Coming together is a beginning. Keeping together is progress. Working together is success. —Henry Ford

CHAPTER OBJECTIVES

Upon completion of this chapter, the reader will be able to do the following:

» Understand the characteristics and components of membership in a profession.

» Define the role of the professional nurse as a member of the profession with focus and emphasis on the rights, privileges, and obligations of professional membership.

» Describe the professional and ethical foundations of membership in a profession and the obligation to demonstrate those ethics in practice behaviors.

» Outline the unique characteristics of professional and knowledge workers and the environment in context necessary to support and advance professional work.

» List at least five elements of evidentiary dynamics (evidence as a system) essential to validate the meaning and value of a profession and the work it does.

» State the personal characteristics of the professional as an individual and explain how they align person and profession in a unitary expression of the life and work of a profession.

» Identify specific characteristics and skills of the team leader in relationship to transdisciplinary collaboration, team dynamics, team decision making, managing conflict, and achieving team outcomes.

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Chapter

2

Becoming a Professional Nurse

As a professional nurse, you are about to embark on one of the most significant careers anyone could experience. As a member of the nursing profession, there are few places in the healing community where you do not have a role to play. One of the most important realities applied to any career is the flexibility and opportunity it provides to fulfill meaningful goals and personal meaning. Nursing is one of the very few professional choices that meets the conditions of providing both financial value and personal meaning (Daly, 2005).

At the same time, nursing brings with it many challenges for the profession's members. While nursing is certainly one of the oldest healing practices in human history, it is one of our youngest professions (McDonald, 2010). The scientific foundations and the affirmation of the art associated with its practice have only recently been acknowledged and expanded upon since the time of Florence Nightingale. Compared with other professions such as medicine and the law, nursing is still in its formative developmental stages and is just beginning to mature in a way that can be equitably compared with other disciplines (Marriner-Tomey & Alligood, 2002).

The journey to a **profession** and as a professional required a great deal of effort by a number of nurse leaders during the 20th century who devoted their work and lives to advancing the foundations, science, and practice of the profession. However, this effort is still considered a work in progress both at the individual and the national levels. This chapter emphasizes the conditions and characteristics of a

REFLECTIVE QUESTION

What are six ways in which a professional (knowledge) worker is different from any other employee work group?

profession and the personal behavior that reflects the action of a profession and demonstrates membership in the professional body. Furthermore, the social mandate (licensure) and characteristics of professionals are outlined, along with the tools and insights necessary to embed professionalism into the role of each professional person.

The Elements of a Profession

Several components define the unique character of a profession. Throughout history, special honor has been bestowed upon those persons who possess wisdom or great knowledge. The notion of collective knowledge associated with a particular group has been a consistent theme throughout human history. The idea of a group with specialized knowledge becoming a profession emerged from the association of a particular arena of knowledge with a specific kind of practice (Bennet & Bennet, 2004). Professions were identified with not just having great knowledge but also doing something important with that knowledge that made a difference in the world. The practice or the use of particular specialized knowledge is generally associated with the emergence of professions.

Professional Work Is Knowledge Work

The central role of knowledge is critical to the existence of professions. In fact, knowledge is one of the characteristics that is an identifier or distinguishing feature that separates professions from other work groups. A central assumption of any profession is that learning within a unique body of knowledge must take place before a person becomes a member of the profession. This body of knowledge is specific and unique to the profession and is sanctioned by the formal

CRITICAL THOUGHT

Being a member of a profession is not just a different way of doing work; it is a different way of being. This expression of the role and its relationship to the world represents a special contract between the person and society (called a "social contract"), and reflects the high expectations for the exercise of that role from those who will depend on it.

profession as the foundation of the expression of its work in the world. All members of the profession are obligated to demonstrate in their own personal capacity the expression of this knowledge and to demonstrate its application in all the work they do. In fact, formal membership is one of the critical elements of a profession. The specialized knowledge of members is a unique professional element that grounds the profession and is one way of showcasing that special membership. Membership is earned, and all members are expected to demonstrate the ability to fully utilize this professional knowledge and participate in the life of the profession. It is also expected that the professional, by virtue of his or her membership and work, is committed to advancing the role and contribution of the profession.

Because knowledge is a centerpiece of the substance of a profession, the continuing relevance of the professional must be demonstrated on an ongoing basis by that person's commitment to expanding personal knowledge and his or her participation in continuing the development of knowledge over the life of membership in the profession (Steiger & Steiger, 2008). This idea that knowledge development continues for the professional and expands his or her personal knowledge base supports the profession's commitment to those persons whom it serves, ensuring that they will experience the most relevant service that represents the latest state-of-the-art information or skills in a way that advances their interests and meets their needs.

SCENARIO

Freda Smith, RN, always seems to sidestep any team or group action on the unit that might improve nursing practice and patient care. Whenever asked to participate, Freda always says other demands and issues limit her availability. Freda has been heard to say, "I do 10-hour shift work; I come here to do my job, and taking care of patients is all my job requires me to do. When I'm done here, I'm done. Don't ask me to do anything more than my job; I don't have time, and I'm just not interested." Freda seems to represent the voice of others on the unit. As a result, a small percentage of nursing colleagues do most of the work related to ensuring shared governance, developing policy, defining best practices, advancing unit learning, resolving unit issues, and making practice decisions. The only problem with this model occurs when decisions are made and those nurses who did not participate in making them complain and often struggle against making recommended changes.

(continues)

SCENARIO *(continued)*

Discussion Questions

1. Name three things that are occurring in this environment that do not represent a context for professional practice.
2. Which kinds of behaviors are Freda and her colleagues representing in their attitudes?
3. Does it appear that professional behavioral expectations have been established and clarified on the unit?
4. Which kinds of professional behavioral expectations might unit staff want to establish first as terms of engagement for members on the unit?
5. After basic professional behavioral foundations are defined, which next-step actions might need to occur to establish them as the patterns of professional behavior on the unit?
6. What is the role of both the clinical leader and the manager in reinforcing these decisions and ensuring these expectations are consistently met throughout the unit?

The Profession Becomes Identified with the Person

A key element of the life of a profession is the understanding that for the professional, the role becomes closely identified with the individual, such that the profession becomes a part of the person's individual identity and the person demonstrates who he or she is through the lens of the profession. In this way the profession and the person become one and cannot be differentiated from each other (I *am* a nurse). For the professional, his or her work is not simply a job. It is, instead, an expression of the person's identity, a representation of his or her ownership of the work and life of the profession 24/7/365 at all times and in all places. For the professional, work is not codified in hourly increments and prescribed only within the context of a job category or an institutional position. Instead, the profession is a personal role the professional occupies and lives everywhere, all the time. The professional understands that members of society expect him or her to represent their best interests at all times and will respond to their call for services any time the need arises.

CRITICAL THOUGHT

Professions have a social mandate; that is, they receive their authority to act from the society they serve. For nursing, as with any licensed profession, it is against the law for institutions to unilaterally control the profession. Instead, such controls are defined by state legislatures and regulated by the state's professional board. Professions and professionals are members of an international discipline, which responds to a human call for care that is broad and universal. Nurses must keep in mind that this mandate responds to a greater call than is expressed in simple institutional employment. Nurses, therefore, always express their accountability to the public, which empowers them; they are not just beholden to the institutions within which they practice.

Professional Work as a Social Mandate

One of the unique characteristics of professionals is the recognition that they provide a socially sanctioned or mandated service. Professions, in fact, often emerge as a response to a social mandate or trust that provides a social good or fulfills a social obligation for their role. As a consequence, licensing regulations usually enumerate the conditions of membership and the statutory requisites for membership and practice in the profession (U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, 2011). The language of such regulations usually specifies the nature of the social mandate and the obligations that it represents. For nurses and physicians, the mandate usually includes language about the service that is provided, the competence necessary to hold membership in the profession, and the social requisites for legitimate expression of that membership in a way that meets the demands of the license.

The social mandate may also identify penalties for nonperformance or professional wrongs. Because the expectation for personal contribution is so clearly outlined and the failure to do so causes severe social deficits, the penalties for failing to live up to the standards of the profession are usually significant. A profession is a social trust; the breach of this trust results in considerable cost to the profession and the person. Society needs to be assured that its professions do not take their obligations lightly or fail to respond to the call for service in a way; they need to know that professionals will minimizes risk to members of society, and advance outcomes and fulfill the interests of those members (Roux & Halstead, 2009).

