of leadership models by faculty and clinical agencies during their clinical experiences, but not necessarily shared governance models.

Survey and interview participants stated that nursing students experienced shared governance in clinical areas through group interactions with faculty, clinical staff, and patients. Participants further perceived that nursing students developed decision-making skills, and learned to be responsible and accountable for patient care decisions. Nursing students learned and experienced the importance of communication and decision-making skills in their interactions with physicians, faculty, clinical staff, patients, and families. Survey and interview participants perceived that as nursing students progressed through their nursing program they developed professional autonomy.

Research Question 4: What educational experiences do nursing students need to prepare them to function as graduates employed in shared governance organizations?

Survey and Interview participants believed that nursing students need to learn and experience various leadership models, including shared governance. Nursing students were required to attend courses in leadership, management or professional roles. They also learned various leadership models through interactions with faculty who demonstrated their personal leadership models. Survey and interview

participants said that clinical agencies were also a source for experiencing various leadership models.

Survey and interview participants believed that decision-making and communication were two vital organizational processes for which nursing students needed skill development. Participants said that communication skills were essential for nursing students' functioning in a shared governance environment and that empowering nursing students to be responsible for all phases of decision-making was important in classroom and clinical areas.

Survey and interview participants believed that group activities were an essential means for learning and experiencing shared governance in classroom and clinical areas. They stated that group activities could provide an environment in which nursing students could experience mutual respect, responsibility for decision-making, collaboration, trust, responsibility, accountability, and conflict management.

The extent of participants knowledge of nursing students' shared governance experiences was varied and related to leadership modeled by faculty and experiences within clinical agencies. Interview participants felt that students' clinical experiences needed to be interactive rather than observational so that nursing students could define and develop their roles as professional nurses.

Additional Findings

According to survey and interview participants, nursing students learned about shared governance in other situations beside classroom and clinical areas. Several

interview participants believed that students who served as class officers played a vital role in learning and experiencing shared governance leadership. In addition, all nursing students were involved in the development and implementation of class projects and activities such as pinning, convocations, and fundraisers. Participants believed that these activities provided the opportunity for nursing students to learn and experience shared governance, depending on the leadership modeled by class leaders.

Interview participants from four schools of nursing said that their programs included student representatives on faculty committees. In these programs, input was encouraged and actively sought from nursing student representatives. These schools had implemented some practices of shared governance. Several interview participants discussed the roles of student nurses associations as a means of group process and interaction on important issues. However, interview participants could not elaborate on the activities of student nurses associations because they were not members.

Conclusions

Interview participants had different understandings of the term "shared governance" and based responses on their perceptions. Participants with no previous knowledge or experience working in shared governance organizations may have been unfamiliar with the meaning of shared governance leadership.

The chief nursing administrators of the eight schools of nursing that granted permission to the researcher to contact faculty perceived their leadership style as

shared governance. Survey data of participants with administrative titles indicated strong agreement with leadership behaviors demonstrating shared governance.

Professional autonomy was highly valued by survey and interview participants. The majority of participants believed that they had professional autonomy in some of their roles as a nursing educator. Interview participants' perceptions of professional autonomy were usually influenced by the number of years they had been employed at their school of nursing and the extent of their administrative responsibilities.

Like health care organizations practicing shared governance, schools of nursing utilized committee structures to empower faculty in decision-making. Faculty were members of several committees or task forces and influenced decision-making in many situations.

Leadership at all participating schools of nursing was multidirectional. The majority of survey and interview participants had many opportunities to provide their input, have their opinions and concerns valued, and influence decisions.

The majority of survey and interview participants believed that nursing students should learn and experience practices of shared governance in classroom and clinical areas. They listed suggestions regarding shared governance experiences in classroom and clinical areas but did not explain how various activities could be implemented. Group activity was valued by the majority of survey and interview participants; however, group activity does not necessarily incorporate shared governance practices. Group dynamics that provide decision-making, responsibility, accountability, trust, collaboration, and conflict management are determinants for

shared governance behaviors. However, survey and interview participants were not able to elaborate on how shared governance should be learned and implemented other than by exposing nursing students to numerous course and clinical experiences during their nursing program.

