Researching Shared Governance

A Futility of Focus

The article by Erickson et al,"The value of collaborative governance/staff empowerment," (2003;33[2]:96-104) impressed me with the amount of commitment and work that the authors undertook to assess their specific approach to empowerment. The data clearly show the relationship between specified work constructs and employee satisfaction. Such work can do nothing but advance the understanding of the workplace and the activities of the profession.

For years, however, I have been concerned about a number of issues related to the study of shared decision-making models. In my own work, I have always advanced that the concept of shared governance is just that, a concept. I have never claimed it was a theory, a conceptual framework, or an organizational principle upon which behavior should be based. It does, however, reflect a set of principles, exemplifies a theoretical context, and gives form to a particular conceptual framework related to work, the workplace, and the worker.

Structures of shared decision-making are based on a set of principles about the relationship between the worker and the workplace. This is exemplified by the extensive theoretical work of the Tavistock group and others during the past 30 to 40 years.[1] Many of the conceptual and theoretical underpinnings have been validated through research done in a wide variety of work settings.[2,3] In fact, shared governance, as I have described it, is really more a structure and process that represents the theoretical and conceptual work of Argyris, Bennis, Lawrence and Lorsch, and others around the characteristics and requisites of empowered

workers and workplaces.[4,5] What my work with shared governance has simply done is given it a nursing contextual framework and applied it to the places where nurses work.

Shared governance is, in short, simply a structural model through which nurses can express and manage their practice with a higher level of professional autonomy. Shared governance really has no substance, does not stand alone, and does not represent an exacting or definable set of characteristics upon which any particular or disciplined research can be based. Regardless of its moniker (shared leadership, clinical governance, collaborative governance, shared decision-making, etc), shared governance cannot itself be studied since, in truth, there is nothing there to study.

I have been criticized over the years for not undertaking more research around the concept of shared governance. As stated above, it would be incongruous for me to undertake a body of research that would explicate the integrity, conceptual rigor, and theoretical validity of something that is no more than a structural configuration.[6] What shared governance represents in all its forms is a format for the expression of the necessary autonomy that any professional body needs to make a vibrant and living contribution to those it serves. Shared governance merely serves as a vehicle for the necessary antecedents to autonomy: partnership, equity, accountability, and ownership.[7]

Because shared governance can take a whole range of forms and formats, there is no one particular construct that is valid enough or sufficiently generalizable to provide any

viable research foundation. Thus, when I see studies, such as those by Hess,[11] Havens,[12] Kennerly,[13] and now Erickson, that purport to evaluate shared governance and its corollaries, I wonder exactly what relationship we are trying to establish. In any effective shared decision-making model that articulates these thoroughly researched and well validated four principles as accurate delineators of empowerment, any study will invariably show a positive relationship between organizational performance, worker value, and work outcomes.[14,15] I have yet to see a study where this is not so.

I would challenge anyone to find contrary evidence when the principles of partnership, equity, accountability, and ownership are exemplified in the workplace and in its relationship to the worker. And, quite frankly, I have never seen any successful shared decision-making model that does not exemplify these four principles.

The same argument can be made for contemporary hospitals having obtained "Magnet Excellence" status. I have personally consulted at over 90 percent of those hospitals that have achieved the Magnet Award. I know those hospitals have shared decision-making models. I'm virtually certain that those models have provided a format that significantly contributed to their having achieved the Magnet Award. However, shared decision-making models did not cause these organizations to obtain the Magnet Award. What their shared decision-making models did accomplish, however, was to provide a format, a framework, a structure within which the processes of practice decision making, autonomy, service excellence, and organiza-

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tional influence, could logically and consistently unfold.[16]

I submit that without such a shared decision-making structural framework, the processes of excellence measured by the Magnet program would have no way to be sustained. In the final analysis, that is the single most valuable thing that can be said about shared governance or any shared decision-making model. Studying the model produces no relevant or meaningful data. On the other hand, broad-based research shows that the continuing application of the principles of partnership, equity, accountability, and ownership, upon which any legitimate shared governance model is based, is essential to sustain both autonomy and professional practice.[17] Shared governance and any other shared decision-making model simply provide a format within which those principles can be applied in a consistent and sustainable way.

For this reason, I am more positively inclined to Linda Aiken's work related to measuring "Magnet" organizations.[18] Here, a comprehensive view is undertaken regarding the presence of the factors that assure success, satisfaction, and positive clinical outcomes. It is the presence of these factors in a sustaining organizational format that is the best validation of the organizational structure and decision-making model that supports these values. It is in the presence of the products of shared governance where the value of shared governance (and any of its corollaries) is most evident.

I am now both confident and mature enough in my own role and professional practice that I no longer have to ask what kind of an organizational structure and decision-making approach an organization maintains when evaluators suggest a workplace that is desirable, satisfying, with good practice and excellent outcomes. I now know with high certitude that it is empowered, shared, autonomous, and satisfying with a structure that assures those processes are sustained. Call that what you will, I have simply chosen to call it shared governance. At the end of the day, any structures that empowers the practitioner, assures autonomy, places decisions where they belong, supports professional practice, and advances clinical outcomes is a place any one of us would want to work.

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