CRITICAL THOUGHT

If you are a professional, you may or may not be an employee of an institution. If your license is active, however, you are always a member of your profession.

Knowledge Work Always Changes

Besides establishing a knowledge foundation for the profession, another obligation for the profession is its ability to advance and change membership and practice expectations as new knowledge informs the actions of the professionals (Megill, 2004). This continual generation of new knowledge is so critical to all professions that they invariably have mechanisms that take the professional beyond the basics to new and higher levels of understanding and contemporary research about practice that alters expectations and changes behaviors. This knowledge generation continually assures society that the professional is fulfilling his or her obligation to advance the practices of the profession in a way that ensures the best interests of the client will always operate as the centerpiece of the work of the profession.

Evidence, Improvement Science, and Translation of Knowledge and Best Practices

The digitalization of data in the 21st century has advanced the quality and effectiveness of the management of data and its utility in informing practice behavior (Becerra-Fernandez & Leidner, 2008). The fluidity, flexibility, portability, and mobility of data and data systems now make it possible to use just-in-time tools to quickly inform clinical decisions and actions. This evidence-based process has now become the fundamental expectation of clinical practice. Indeed, it serves as the frame of reference for the future of clinical professions and the work they do.

Although it is not within the scope of this text, **evidence-based practices** and the **evidentiary dynamics** (referring to evidence as a system) upon which they are based are critical characteristics of the behavior of professionals. Professionals are expected to make judgments in a way that reflects facts and truth. Because of the highly variable nature of persons, conditions, and circumstances related to clinical practice, building an evidentiary foundation for deliberation and **decision making** is important to best inform clinical judgment, choices, and actions (Rapp et al., 2010).

Every contemporary knowledge-based profession, including nursing, needs to be able to demonstrate its commitment to fact- and value-based choice making

REFLECTIVE QUESTION

What is the difference between a knowledge worker and an employee work group? Are there different performance expectations for knowledge workers and for regular employee work groups?

and clinical action. No matter which approaches to evidence-based practice are used by the professional, the result must reflect the best evidence regarding what is both viable and effective in advancing the health and safety of the population (Melnyk & Fineout-Overholt, 2014). Evidence-based practice is both a science and a discipline. Every approach that relies on the use of evidentiary dynamics includes five components:

1. Formulating a critical clinical question using a **PICO approach** (P: patient or problem; I: intervention; C: comparison; O: outcomes).
2. Searching for, gathering, and integrating data and relevant evidence using a variety of information resources (general, filtered, and unfiltered). Officially sanctioned and integrated clinical systems databases must be used to ensure that any information used for decision making is relevant, comparable, and rigorous. Table 2-1 identifies some of the recommended databases.
3. Determining the validity of the data. This requires critical deliberation regarding the relevance of the data to the clinical situation and the applicability of the specific data to which the clinical practice is being compared.

Table 2-1 Recommended Databases

Background Information	Filtered Resources	Unfiltered Resources
UptoDate	ACP Pier	OVID MEDLINE
Harrison's Online	Cochrane	PubMed
E-books	Natural Standard	CINAHL
	InfoPOEMS	PsycINFO
	MDConsult (First Consult)	BIOSIS
	Natural Medicines Comprehensive Database	
	OTseeker	
	Physiotherapy Evidence Database (PEDro)	
	National Guideline Clearinghouse	

CRITICAL THOUGHT

Evidence-based practice suggests that practice competence is constantly in motion, reflecting the latest just-in-time information that guides patient care. Therefore, practice knowledge is always changing, and professionals change with it. The professional makes sure that every element of practice reflects the latest understanding of the best standards of patient care in everything he or she does.

4. Using the evidence for a particular clinical scenario. Determining the efficacy and closeness of the relationship to the diagnosis, treatment or intervention, therapeutic impact, potential, and possible outcomes within a specific patient situation or clinical scenario.
5. Evaluating the impact of evidence-based choice(s). Evaluation questions relate to the appropriateness of the choice for diagnosis, intervention, clinical change, practice processes, or patient condition. This critical fifth stage is what informs the most relevant up-to-date practices. When consolidated with other information related to the same clinical circumstance or scenario, this information serves to build the database and inform future practice.

Evidence-based practice principles are explained in greater detail in many other resources.

One notable characteristic of good professional reflection, interaction, and communication is the ability of professionals' to base their arguments on evidence that has been well researched, clarified, and formed into a legitimate presentation or communication. The professional nurse should look at this process as a foundational framework for practice by every nurse, thereby ensuring that communication within the discipline and with other disciplines is always informed by the understanding of evidence-grounded principles. Translating these principles into specific patient applications and effectively and rationally communicating their purpose, reason, and the clear logic of nursing action informed by good evidence represent the very foundations of professional practice.

With regard to professional work, the professional nurse has no accidental conversations. Every opportunity for dialogue and interaction includes careful thought and planned communication. Evidentiary dynamics (the system of evidence) provides a systemic and scientific format that frames the logic that drives effective clinical decision making. Within the context of the PICO process and its faithful execution, the professional nurse relies on a consistent format within

which the deliberations of practice and clinical application unfold in a confident, informed, and rational manner. The ability to express this model of communication and the disciplines embedded in it demonstrates the professional character of the nurse to everyone with whom she or he communicates. This competence generates a sense of clarity, personal confidence, accuracy, and trust in the validity of the clinical, patient care content shared in the conversation.

The importance of this aspect of evidentiary dynamics, in which the nurse takes a systematic/scientific approach to clinical judgments and actions cannot be understated. The professional decision-making mechanism and clinical relationship reflect a scientific manner of conversation and interaction. Furthermore, good clinical decision making is negatively affected to the extent that any of the elements of care wind up being poorly constructed, badly thought out, or not expressed in a conscious, intentional, and scientific manner (Bennet & Bennet, 2010). Ideally, the need for positive and professional communication will be addressed in the classroom during nurses' education, being explicitly recognized as a particular characteristic of competence. An evidence-based framework then becomes the tool set with which the professional nurse demonstrates great skill and accuracy in the clinical setting by projecting clarity, confidence, and understanding about practice and patient care that is palpable to those with whom he or she is communicating. Effective, clear, confident, precise, and accurate generation of information in a focused presentation leads to a more effective response, higher trust, and greater perceived value of both the informant and the information.

The Ethical Foundations of a Profession

Professions generally make an explicit statement about their trust relationship with society by developing a strong **code of ethics**. Such a code generally assures others that patients' best interests will not be jeopardized by members of the profession, that members will act within the parameters of the code and the law, that they will enforce their code with all members, and that they will update that code in ways that reflect the latest understanding of appropriate behaviors and practices.

The Nursing Code of Ethics

The nursing profession, like all professions, has a code of ethics that enumerates the expectations of members of the profession. It also defines the personal and performance standards that represent what is best in the work of the profession. The nurses' code of ethics specifically spells out the role and relationship of the

nurse with individual patients and in regard to issues that advance the health needs of society as a whole. The code further defines the behavioral expectations of members of the nursing profession in terms that relate to who and how they serve the public and advance the social good.

The American Nurses Association (ANA) has historically created the professional code of ethics and conduct for professional nurses in the United States (Hain, 2009). This code of ethics has strong roots in ethical theory and principles and in the establishment of a culture of virtue and value. It focuses on the specific and individual role of the nurse as a professional and as a key healthcare provider. The ANA code enumerates ethical foundations of the individual and collective action taken by professionals in relationship to patients' health and the health of the community. The code of ethics is grounded in the understanding that the profession as a whole and the individual nurse will use the code as the foundation for ethical analysis, decision making, and professional behavior.

The ANA's Code of Ethics for Nurses includes nine specific provisions, each of which is accompanied by detailed explication of its interpretation in the application of related principles. These nine provisions are as follows:

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimal patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy (ANA, 2001).

A code of ethics is generally adopted by a profession to assist professionals in making appropriate decisions in a way that helps the individual differentiate between right and wrong and apply this understanding to critical decision making. A hallmark of a profession is that a code of ethics is considered part of the regulation of the profession. It outlines a defined framework for professional responsibility and guides **critical thinking**, especially that related to difficult decisions. The code of ethics provides as clear a framework as possible regarding which behavior meets the criteria for ethical behavior, guiding the

SCENARIO

A young man was admitted to your nursing unit with severe infectious complications caused by acquired immunodeficiency syndrome (AIDS). He was very sick, with a large number of opportunistic infections, and required continuous complex medical and nursing care.