Recommendations for Further Research

Findings and conclusions from this study generated recommendations for further research. They include the following:

1. This study should be replicated in another state with baccalaureate degree nursing programs as the study population and with some modifications made to the Leadership Survey.
2. Nursing students should be included as survey and interview participants in addition to nursing administrators and faculty. The inclusion of nursing students would provide additional perceptions of shared governance leadership behaviors in a school of nursing.
3. Results of this study indicate that some shared governance practices are being implemented in Tennessee's baccalaureate schools of nursing. A study should be conducted to assess how nursing students graduating from nursing programs with shared governance practices adapt to professional practice in traditional autocratic health care organizations.

4. Nursing student activities outside of the classroom and clinical areas should be included as part of the identification of shared governance practices to survey participants.

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APPENDIX

APPENDIX A

GAINING ACCESS

LETTER TO DEAN/DIRECTOR OF BACCALAUREATE NURSING PROGRAMS

Date

Dean/Director
University
School of Nursing
Address
City, TN Z.C.

Dear:

I am a registered nurse with twenty three years of experience. Currently, I am working toward completion of a Ph.D. in education at the University of Tennessee in Knoxville. The research topic for my dissertation concerns the practices of shared governance models of leadership in nursing education. I wish to study practices of shared governance of nursing administration and faculty, in baccalaureate nursing programs in my state. In addition, I am interested in what graduate nurses need to know to practice in health care organizations implementing the shared governance model of leadership.

In order to gather data to answer my research questions, I am requesting permission from you to contact administrators and faculty at your nursing school. Participation in the study will be voluntary. Participants may withdraw at anytime without penalty. Data will first be collected through quantitative questionnaire surveys to obtain initial information on practices. Participants will also be asked to complete a short demographic survey.

Qualitative data in the form of semi-structured interviews will be conducted later with some of the participants. Interviews would take less than an hour. Interviews will be audiotaped to assure accuracy of participant's responses. Written approval would be obtained for use of audiotaping prior to the interview.

Due to the nature of the research, all data will be handled by the researcher. Neither the names of the participants nor the nursing schools will be used at any time during the presentation or writing of the study. Anonymity and confidentiality shall be maintained throughout the study. After completion and acceptance of this study by the University of Tennessee all written data will be shredded and tapes will be erased after transcription.

You may contact the researcher at any time a question or concern arises regarding the research project at {Phone Number}. I would be pleased to share study

results with you.

I will begin my data collection in the near future. I would greatly appreciate your willingness to participate as well as granting of permission to contact faculty members regarding their participation. Your participation will benefit nursing education and is essential to the success and validity of this project. If you give consent for participation I request that you forward written approval with your signature and provide a list of faculty members for mailing of a letter of intent and data collection instruments.

Thank you.

Sincerely,

Mary Lynn Brown, RN, MSN
Doctoral Candidate
College of Education
University of Tennessee

LETTER TO POTENTIAL SURVEY PARTICIPANTS

Date

Name

University

School of Nursing

Address

City, TN Z.C.

Dear:

I am a registered nurse with twenty three years of experience. Currently, I am working toward completion of a Ph.D. in education at the University of Tennessee in Knoxville. The purpose of this letter is to request your support in a nursing research project. An overview of the project follows.

The research topic for my dissertation concerns the practices of shared governance models of leadership in nursing education. The primary purpose of the study is to determine the status of shared governance in baccalaureate nursing programs in the state of Tennessee. In addition, I am interested in what nursing administrators and faculty think graduate nurses need to know to practice in health care organizations implementing the shared governance model of leadership.

I have been granted permission from {Name of Dean/Director} to ask for your participation in this study. Participation in the study is voluntary. You may withdraw from participation at anytime without penalty.