Sarah, one of the staff licensed practical nurses on the unit, had made her religious and personal feelings related to AIDS and homosexuality very clear, often stating that the disease was "a sentence from God." She was often heard to say that those who get such diseases were receiving the "wrath and punishment of God." Although many of the nursing staff did not hold the same beliefs as Sarah did, they avoided scheduling Sarah as a caretaker for this patient and simply did not discuss the issue further.

Discussion Questions

1. Does the ANA Nurses Code of Ethics address this clinical scenario as an ethical issue?
2. Should there be nursing code of ethics policies related to these kinds of patient care issues?
3. How should the ANA Nurses Code of Ethics be implemented in the clinical environment by the professional nurse(s)?

individual or discipline to make a correct or right decision within a particular set of circumstances. From the perspective of the profession, failure to comply with the code of ethics for practice can result in questions regarding the appropriateness of the individual's behavior and its impact on continuing membership in the profession.

Strong moral and ethical foundations are an essential element of the behavior of all professionals. Because the professions act within a trusting relationship forged with the society they serve, the social expectation that professionals will maintain a high level of ethical behaviors is itself considerable. Nurses' adherence to a strong code of ethics justifies the confidence placed in them by society, allowing members of society to maintain personal trust toward the professional as an individual and believe that this individual will always act in the best interests of those patients whom he or she serves. It is incumbent upon each professional nurse to be familiar with the profession's code of ethics and the ethical principles articulated by the organizations within which the nursing professional practices. Whenever questions related to ethical nursing behaviors arise in the practice environment, it is always expected that the professional nurse will explore these issues and work to resolve ethical challenges in a way that best addresses the standards of the profession and the needs of those it serves.

Shared Governance and Creation of a Professional Infrastructure

It has been more than 30 years since a professional structure of **shared governance** for nursing emerged (Allen, Calkin, & Peterson, 1988). Over that time span, many approaches have been proposed to demonstrate the appropriate applications of professional governance in a wide variety of international settings (Porter-O'Grady, 2009). Whether many of these models of professional governance (within the concept of shared governance) actually represent the principles grounding professional governance is the subject of much debate and the source of many challenges and implementation models.

The basic structures of professional governance are generally straightforward. Law, medicine, engineering, architecture, academics, and other fields have exhibited many shared characteristics of self-governance for generations, in spite of modifications to their models reflecting those disciplines' professional and cultural differentiation. Notions of self-governance applied to nursing and nurses, by comparison, have emerged more recently and have been approached more tentatively, with a level of reticence not generally experienced by the other professional disciplines. Although much of this uncertainty can be attributed to the relatively recent emergence of the idea of self-governance as applied to an

almost completely employed profession such as nursing, the following issues also influence nursing's engagement with shared governance:

- Self-governance has historically been a masculine exercise with no prevailing mechanisms for its modification to a predominantly feminine application.
- Nursing has almost always been an employed profession; the nurse is generally an employee and, therefore, is subordinated to traditional employment conditions and legal requisites.
- Historically, power relationships in nursing have been predominantly vertically derived (hierarchical) and directed, whereas the power relationships in the major professions have traditionally been much more classically horizontally (collateral, collaborative) delineated.
- Much of the social and legal framework for the traditional professions is designed to protect the public and the independence of the discipline—that is, the discipline's control over its right to practice with little external or regulatory constraint. Much of the social and legal language applied to nursing is also designed to protect the public. However, most regulations more carefully circumscribe nurses' practice boundaries, limiting nursing's scope in a way that keeps it fully within those defined parameters and curtailing the nursing's independence.
- The requirements of professional membership in the traditional professions are clear in making succinct, crisp, and definitive statements about members' education, certification, and experience. In nursing, such statements are often diffuse, undifferentiated, and broadly described, leading to requirements that are often confusing and differ in each state.

A Profession Is as a Profession Does

The journey of nursing to professional maturity has been slow and challenging. Unbundling the historical gender challenges faced by nurses (who have traditionally been mostly female) has been a significant undertaking. Because of the social discomfort associated with working women in the past and the public challenges of institutionalized sexism and oppressed group syndrome, nursing's capacity to break out of traditional models of institutional control and to function as a viable profession has met with highly variable degrees of success. In addition, nurses have themselves at times been a great source of the problem in limiting nursing's ability to be recognized as a fully professional discipline.

Constructing a Structure for Professional Practice

The initial purpose of implementing shared governance models within nursing was to provide a structural format that would enable the profession to implement the more horizontal professional relationships and practice power enablers so essential to professional self-governance.

The basic principles of shared governance include the following ideas:

- Ninety percent of decisions are local.
- Decisions are made where they are implemented.
- The work is knowledge work.
- Quality is achieved by the owners of the work.
- Decisional competence is required.
- Clinical decisions require ownership and investment by clinicians.

While acknowledging the social and employment structures that have long characterized the practice of nursing, shared governance provides a model where shared **accountability** serves as the framework for partnering practicing nurses with their institutions. Shared governance mechanisms provide for mutual obligation and advantage in the interest of advancing shared commitment by both nurse and institution in advancing patient care excellence. The four cornerstones of a profession's ownership and accountability—practice, quality, competence, and knowledge management—serve as the structural framework that enables nursing staff to demonstrate these professional requisites and that supports the institutional partnership necessary to incorporate resource and institutional stewardship into patient care.

Efforts to build nursing's structural forms and bylaws that state how those structures work have provided much evidence of the ability of such models to distribute ownership and instill accountability in members of the profession. Although the power balancing necessary for true professional behavior remains far from fully realized, the infrastructure for its emergence has certainly been well established. This, of course, raises an important question: Why has so little professional empowerment and transdisciplinary interdependence among nurses emerged even in organizations where significant progress toward real professional status has been evidenced?

The Four Requisites of Professional Governance

Much contemporary leadership research demonstrates the importance of differentiating the patterns of behaviors in knowledge workers from those in employee work groups (Maliszewska, 2013). Although it is considerably more

CRITICAL THOUGHT

Professional delineation and functional job categories do not mix. In a professional environment, job categorization based on knowledge work is simply not an adequate framework for addressing both the requirements and the nature of professional work. Position charters and role expectations serve as better tools for defining the accountability and obligations of professionals than do job descriptions that focus on tasks and functions. It will be a continuing challenge for professional nurses to revise the language used to describe their work by adopting more professional terminology for it.

difficult for nursing than for traditionally masculine professions, work has progressed to make this kind of identification possible. Since the early 1980s, considerable effort has been undertaken to challenge traditional organizational constructs and their legitimacy in light of the need to develop an organizational framework for professional behaviors. Much of the research has suggested that professional (knowledge work) behaviors can be neither obtained nor sustained in an employee work group structure where the expectations for performance are defined and controlled by the workplace and are predominantly functional in orientation; where few peer-driven performance and evaluation processes operate; where greater value is assigned to volume (how many patients are seen), time, and motion determinants (how much work the nurse is doing); and where work is highly subordinated to others and essentially management controlled and driven (managers make the decisions about clinical work). In fact, these practices actually impede the occurrence of professional behaviors and prevent them from being demonstrated by practicing nurses.

These identified organizational characteristics have been entrenched in the healthcare system since its onset. Even today, medical predominance in decision making is supported by a highly vertical, tightly structured organizational construct (management and physician control) that has limited the professional growth and development of nursing in significant ways and created particular challenges to the development of a professional control framework for nursing practice. Even though contemporary nurses are academically well prepared and the nursing profession includes the largest number of women with bachelor of science in nursing degrees and graduate-educated women in health care, professional, social, and relational equity—a status commonly achieved through such academic parity—has eluded nursing. The strongly hierarchical organizational framework woven into the fabric of the healthcare system and the rigid control exerted by the medical model over clinical decision making have served as

REFLECTIVE QUESTION

Does the change in the status and role of nursing parallel changes that have occurred as a result of the women's movement over the past five or six decades, or is the change specifically related to advancing women's education and its impact on nursing?

strong impediments to nursing's ability to obtain the equity necessary to claim (and advance) the comparable professional value of nurses.

Yet, much has changed over the past two decades to open up the opportunity to create a stronger professional framework for nursing, thereby laying the groundwork for equity, inclusion, and leadership. Advancements in the education of nurses, the growth of nurse practitioners and their leadership in primary care, and the expansion of the nursing role in politics and policy development have all converged to enhance the credibility and status of nurses across the broad landscape of the public sector. In contrast, in the hospitals and healthcare organizations where the majority of nurses still work, much of the essential structure driving organized nursing has not fundamentally changed. The introduction of the Magnet program for nursing excellence and the requisites of "structural empowerment" (shared governance) has done much to recalibrate the professional nurse's role in decision making affecting practice, education, quality of care, and clinical care. The construction of a professional, sustainable infrastructure that governs the nursing profession's decision making and relationship to healthcare organizations has laid the foundation for a partnership with such organizations that advances the interests of quality health care and the integrity and contribution of nursing professionals.

Personal Obligation for Participating in Governance

One of the basic obligations of members in any discipline is active participation in the life of the profession. Professions depend on the committed, concerted action of individual members who join in the collective enterprise to advance the interests of the profession and to assure the public that the profession is making its best commitment to meet the needs of the public. Professions are not amorphous bodies that do their work in an automatic or mindless manner. Because the profession is a trust held to a particularly high standard of accountability by the public, it must constantly be aware of its obligation to change and adapt to the adjusting needs of the shifting social context. Human existence never remains static. If positive and appreciative work is being undertaken, the

human condition advances and improves. Because complexity science teaches us that nothing can stay the same, humans are always either advancing or retreating in their social circumstances. Advancing human interest requires continuous and dynamic proactive effort. This is no less true for the professions than it is for societies in general.

Nursing has a tradition of encountering difficulty in fully engaging its members to participate in the life of the profession. Because of the long history of job and functional orientation, many, if not most, professional nurses have not always interacted with the obligations of their profession in a meaningful way to advance its interests, their role, and the practices necessary to meet changing contemporary patient needs. Yet, membership in a profession implies ownership, investment, and engagement. When a person becomes a member of the profession, it represents a change in that individual's life circumstance, especially given

SCENARIO

The nursing staff on the medical unit has noticed that numerous nursing beliefs and practices exist with regard to particular approaches to preventing pressure ulcers in geriatric patients cared for over the long term. There is a wide variety of long-held clinical approaches, depending on the learning and experiential background of individual nurses. No uniform standard appears to be used on the unit. The issue has been referred to the unit practice council.

Discussion Questions

1. Does the unit practice counsel have the authority to establish clinical standards and practice for all nurses on the unit?
2. Which evidence-based approaches should the unit practice council employ in making decisions about setting a clinical standard?
3. After the clinical standard has been established for the unit, are all nursing staff required to adhere to and implement the standard in their own practice?
4. How does the unit council hold nursing staff members accountable for correctly performing the standard?
5. Should all professional staff expect to serve as members of the practice council, and how is that obligation rotated among staff members?

CRITICAL THOUGHT

All professional nurses are members of the professional nursing staff. This means they have a personal obligation to advance the profession of nursing, to fully participate and engage in professional activities that support practice, and to translate the decisions of the profession into personal practice standards that advance the delivery of high-quality nursing care.

that professional membership also implies social identification of the profession with each person who holds membership in the profession. This "I am a nurse" character of professional identification entails a kind of personal ownership of the life and work of the profession that is not bound by time, job, organization, or circumstance. One is a member of a profession 24/7/365; there is no respite, escape, or separation of the person from the role. If an individual seeks only job or functional work that can be dropped or forgotten when the workday ends or simply left in the workplace, then membership in a profession should not be pursued. The individual professional never really leaves the work of the profession. That is, this professional work accompanies the professional into every circumstance and activity every day he or she is a member of the profession. For true professionals, every activity they pursue represents their continuous membership in the profession. Everything the professional is and does is seen by others through the lens of the individual's membership in the profession. In any particular moment of action, the individual professional represents the whole profession. Often the only glimpse the patient has into what the nursing profession as a whole is or is not depends on the patient's view of the profession seen through the lens of the patient's relationship with a single nurse. At any given moment, the public's view of the nursing profession is influenced by what they see in a specific member of the profession and how that person represents the profession in the relationship between nurse and patient. For that moment, the whole of the profession rests on that professional's shoulders; he or she is, in that moment, the only window others have into the profession of nursing.

Participation in the life of the profession for the professional is not an invitation, but rather an expectation (Porter-O'Grady & Malloch, 2010). Far too often in organizations and systems where nurses work, they are invited to engage in the life of the profession where they practice. The problem with invitation is that it implies a capacity to opt out, to turn down the invitation. Far too often, given the option implied by invitation, nurses readily reject participation in the life of their profession. Often this professional activity is seen as "extra work" or beyond the basic "call to duty." Consistent with their character, professions

distinguish between the obligations of membership (expectation) and the optional elements of engagement (invitation). For example, it is optional for a professional to engage in social events and gatherings of professional members. At the same time, for example, it is an expectation that professionals will engage in quality improvement activities that demonstrate the value of their practice.

Professional membership and the structures of governance require any discipline to delineate between expectations of membership and invitational occasions. For their part, members of the nursing profession are expected to fully participate in decisions affecting practice, quality of care, education and competence, and research and the generation of knowledge. These are the fundamental activities of the nursing profession that inform the functional work of the professional nurse; they are the professional "non-negotiables." When nurses shirk these active obligations of members in the nursing profession, it diminishes the professional character of nursing, limits the performance of its professional work, and presents an image to others of nonengagement, ultimately resulting in basic task-based, functional, process oriented, employee workgroup behavior.

The Use of Language Characterizing Professional Dialogue

All of these delineations of the professional character of nursing work suggest a critical focus on the appropriateness of language or profession. Language is a highly visible characteristic of communication that suggests to both the speaker/writer and the listener/reader a particular kind of interaction. Language communication is a specific kind of dialogue that takes into account the circumstances as well as the content of the dialogue. Language is important; others hear and perceive it in a way that represents the character and circumstances of the speaker (Zerbe, Ashkanasy, & Hartel, 2006). For good or for ill, professions have a unique framework for their dialogue that includes specific patterns of communication and interaction that represent the "personality" of the discipline. Whether the profession is law, architecture, engineering, medicine, or nursing, each has a language that uniquely frames relationships and demonstrates to the world the unique character of the discipline.

Shared decisions have the following characteristics:

- Decentralized
- Team based
- Horizontal

- Inclusive
- Engaging
- Accountable
- Point-of-service based

One of the challenges for nursing is the historical language of work embedded in the traditional job-oriented categorization of organizational activity. It is easy to see why the perceptions of nurses and nursing are informed by language that demonstrates the nurse's unilateral representations and perceptions of role and function. When the nurse is heard saying, "I'm just a nurse" or "I'm a floor nurse" or "I'm just doing my job" or "I'm here for the pay," it is not surprising that those listening would assume that the individual has a more vocational or employee work group orientation. Such mistakes in identification are not supported when the professional is overheard saying, "My area of practice is . . ." or "Our standard for practice is . . ." or "I am Sandra, your professional nurse today" or "Let's change our practice plan for this patient." Such language frames serve as evidence of professional interaction and present the profession to others in a way that emphasizes the professional orientation of the nurse.

For the professional nurse, there are no accidental conversations with colleagues and patients. Every interaction has the potential to create a perceptive reaction. The professional nurse is careful to clearly reflect in her or his personal behavior and language those images that best demonstrate professional demeanor, interaction, and character.

Personal Presentation of the Professional Self

Along with language, personal behavior plays an important role in representing professional character. Personal codes of dress, conversation, action, and expression play a critical role in how persons present themselves to, and are perceived by, both other members of the profession and outsiders to the profession (Samovar, Porter, & McDaniel, 2012). Professionals recognize that the codes of conduct defined by the profession and by membership in a profession operate at all times and set the parameters for behavioral and role expectations with self and others. The requisites to respect oneself and all others regardless of personal feelings or differences is an important foundation in demonstrating collateral and equitable behavior.

The personal characteristics of the leader are as follows:

- Colleague role with the staff
- Seeks to engage staff decisions

- Provides information for staff decisions
- Open to staff direction and partnership
- Uses good group process
- Models engaging, challenging decisions
- Advocates for staff leadership

Evidence indicates that the perceptual presentation an individual makes during the first 3 minutes of interactions with others sets the perceptual frame of reference that will linger for the longest time in the memory of others (Davidhizar, 2005). There is rarely an opportunity to redo these initial 3 minutes and recalibrate that first perceptual image obtained by others in what is essentially a flash in time. Therefore, it is important for individuals to constantly be aware of how they present themselves to their various publics and which specific image they want others to sustain about them over time.