You are being asked to respond to two data collection instruments. There are no identifiers on these instruments so anonymity is maintained. The first instrument collects general demographic data. The second instrument has two parts. Part One lists 48 statements with a Likert scale response. Part Two lists five statements each followed by an open-ended question asking participants to provide a more detailed response. It will take approximately 30-40 minutes to complete the survey. A stamped, addressed envelope is provided for survey return.

I would like to also collect qualitative data in the form of semi-structured interviews from willing participants. Interviews would take approximately an hour. Interviews will be audiotaped to assure accuracy of your responses. Written approval will be obtained for use of audiotaping prior to the interview. At the end of the quantitative data collection instrument, on a separate sheet of paper, participants are asked to indicate their willingness to be interviewed. Participants willing to be interviewed are asked to provide their name and the name of their school so an interview time can be arranged. The interview process is a vital part of this study. I

would appreciate your participation in the interview process.

Due to the nature of the research, all data will be handled by the researcher. Neither the names of the participants nor the nursing schools will be used at any time. Confidentiality shall be maintained throughout data collection, presentation, and writing of the study. All written data will be kept in a locked cabinet at the researcher's residence. After completion and acceptance of this study by the University of Tennessee all written data will be shredded and all interview tapes will be erased after transcription.

You may contact the researcher at any time a question or concern arises regarding the research project at {Phone Number}. I would be pleased to share study results with you. Your return of the survey instrument will constitute informed consent to participate in the study. Please return completed survey instrument by {Date, 1995}. Thank you for your time and interest in this research project. I believe study results will provide some important insights for nursing education and the nursing profession.

Sincerely,

Mary Lynn Brown, RN, MSN
Doctoral Candidate
College of Education
University of Tennessee

P.S. If you do not wish to participate in this study, please return unanswered data collection instruments in the stamped, addressed envelope provided. Thank You.

APPENDIX B

LETTER TO INTERVIEW PARTICIPANTS

Date

Name

University

School of Nursing

Address

City, TN Z.C.

Dear:

You expressed interest in being interviewed by responding yes to the last question on the survey instrument "Would you be willing to be interviewed on practices of shared governance?". Now, I am ready to collect qualitative data in the form of semi-structured interviews. Interviews will take approximately 30-60 minutes. Interviews will be audiotaped to assure accuracy of your responses. Written approval will be obtained for use of audiotaping prior to the interview.

Due to the nature of the research, all data will be handled by the researcher. Neither the names of the participants nor the nursing schools will be used at any time. Confidentiality shall be maintained throughout data collection, presentation, and writing of the study. All audiotapes will be kept in a locked cabinet at the researcher's residence. After transcription of audiotapes, tapes will be erased. After completion and acceptance of this study by the University of Tennessee all transcriptions will be shredded.

Signed consent forms are required by federal law to be kept for three years. They will be kept in a locked filing cabinet at my residence and after three years will be shredded.

If you desire to participate in this part of the study please contact me at {Address} or by phone at {Phone Number} to arrange an interview time. Enclosed is a copy of the consent form for your review. Thank you for your interest in this research project. Your participation provides vital information for nursing education.

Sincerely,

Mary Lynn Brown, RN, MSN
Doctoral Candidate
College of Education
University of Tennessee

CONSENT FORM FOR INTERVIEW

I am conducting a research study as part of the requirements for a doctoral program at the University of Tennessee, Knoxville. The title of the research study is "The Administrative and Educational Practices of Shared Governance in Baccalaureate Nursing Programs in the State of Tennessee". The purpose of the study is to determine what the status of shared governance is in nursing education in one state.

You have voluntarily accepted to participate in this study. You are being asked to respond to semi-structured interview questions. Your responses to interview questions will help clarify practices of shared governance in your baccalaureate nursing program.

The interview process will involve approximately 30-60 minutes. I will audiotape the interview to assure accuracy of your responses. Neither you nor your school will be identified on the tape or transcriptions of the tapes. Complete confidentiality will be guaranteed. Tapes will be stored in a locked cabinet and will be erased after being transcribed. Written transcriptions will be shredded after acceptance of the dissertation by the University of Tennessee. You may direct any questions to Mary Lynn Brown at {Phone Number}.