The intention and clarity of the professional person with regard to codes of dress, conduct, communication, competence, relationship, and interaction are critical considerations for the establishment of professional standards and guidelines for peer behavior. It is important for the professional nurse to remember that at any given moment in time, from the perspective of the patient, whatever image the individual nurse presents to the patient is the one to which the patient will consistently refer in future conversations about the nurse or the nursing profession. If the nurse's demeanor is gruff and uncaring, if an action is brusque and impatient, if the nurse's attitude is egotistical or haughty, or if the interaction is hurried and dismissive, it will contribute to the observing individual's perception and ultimately will be generalized to the profession as a whole. There are no accidental moments in the interaction between the professional nurse and others. All interaction and communication for the professional is intentional and

THE FIRST 3 MINUTES LAST FOREVER

- Dress
- Grooming
- Eye engagement
- Inclusive
- Confident
- Facial features
- Posture

purposeful and, therefore, must be carefully considered as the nurse operates within the context of her or his role, knowing that the effects of these actions will be significant and lingering.

Interactions with Other Disciplines

Perhaps one of the most significant barriers to full professional recognition of nursing is the perceptions that nurses create among fellow employees that influence their view of nurses (Heuer, Geisler, Kamienski, Langevin, & O'Sullivan Maillet, 2010). As psychiatric clinical studies have clearly shown, all behavior has meaning. Also, in terms of personal identity, each persons is treated precisely as he or she expects to be treated and generally no different from that expectation. Although this understanding can be hotly debated, the intent here is to emphasize that how individuals express their expectations of self and others influences which behaviors toward those individuals are expressed and how others generally and consistently relate to those individuals because of those self-expectations.

Behavioral self-expectations need first to be clear to the individual before he or she can expect to see those expectations reflected in how others treat the individual. If a person is unclear about what those behavioral expectations are within his or her own role and relationship, then it should come as no surprise that others perceive mixed messages with regard to which relationships and behaviors are acceptable, marginal, or completely unacceptable to the individual. Lack of clarity around expectations makes it impossible to determine correct and appropriate patterns of sustainable behavior and responses, leading to ambiguity and uncertainty that results in confusion and risk in practice and patient care.

In the absence of clearly congruent and well-defined behavioral expectations, others will often respond within the context of what they see regarding the person's behaviors. If, for example, a person is consistently angry and acting out, others' reactions to that person will be predominantly a response to the consistent anger-based behavior. This holds true if the person consistently acts passively, childishly, aggressively, or dependently or if he or she exhibits behaviors that indicate fear, anxiety, uncertainty, lack of confidence, or subordinating. In each case, the individual might expect a direct response to those behaviors, not necessarily the equitable response received. When congruence between the behavior defined by the individual and the behavior exhibited by him or her is lacking, the response from others will be unclear, uncertain, and confused.

Clarity with regard to professional behavior and personal behavior that demonstrates congruence is critical to ensuring consistent and appropriate

interprofessional interaction. Much of a person's perception of himself or herself as a professional depends on the person having worked through his or her role and contribution within the profession. How well a person displays feelings of equity related to his or her self-perception and relationship with other professionals, and how well the person demonstrates a clear set of expectations by behaving and performing equitably, will lead, in turn, to equitable respect and behavior from others.

The issue of poor self-image within the nursing profession has some notable roots that are worth exploring, and they deserve further discussion. Indeed, it is important for nursing faculty and leadership to engage in a discussion of this issue with novice nurses prior to their beginning professional practice. Such a dialogue should address many of the impediments to equitable behavior among the professions in a frank and critical manner before new nurses begin professional practice. This frank and open class discussion or small-group dialogue between faculty and students should cover many, if not all, of the following issues affecting professional equity:

- Nurse must overcome and dismiss the notion that other disciplines (notably physicians) are better educated and more well informed; have a deeper understanding of patients' needs; are fully knowledgeable regarding the work of others in a way that informs patients' needs; are directly in control of all clinical practice; and are, in the final analysis, the captain of the clinical ship.
- Nurses must find clarity around historical gender equity issues that often persist as undercurrents in many interdisciplinary relationships. This exploration needs to include an accurate understanding of the role of women in human and workplace history; the unique contribution of women to the human experience; a full understanding of gender differentiation and its role in understanding equity; cultural gender typing, which often suggests subordinating roles for women; the unique values women contribute to knowledge management; and women's ways of critical thinking, knowledge translation, and decision processing.
- For nursing and nurses, it is important to explore traditional and originating role characteristics of the nurse; the journey from functional to professional delineations for nurses; the growing scientific foundation for nursing practice; the different foundations for clinical judgment and decision making; the centrality of nursing to the coordination, integration, and facilitation of the clinical continuum; and the health script of the nursing role forming its foundations and driving its practice.

- Nurses must consider how they present themselves to their peers and their publics. Foundational and practical issues should be explored related to dress, presentation, manner, articulation, clarity, self-acceptance, professional pride, and the dynamics of interdisciplinary interaction. Simulation or practice opportunities that clearly demonstrate appropriate patterns of behavior are critical to establish a foundation for these behaviors upon which subsequent professional interactions can be built.
- Some dialogue should center on the sociological, ethnographic, cultural, and economic forces that influence the character of self-perception and the framework for personal expression and interdisciplinary relationships. This discussion should include mechanisms that reflect nurses' and physicians' different economic, cultural, and sociological foundations, which underpin self-perception, worldview, relational characteristics, role choices, and relational capacity. Nurse educators should suggest strategies for accommodating such differences as part of the development of behavioral patterns that will help the new nurse adopt equitable behaviors that reflect his or her personal resolution of inequitable circumstances.

SCENARIO

A new drug protocol has emerged for specific cancer patients, requiring a change in the mixture, administration, and evaluation of the drug. A notice has been generated from the pharmacy regarding these issues, indicating that several changes in both interdisciplinary interaction and particular discipline-specific clinical actions are necessary. There is much reaction to the written directive, and some concerns arise regarding the roles of each of the providers and particular issues impacting clinical administration and evaluation.

Discussion Questions

1. Should there be a regular interdisciplinary meeting or council where critical cross-disciplinary clinical issues are addressed at a common table?

2. What is the nurse clinical leader's role as he or she represents nursing at the interdisciplinary table with regard to participation, decision

making, reporting, and implementing decision standards that were arrived at among the disciplines?

3. How do the nursing staff and leadership ensure continuity in collaboration and decision making within the nursing staff and between nursing and other disciplines?

4. Is participation in clinical decision making in a shared governance organization a clinical responsibility or a management responsibility? If it is a clinical responsibility, how do we ensure the clinical representative is the most competent person to represent clinical issues at the interdisciplinary table?

There is clearly a long history of gender and cultural inequity associated with women's prevalence in the role of the nurse. It cannot be expected that individuals new to this role will automatically or "on demand" accept these prevailing realities and experientially adopt new behaviors to overcome them. Nursing as a discipline is currently grappling with fundamental issues that reflect its history as a subordinate, female-dominated discipline and that inform contemporary challenges in building professional practice. Work devoted to resolving these ongoing issues must be intentional and incorporated into the development of the nurse. Rather than simply identifying coursework within which these contemporary issues will be implicitly embodied, it is more important for nurse educators to explicitly address them inside the curriculum and the clinical practice experience of the emerging professional nurse. In addition, faculty and practice leaders must represent, through their own patterns of behavior, that they have personally addressed and resolved many of these issues for themselves. As part of these efforts, they must mentor new nurses, emphasizing the continuing efforts necessary to overcome traditional inequities and to better articulate balanced and equitable behaviors inside the role and relationship of professional nurses and their interaction with the world.

CRITICAL THOUGHT

A person is always treated precisely as he or she expects to be treated, and no differently. The real question is, how do you enable or permit others to behave toward you, and how does their treatment of you closely manifest your own expectations and self-treatment?

The Public and Policy Role of the Nursing Profession

All professions work in a public forum. If a profession is to be relevant and contemporary, and to share in writing the script for its future, its members must commit to undertaking concerted and informed action in the public sector. To advance this effort, the profession must be willing to invest in those things that influence the profession to fulfill its social mandate, to achieve the ends of its work, and to make a difference in the lives of the people it serves (Finkelman, 2012).

Because nursing has been a predominantly employed profession in the past and has been generally managed and seen as an employee work group, it has proved difficult to expand nurses' presence in important roles in the public arena. Physicians and some other health professions have long recognized the critical nature of fully participating in the political and policy sector. Their willingness to actively seek out this level of engagement has advanced the medical agenda, but often created preferred roles and circumstances for physicians that are not always in the best interests of those whom they serve and society as a whole. Because much of physicians' power and influence has not been countered by fuller, more robust participation in the public sector by nurses, much of what patients need and nurses require to advance the health of the communities they serve has gone wanting.

Public Policy

Public policy is usually defined as principled action undertaken by governments. It usually involves political decision making and legislative action. Professional involvement in public policy often demonstrates a profession's interest in advocating for those whom it serves by seeking to influence government and legislation. Public policy can occur at every level of government in the United States. Indeed, health care generally impacts all levels of government, but local entities are more heavily impacted because almost all health service is essentially local.

Shaping public policy generally comprises a multifaceted dynamic that usually involves the interaction and concerted contribution of a wide variety of individuals and collective groups that work in their own best interests to advance particular political or policy agendas (Cheung, Mirzaei, & Leeder, 2010). Using a variety of tactics, these individuals and groups seek to influence policy in those ways they think are best for themselves or others.

In the pursuit of favorable policy, advocacy can take many forms and can represent a variety of interests. Advocacy comprises efforts to influence public

policy by educating others, lobbying for specific interests, and working within the political system to make desired or needed change. Advocates suggest that the issues on which they are speaking are critical to the quality of life of those persons whom they represent. While such activity remains controversial, many professionals and knowledge workers actively advocate for those interests they feel they best represent, thereby seeking to improve the circumstances of those whom they represent and serve. Questions are often raised, however, as to whether advocates best represent those whom they serve or whether, in fact, they represent their own best interests.

Regardless of the discussion and challenges that surround advocacy and public policy involvement, it is generally assumed that professionals are interested in the welfare of those people whom they serve. Professionals often link the welfare of their profession with the greater well-being of those served by that profession. For example, they do the following:

- Illuminate the welfare of the community
- Link the profession to the community
- Meet the ethical obligation to protect the health of all people
- Ensure the healthcare system meets the community's health needs
- Look for a fit between care and people
- Create a common vision for health

Although this can be treacherous ground to walk, this stance indicates the profession's strong ethical and moral drive to more clearly articulate the needs of those who are served and to better organize public systems to meet those needs in a more effective manner (Jaja, Gibson, & Quarles, 2013). For good or for ill, policy and political advocates have played a critical role in establishing much of the existing U.S. healthcare system, which has advanced both the quality of health and the quality of life of American citizens. Without such advocates, little would change in a democratic society.

Nurses have historically been underrepresented in public forums and in the political and legislative arena. Although nursing is the single largest health profession in the United States, nurses' per capita representation in the political and legislative arena has not demonstrated the impact that such large population numbers would suggest. While speaking out on behalf of the health interests of the community is central to the role of the nurse, it is difficult to measure that commitment with a simple headcount of nursing advocates who are active in the public forum (Jameson, 2009).

Membership in a profession assumes that a certain percentage of the member's time is spent working for the interests of the profession at some level of the

public forum. Nursing professionals recognize that policy, political, and legislative action is an important vehicle for advancing improved standards of health, clinical care, and community health (Sonfield & Pollack, 2013). At least some time in the life of each professional should be devoted to addressing issues of public concern. Each professional should demonstrate the fulfillment of his or her personal obligation to make a difference in the life of the broader community and to demonstrate the value of the nursing profession in doing so. There are a number of ways in which the nursing professional can be expected to have an impact on the quality of life of the community:

- Nurses may periodically participate in the life of the profession as an active member of a professional organization and potentially as an officer of the organization. Because much of public advocacy is undertaken by professional organizations, participation in such an organization strengthens its capacity to speak out for the best interests of the population for which it advocates.
- Serving on local boards, committees, and task forces related to health and the quality of life in the community is one of the best ways to demonstrate health advocacy. These roles are generally specific, focused, and time limited, giving the participant an opportunity to contribute at the local level in a role that can have a broad impact on the quality of health in the community.
- Testifying before boards, committees, and commissions regarding specific elements of care and service provides a notable and effective way of educating others and deepening understanding of specific issues, policies, or changes necessary to advance the health and quality-of-life issues of the community.
- Serving on specific health-related boards, committees, and commissions can enable the nurse to influence policy and support particular health causes. Such sources of collective wisdom can strongly influence changes in policy, practice, and education.
- Serving in elective office provides a more definitive and specific process for advocating and legislating advancing public policy and law. Full engagement in the political process ensures stronger ownership, direct political accountability, ability to establish law, and the capacity to drive meaningful and sustainable change.

At every level of professional life, from local agency advocacy to representation in broad-based political roles and legislation, nurses have an opportunity to significantly influence the quality of life of the community. The nurse can act as a change agent by embracing the political and social role of the

REFLECTIVE QUESTION

Does membership in the profession also imply obligation to the community? Does that mean members of the profession have an obligation to demonstrate their commitment by also serving their community in a wide range of public and personal efforts?

profession, and supporting the passage of laws and regulations that establish firm standards upon which quality, safety, and health can be advanced and assured. Each nurse should be fully aware of the personal obligation the professional has to address issues of advocacy and public policy. Making a difference in the life of the community, individual patients, and the profession itself is a fundamental obligation of membership in the professional community (Cowen & Moorhead, 2011). This obligation should not be taken lightly. Each nurse must reflect individually on his or her level of commitment and specific role in addressing personal professional advocacy in a way that advances the interests of those whom each nurse serves. Such advocacy need not be widely publicized; often, it may consist of taking on a quiet normative role in making meaningful changes in health care. For example, the acts of writing letters to politicians, participating in the formulation of position papers, gathering data to support advocacy positions, and developing information materials for patients and community members all demonstrate professional participation in public policy. All nurses should see for themselves the extent to which they can participate in such activities, while recognizing their essential obligation as members of the nursing profession to have an impact on the public and the health of the community. As Florence Nightingale's life suggests, these obligations for professional nurses should not be seen as exceptional, but instead represent usual and ordinary functions congruent with the obligations of the nursing profession and representative of its commitment to expanding health in the community it serves.

CRITICAL THOUGHT

For a professional, personal identity and professional identity act together as one. When individuals become members of the profession, they become so tightly identified with the profession that their membership in it cannot be separated from their personal identity. "I am a nurse" is a statement that enumerates who I am, not just what I do.

Nursing and Transdisciplinary Partnership

As new models of clinical service and care unfold in the United States over the next decade, nursing will find itself more strongly intertwined with care partners in rendering effective patient service. The movement toward accountable care, the focus on the patient's position within healthcare continuum, and the need to demonstrate the value of healthcare services will all radically alter patient care delivery. More strongly developed team-based approaches to planning and managing a patient's care will be essential to meet the "triple aim"—advancing the patient's experience in the healthcare system, raising the quality of care using comparable metrics, and better managing affordability through good stewardship of resources. As payment for services becomes "bundled" within service categories, the partnership between healthcare disciplines will become increasingly important. Under bundled payments, one price will be paid for particular patient populations, episodes of care, or a particular continuum of care, with the single payment covering the costs of all services related to that individual patient, population, episode, or continuum.

Within this system, nurses will work much more closely with other disciplines to coordinate, integrate, and facilitate the relationship between the clinical services that all practitioners provide so as to assure that care is integrated, relevant, and cost-effective, and demonstrates a positive impact on the health experience of the patient. The professional nurse will need to clearly understand her or his contribution to the team, appreciate the value of the role of the nurse as a member of the team, and be able to plan and evaluate services and care with team members. Increasingly, practicing nurses will work independently and interdependently on clinical teams where the majority of provider partners are not nurses. In addition, small groups of nurses will work together with other clinical partners with specific populations or categories of patients and provide the full range of services they need along their continuum of care. Many of these services—if not most—will not be offered in the hospital; rather, they will require that nurses work in smaller practice communities with other nurses and provider partners in unique, often customized models of patient care. Within this model, the new nurse may have as her or his first clinical experiences upon licensure service opportunities that are not hospital based. Indeed, nurses may increasingly seek employment in settings other than hospitals, such as clinics, hospice care, home services, care management, medical homes, community clinical settings, and a range of new and emerging health service delivery settings.