Your participation in the study is voluntary. You may withdraw from your participation at any time without penalty. I will be pleased to share the results of the study with you if you desire.

I, the undersigned dean/faculty member, have read and understand the above explanation of the research project. I have had my questions satisfactorily answered concerning the study. I give my consent to Mary Lynn Brown to use any data I have provided as stipulated above.

Name

Date

Signature

APPENDIX C

DEMOGRAPHIC DATA INSTRUMENT

A. Age to nearest birthday:

☐ 20 and younger	☐ 36-40	☐ 56-60
☐ 21-25	☐ 41-45	☐ 61-65
☐ 26-30	☐ 46-50	☐ over 65
☐ 31-35	☐ 51-55	

B. Sex: ☐ Female ☐ Male

C. Race:

☐ Asian	☐ Hispanic	☐ Other
☐ Black (African American)	☐ Native American	
☐ Caucasian	☐ Oriental	

D. Initial Nursing Education:

☐ Associate Degree in Nursing
☐ Diploma
☐ Baccalaureate Degree in Nursing
☐ Master of Science in Nursing

E. Highest Degree Presently Held:

☐ Associate Degree in Nursing	☐ Other (specify):
☐ Baccalaureate Degree in Nursing	
☐ Baccalaureate Degree in other field	
☐ Master's Degree in Nursing	
☐ Master's Degree in other field	
☐ Ed.D.	
☐ Ph.D. in Nursing	
☐ Ph.D. in other field	
☐ D.S.	
☐ D.S.N.	

F. Academic Rank/Administrative Title (check both if applicable):

☐ Teaching Assistant	☐ Assistant Professor	☐ Dean
☐ Lecturer	☐ Associate Professor	☐ Chair
☐ Clinical Instructor	☐ Professor	☐ Other
☐ Assistant Instructor	☐ Director	(Specify)
☐ Instructor	☐ Assistant Director	

G. How many years have you been employed at this nursing school, include present year?

☐ 1	☐ 10-11	☐ 20-21
☐ 2-3	☐ 12-13	☐ 22-23
☐ 4-5	☐ 14-15	☐ 24-25
☐ 6-7	☐ 16-17	☐ over 25
☐ 8-9	☐ 18-19	

H. Tenure: ☐ Yes ☐ No ☐ Tenure Track

I. Employment Status: ☐ Full Time ☐ Part Time

APPENDIX D

LEADERSHIP SURVEY

The purpose of this survey instrument is to assess leadership variables relating to the shared governance model of leadership demonstrated by administrators, faculty, and students in a nursing program.

PART I:

Instructions:

This series of statements was drawn from the literature and summarizes the functions and responsibilities of various members in a nursing education program. Please answer each statement by circling only ONE number. Base your response on practices at your nursing school.

LEGEND: SA (Strongly Agree), A (Agree), U (Undecided),
D (Disagree), SD (Strongly Disagree)

	SA	A	U	D	SD
1. The Dean/Chair delegates authority.	5	4	3	2	1
2. The Dean/Chair empowers faculty to make decisions.	5	4	3	2	1
3. The Dean/Chair empowers nursing students to make decisions.	5	4	3	2	1
4. The Dean/Chair communicates clearly with faculty.	5	4	3	2	1
5. The Dean/Chair communicates clearly with nursing students.	5	4	3	2	1
6. The Dean/Chair understands the needs of faculty members to share governance in the organization.	5	4	3	2	1
7. The Dean/Chair understands the needs of nursing students to share governance in the organization.	5	4	3	2	1
8. The Dean/Chair encourages faculty to make decisions and act on them.	5	4	3	2	1