The professional nurse must be aware of these emerging and growing settings for health service delivery and be prepared to ask the right questions about

these opportunities and the role expectations of the nurse. Some of the issues the nurse must explore are summarized here:

1. Are clinical expectations, orientation, staff learning, and developmental opportunities available to develop and refine skills specific to success in the setting?
2. Is the documentation system seamless, integrated, and designed in a way that facilitates the management of data and information in a manner supportive of the nurse's practice and the patient's care continuum and that is relevant to both the environment and the content of clinical care?
3. Are the expectations of the nurse clearly defined in relationship to those of other partners? Is the model of care designed in a way that clarifies individual roles, links individual roles to the collective role expectations, and is flexible and responds to the need for adjustment?
4. Is the physician's role as a partner clearly defined, with easy access and good communication mechanisms demonstrating availability and openness between team and physician?
5. Are patients considered as care partners and incorporated into the plan of care, in clinical communication and interaction, and in major decisions that affect the provider's role and the patient's experience?

Clinically integrated care models that include a broad range of health professionals, whose services are often coordinated within the plan of care by the nurse, are becoming more common as a foundation for clinical practice in almost every setting. These approaches remain a work in progress, and they will need continuing care and attention to their development, application, and evaluation of value. Given that payment mechanisms of the future will increasingly be focused on defined health values that are achieved and sustained (i.e., how the care improved the health circumstances of patients) instead of simply volume metrics (i.e., how many and how often patients use the health system), it will be important for the nurse and her or his partners to carefully evaluate care and determine which services achieve the greatest value for patients.

I Am the Profession

Whatever a profession is or does depends on the contribution and commitment made by its members. How a profession is perceived by others depends on the perception generated by members of the profession who represent its interests to the public it serves. Each person who characterizes himself or herself as a member of the profession has a specific obligation to demonstrate in his or her role the characteristics of what the profession has to offer. Each professional

needs to demonstrate the foundations of what constitutes a profession—skills that represent theoretical and evidence-based foundations in knowledge; active participation in the life of the profession in ways that advance the interests of the profession; continuous, lifelong commitment to education and learning; peer-based competency expectations and performance measurement; meeting the ethical and moral obligations of the profession; demonstrating personal and professional behavior according to the code of ethics for the profession; evidenced by personal disposition, deportment, self-confidence, personal competence, and positive relationship to others, showing the strength and character of the profession. This pattern of professional behavior is exemplified by mentoring, modeling, and contributing to the education and development of peers. Most importantly, it makes a real difference in the individual and collective lives and health of the community. Collectively, these characteristics articulate what a profession does and who a professional is. They are the non-negotiable foundations upon which a profession is built, and they are definitive requisites that

SCENARIO

Sandy Jones, RN, BSN, was a new nurse in the Medical Community Services division of Smith Health System. She had completed orientation and her mentorship, and was now taking on a full patient care assignment on the clinical team devoted to the treatment of patients with chronic congestive heart failure across the continuum of care. This program represented a new approach to delivering care to this at-risk population in a way that brought care services closer to the patient. Much of the design of care focused on supporting the patient in the home and providing support services to keep the patient from needing frequent hospitalizations, as had occurred in the past.

Sandy was doing well in learning the fundamentals of respiratory and cardiac care services. She established a good relationship with some of the nurses involved in the congestive heart continuum of care and was learning a great deal from their colleagueship and mentorship. She was also included as a clinical team member within a larger multidisciplinary team that involved service partners from social work, respiratory therapy, physical therapy, pharmacy, and a physician member. This team was assigned to handle the coordination and integration of services across the patient's continuum of care and was dealing with all of the issues that might arise in this population of patients. They were paid for the services provided to each patient through a capitated bundle prospective model (paid in advance with a fixed fee for all the services provided to this patient population).

Sandy found herself having a difficult time clearly understanding her role as a member of the team. The physician was also a new member but was minimally present and often directive and instructive in his conversation when the care team was meeting to discuss the plan of care for the population as a whole and in individual care team meetings focused on specific patients. Sandy felt that she got mixed signals from the physician and did not fully understand the plan of care and the role of each team member in regard to responsibilities for specific elements of care. Sandy had established a good relationship with the pharmacist, who stated that he also felt that the work of the team was unclear, sometimes fragmented, and led to questionable outcomes.

Sandy saw herself as responsible for coordinating, integrating, and facilitating the efforts of the team and the relationship with the patient. Since she was a new nurse, she was unsure how to demonstrate leadership in this role. She wanted to bring the team together in a way that would more strongly define the team members' roles and their partnership and more clearly identify and distribute functions and activities, but was not sure that she had either the permission or the skills to do so. Sandy was uncertain and needed a plan.

Discussion Questions

1. As a professional nurse, what is Sandy's specific role in relationship to planning patient care?
2. What should Sandy expect with regard to clarity of roles between the disciplines in planning her patient's care?
3. What is the "triple aim" and how does it apply to Sandy's work? How will it be used to measure the impact of that work on the patient's experience, quality of care, and cost of service?
4. Which skills does Sandy need to have in working with the team to clarify roles, integrate the individual efforts of the team, improve good communications between team members, and address specific challenges to the team's effectiveness in planning and delivering patient care?
5. Are there any issues in Sandy's current challenge related to the nursing code of ethics of which she needs to be aware when addressing her concerns and resolving these issues that affect the appropriate delivery of good patient care?

SCENARIO

Jane Thorton, RN, BSN, had worked on the neurology unit at Angel Hospital for a year. She was generally satisfied with her experience and had grown a great deal in terms of her clinical expertise and practice. Jane had established good relationships with her colleagues and with the management of the organization and was very well liked by both. While her patients were complex, Jane had learned a great deal about care of the patient with neurological concerns; she had recently successfully taken her neurological specialty examination and was certified as a neurological nurse.

Jane had taken on a number of responsibilities related to planning and improving nursing care, and had agreed to participate in activities that would strengthen the evidence-based practice approach to policy and protocol development on the nursing unit. She and some of her colleagues were having a difficult time in getting general participation from other staff in these clinical activities on the unit, even though the activities were designed to improve and advance patient care. Jane had approached the manager a number of times asking for support in getting more participation in clinical nursing leadership activities, but the response remained minimal on the unit.

While reviewing articles in one of her nursing journals, Jane came across an article on implementing nursing shared governance in hospital similar to hers. The article outlined some of the challenges and processes associated with successful implementing shared governance approaches in the hospital. Jane was especially intrigued with how empowering the staff by allocating accountability for decisions and actions had improved staff satisfaction, quality of care, and patient outcomes. The hospital that implemented this shared governance model had subsequently received Magnet recognition and presented itself as a hospital of excellence because of the exemplary work of the nursing staff.

Jane was excited and wanted to bring shared governance to Angel Hospital. But where to start? Jane realized that shared governance was a structural model that led to empowerment of the staff, increased the staff authority and accountability for decisions that affected practice, raised the professional character and behavior of the nursing staff, and advanced patient care and the patient experience. Jane was strongly encouraged by how each of those changes demonstrated significant professional value and how both the perception and the role of nursing

could be transformed through the implementation of shared governance. She wondered, however, if she could start small—that is, start at the unit level and create a unique exemplar of shared governance that could grow in a way that one day could affect the whole hospital. Jane decided the time was right and began to think about how she might get started.

Discussion Questions

Respond to the following questions using information gained from this chapter related to shared governance. Expand your information base by using other references on shared governance that may be helpful in dealing with these questions.

1. As a starting point, how can Jane begin to address the possibilities of shared governance with her manager? What might you suggest would help interest her manager in supporting her?

2. Why do professions need to be self-governing when they are accountable to society and to patients? Is it enough to simply have job responsibilities as an employee? If nursing is a profession, what distinguishes it from other work groups and requires it to have a professional governance structure?

3. In implementing shared governance, how would you differentiate invitation (asking people to participate) from expectation (clearly defining which level of participation by professional members is required) so that you can make sure all professional members have a role?

4. What role would practicing staff nurses play in decision making and how does it differ from the role the unit manager would play? How do you clearly differentiate the decisions that staff can make from those decisions that the manager must make? Which decisions require partnership and engagement of both manager and staff that facilitates an effective shared governance structure?

5. When shared governance is in place, how do peers assure engagement by all nurses in the decisions made and the standards set by the professional staff when an individual challenge is issued to them? What is the role of the manager in supporting the decisions of the staff and assuring consistent engagement with them by all members of the staff?

form the foundation of professional life. Without them there is no profession. In turn, without the full engagement, ownership, and investment in the activities associated with advancing these characteristics, a person cannot claim membership in a professional community. As nursing moves into the adulthood of its professional life, these characteristics become the non-negotiable characteristics to which each professional member commits with his or her personal behavior, interactions, and clinical performance.

CHAPTER TEST QUESTIONS

1. Nursing is a fully mature and adult profession now reflecting all of the particular characteristics of professional delineation. True or false?
2. Professionals act predominantly on principle, not simply based on their knowledge, reflecting a belief that principle drives knowledge. True or false?
3. Evidence-based practice is grounded in good policy and reflects inconsistent standardization and procedures. True or false?
4. The Nurses Code of Ethics serves as a foundation for the exercise of nursing practice. True or false?
5. Shared governance is a voluntary process that invites staff to participate in decisions that affect patient care. True or false?
6. Very few professional decisions are made at the point of service or in the patient environment. Most decisions influencing nursing practice in shared governance should be made away from the patient care setting. True or false?
7. All staff must participate in shared governance activities. True or false?
8. For a professional, the identification of the profession becomes a part of personal identity such that it is impossible to separate the person from the profession. True or false?
9. Language is not nearly as important as action is. The way in which a nurse acts is the most important indicator of who the nurse is. True or false?
10. One of the primary roles of the nurse is to coordinate, facilitate, and integrate interdisciplinary interaction around elements of professional practice and patient care so as to ensure synthesis and safety for the patient. True or false?

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Appendix A

Extinguishing Childlike Behaviors in the Professional Nursing Staff

For years, the staff have been positioned as the children of the organization. Many of the control mechanisms in the organization were directed to controlling the otherwise undisciplined and misdirected energies of the workers. Because of their relative ignorance and lack of personal discipline and their willingness to escape the demands of work, it was thought necessary to develop management-derived control mechanisms to provide the frame for acceptable behaviors. Interestingly enough, such mechanisms proved to be a self-fulfilling prophesy for leaders, and the staff ended up behaving exactly as expected. Indeed, such behaviors have now become entrenched within the American workplace on the part of both managers and staff. The staff now exhibit the following patterns of behavior:

- No control over their own work schedules
- No full participation in the assignment of work tasks and responsibilities
- External resolution of personal problems from home or work circumstances
- Nonresolution of relationship conflicts arising out of the work relationship
- Being told what to learn and what is required for personal continuing education
- Parental disciplinary procedures that punish bad behavior and reward good behaviors

Pushing the Children into Adulthood

Leaders must stop the parental patterns of behavior in their tracks if there is to be any meaningful accountability and ownership in the staff. No longer can those parental behaviors be used as a tool of control and staff management. The leader must undertake at least the following measures if that pattern is to be broken:

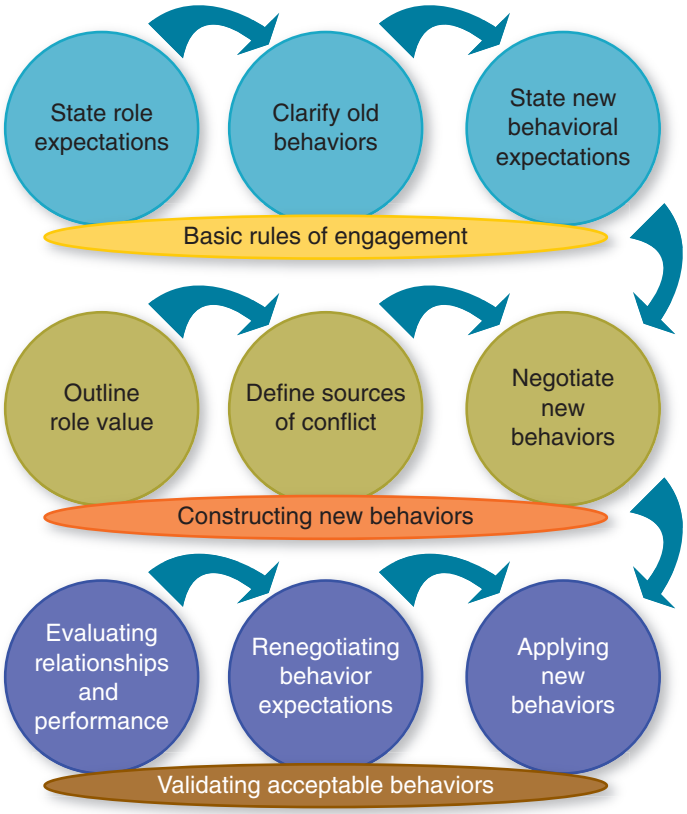
- Mama doesn't work here anymore.
- Staff must manage themselves and their work schedules.

- Staff must be able to problem solve their own issues.
- Staff must fully participate in setting work goals and processes.
- Evaluation of competence is always a staff process.
- Staff must be competent enough to solve their own problems.
- Team-based approaches must be used to set direction, undertake work, and evaluate outcomes.

Leaders of the Profession Extinguish Parental Behaviors

Identify Ideal Leader Role	Name Gap Between Current Behavior and Ideal	State New Performance Expectations
→		→
Outline Developmental Stages for Desired Leader Behaviors	Undertake Program of Leader Development	Apply Expected Leader Behaviors
→		→
Evaluate Leader Progress Against Objectives	Enumerate Corrective Action Strategies	Apply Successful Behaviors in Constant Role Performance

Professionals Get Past Parent–Child Behaviors



Expectation, Not Invitation: The Professional's Membership Obligation

In the adult workplace, all participants are expected to play the role they consented to. There are no participants who do not express an obligation to the role they occupy. Indeed, there are no invited guests to the experience of life. One either owns the role played or the role is not occupied. This seems strange at first glance, but on deeper reflection, it is an extremely important tenet of the adult-to-adult workplace.

NOTE

No one should expect to be invited to the full expression of partnership in the work of the organization. That invitation occurred earlier, when the person accepted the opportunity to work. Everyone has the right to expect the full engagement of their work colleagues and the commitment necessary to make that successful.

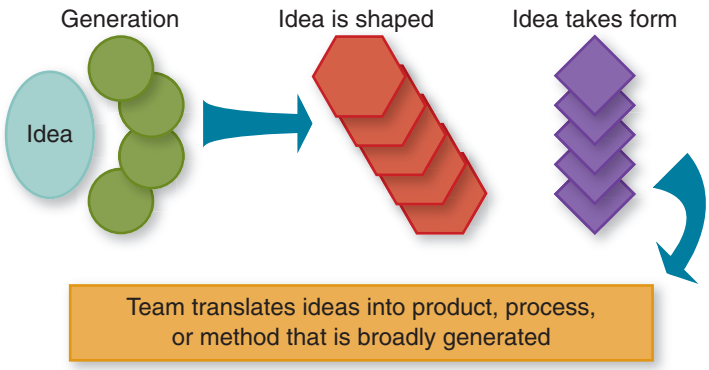
An invitation to play the full role and engage in partnership in meeting the organization's obligations is not a subset of membership in the work community. One is engaged in work precisely to make a contribution within the skill set defined for the role. It is anticipated that the individual will commit all of his or her energies to the exercise of the role without encouragement or coercion. That commitment is a clear element of the expression of the role. Anyone not aware of that expectation as he or she begins the role will not demonstrate it, even if the person is invited to further commit to the behaviors or expectations for the role.

In the adult-to-adult equation, it is anticipated that all players are equally on board. This notion of equity is a primary centerpiece of the valuing of each role and the expression of its relationship and impact on the roles of others. The aggregated effort of all roles is necessary to create the effective interface of energy in a way that ensures good outcomes and work products. Anyone shirking any part of the role will have a clear effect on the work of others and ultimately affect the achievement of good outcomes. In such a circumstance, the effect is a negative one that reduces the net value of the work of all and pulls energy away from the collective effort to add value and produce good outcomes.

Appendix B

The Professional Is a Cocreator

Wise leaders recognize that innovation cannot be unilaterally driven. Ultimately, the creative act is a collective one and requires an ability to excite others and get them on board. No one person is responsible for creating the future, even if the idea was generated out of the thinking and reflecting of an individual. To translate ideas into action requires the concerted effort of a number of committed people in the dynamic act of cocreating—the transformation of an idea into reality.

Creativity Demands Engagement

- Creativity can be generated by individuals or teams, but must be shared to be translated into something of value.
- The leader gathers the creative team together to feed their insight with dialogue, challenge, new thinking, and willingness to explore further.
- The leader can identify in the creative person the unique expression of creativity and make it possible to be nurtured and expressed.
- Creativity within must be regularly nourished by new thinking and exposure to other creative people; otherwise, it dies.