	SA	A	U	D	SD
9. The Dean/Chair trusts faculty to be responsible and accountable.	5	4	3	2	1
10. The Dean/Chair trusts nursing students to be responsible and accountable.	5	4	3	2	1
11. The Dean/Chair manages conflict by interaction and resolution.	5	4	3	2	1
12. The Dean/Chair encourages and promotes attendance at professional meetings and conferences.	5	4	3	2	1
13. Faculty assist in curriculum planning and development.	5	4	3	2	1
14. Faculty are encouraged to explore and initiate curriculum changes.	5	4	3	2	1
15. Faculty are consulted prior to the Dean/Chair making major decisions.	5	4	3	2	1
16. Faculty are involved with curriculum evaluation.	5	4	3	2	1
17. Faculty are encouraged to plan and develop academic policies.	5	4	3	2	1
18. Faculty are involved with evaluating the Dean/Chair.	5	4	3	2	1
19. Faculty are involved with the evaluation of other faculty members.	5	4	3	2	1
20. Faculty are involved in identifying the strengths and weaknesses of the nursing program.	5	4	3	2	1
21. Faculty are given the opportunity to share in decision-making.	5	4	3	2	1

	SA	A	U	D	SD
22. Faculty encourage nursing students to participate in the evaluation of their strengths and weaknesses.	5	4	3	2	1
23. Faculty have the autonomy to identify and implement meaningful learning activities for their nursing students in the <u>classroom</u> .	5	4	3	2	1
24. Faculty have the autonomy to identify and implement meaningful learning activities for their nursing students in <u>clinical</u> areas.	5	4	3	2	1
25. Faculty are involved in identifying the competencies nursing students from their program need for entry into the nursing profession.	5	4	3	2	1
26. Faculty are involved in the preparation of <u>short</u> term goals for their nursing program.	5	4	3	2	1
27. Faculty are involved in the preparation of <u>long</u> term goals for their nursing program.	5	4	3	2	1
28. Faculty are involved in the planning and development of the philosophy of their nursing program.	5	4	3	2	1
29. Faculty are involved in the planning and development of objectives for their nursing program.	5	4	3	2	1
30. Faculty are involved in the planning and development of the nursing courses they teach.	5	4	3	2	1
31. Faculty make changes in curriculum and instruction according to the needs of nursing students.	5	4	3	2	1

	SA	A	U	D	SD
32. Faculty feel they are an important part of the academic team.	5	4	3	2	1
33. Faculty manage conflict by interaction and resolution.	5	4	3	2	1
34. Faculty trust nursing students to be responsible and accountable.	5	4	3	2	1
35. Nursing students have input in curriculum planning and development.	5	4	3	2	1
36. Nursing students are encouraged to explore and be self directed in achieving their goals and objectives.	5	4	3	2	1
37. Nursing students are encouraged to evaluate their curriculum.	5	4	3	2	1
38. Nursing students are encouraged to evaluate their clinical experiences.	5	4	3	2	1
39. Nursing students are encouraged to be involved in development of academic policies.	5	4	3	2	1
40. Nursing students participate in evaluation of faculty members.	5	4	3	2	1
41. Nursing students are prepared to function as autonomous professionals.	5	4	3	2	1
42. Nursing students participate in evaluation of the Dean/Chair.	5	4	3	2	1
43. Nursing students participate in identifying the strengths and weaknesses of their nursing program.	5	4	3	2	1
44. Nursing students learn to manage conflict by interaction and resolution.	5	4	3	2	1

	SA	A	U	D	SD
45. Nursing students are active participants in their educational process.	5	4	3	2	1
46. Nursing students collaborate with faculty.	5	4	3	2	1
47. Nursing students collaborate with the Dean/Chair.	5	4	3	2	1
48. Nursing students are given the opportunity to share in decision-making.	5	4	3	2	1

PART II:

Instructions:

This series of statements and questions assess what nursing students are being taught and experience relating to the shared governance model of leadership in the classroom and clinical areas. Please answer each statement by circling only ONE number. After each statement a question is asking the participant to give more details.

LEGEND: SA (Strongly Agree), A (Agree), U (Undecided),
D (Disagree), SD (Strongly Disagree)

	SA	A	U	D	SD
1. Nursing students are prepared to function within various leadership models upon graduation.	5	4	3	2	1
2. Specify and describe leadership models that nursing students learn and experience (Autocratic, Democratic, Laissez Faire, Transformational, Transactional, Shared Governance):					
3. Nursing students learn about concepts of shared governance within the <u>classroom</u> .	5	4	3	2	1

4. Specify and describe concepts of shared governance presented in the classroom (empowerment, decision-making, communication, trust, professional autonomy, accountability):

5. Nursing students learn about concepts of shared governance while in clinical areas. 5 4 3 2 1

6. Specify and describe concepts of shared governance presented in clinical areas:

7. Nursing students experience the shared governance model of leadership within the classroom. 5 4 3 2 1

8. Describe classroom experiences that model or reinforce principles of shared governance:

9. Nursing students experience the shared governance model of leadership in clinical areas. 5 4 3 2 1

10. Describe experiences in clinical areas that model or reinforce principles of shared governance:

11. What do you believe nursing students should learn and experience in classrooms and clinical areas to prepare them for participating in a shared governance organization?

Would you be willing to be interviewed on practices of shared governance?

Yes _____

No _____

If you answered yes to the above question, please provide your name and the name of your school on this paper so that I may contact you at a later date. Your participation in the interview process is an important aspect of this study. Your assistance will benefit nursing education. A stamped, addressed envelope has been provided for separate return of this page so that anonymity of the quantitative data is maintained. Thank you for your time and interest.

APPENDIX E

INTERVIEW GUIDE

1. How long have you been in your present position?
2. What do you like most about nursing education?
3. How would you describe the nursing leadership practiced in your nursing school.
4. Explain the organizational structure of your nursing school and reflect on your role in that structure.
5. Describe typical decision-making processes at your nursing school.
6. What is your role in the decision-making process?
7. How satisfied are you with your decision-making role in your nursing school? Explain.
8. Describe how information is communicated in your nursing school between administration, faculty, and nursing students.
9. Describe your understanding of the term "professional autonomy".
10. To what extent do you believe you have professional autonomy in your position at this nursing school? Explain.
11. Describe your understanding of the term "shared governance".
12. Describe specific applications of shared governance practiced at your nursing school.
13. What specific practices of shared governance would you like to see implemented at your nursing school? Why?
14. What educational experiences do nursing students need in classroom and clinical areas to prepare them to function as graduates employed in shared governance organizations?

VITA

Mary Lynn Brown was born on July 25, 1948 in Martins Ferry, Ohio. She stayed in Martins Ferry for a short time then returned to Detroit, Michigan with her parents. She grew up in the Detroit area graduating from St. Francis Xavier High School in June, 1966. She received her Bachelor of Science degree in Nursing from Mercy College of Detroit in May, 1971 and began her nursing career at Outer Drive Hospital in Lincoln Park, Michigan. A year after graduating from college she married and moved to the northeast suburbs of Detroit and began a career in critical care nursing. In 1973 she resumed academic studies and received a Master's Degree in Nursing from Wayne State University in June, 1975.

In December, 1975 she moved to Bolingbrook, Illinois with her husband and son resuming her career in critical care nursing. In 1978 after living in the Chicago area for a couple of years her family was transferred to Knoxville, Tennessee.

Shortly after moving to Knoxville she returned to nursing as a clinical instructor in respiratory nursing . After two years in teaching and the birth of a premature daughter, she returned to critical care nursing for a year. In 1981 after divorcing she was a nurse manager on a Respiratory Urology Unit from 1982-1985.

In the fall of 1986 she entered the University of Tennessee, Knoxville to resume graduate studies. She was employed as a staff nurse on an Orthopedic Neuro Unit while pursuing graduate studies.

Her major field of study was Curriculum and Instruction. She received the Doctor of Philosophy degree in August, 1995.