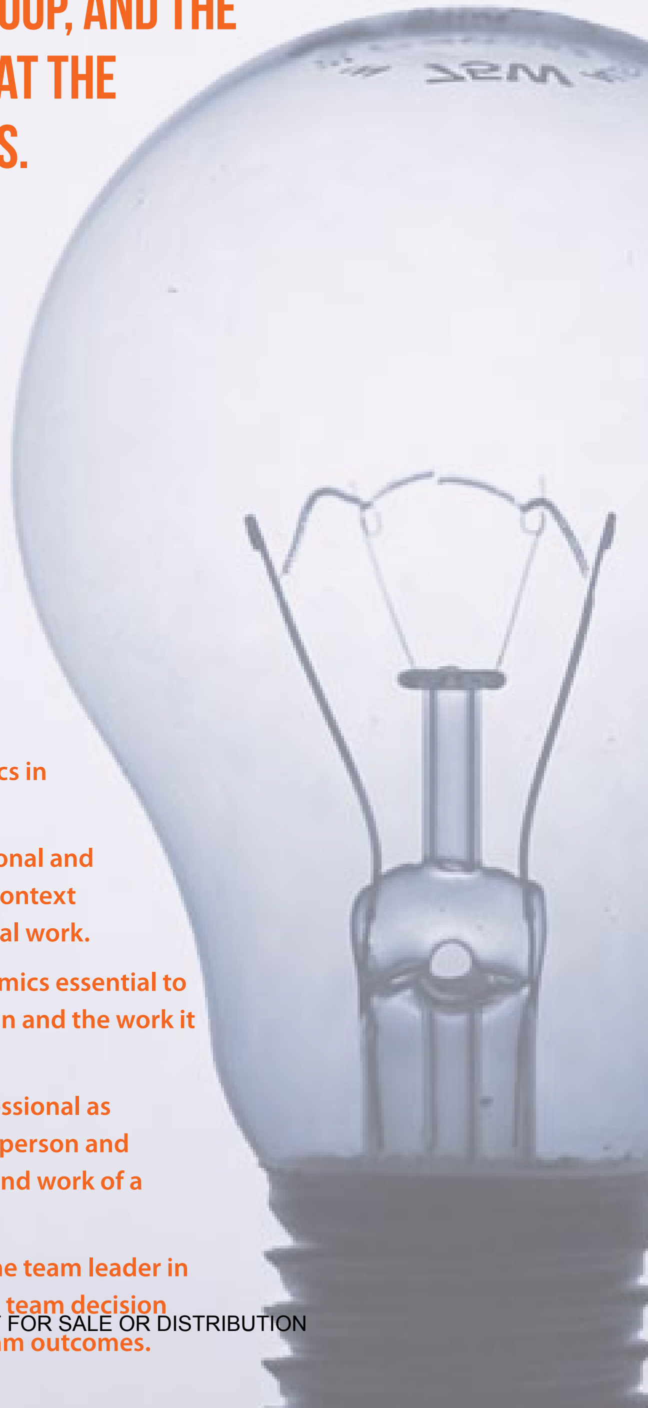
THE GREATER THE LOYALTY OF A GROUP TOWARD THE GROUP, THE GREATER IS THE MOTIVATION AMONG THE MEMBERS TO ACHIEVE THE GOALS OF THE GROUP, AND THE GREATER THE PROBABILITY THAT THE GROUP WILL ACHIEVE ITS GOALS.

—RENSIS LIKERT



CHAPTER OBJECTIVES

WWW

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.

» Enumerate 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 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 enumerate how that aligns 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 collaboration, team dynamics, team decision making, managing conflict, and achieving team outcomes.

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Chapter 1

Transitioning to the Professional Role

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 that 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 both the conditions of value and of meaning (Daly, 2005).

At the same time, nursing brings with it many challenges for its 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 codification of the art associated with its practice have only recently been affirmed and expanded upon since the time of Florence Nightingale. When compared with the other professions such as medicine and the law, nursing is still in its formative stages and is just beginning to mature in a way that can be compared with other disciplines (Marriner-Tomey & Alligood, 2002).

REFLECTIVE QUESTION

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

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The journey to a profession and as a professional has required a great deal of effort by a number of nurse leaders who have devoted their work and lives to advancing the foundations, science, and practice of the profession. However, this effort can be considered a work in progress both at the personal and collective levels. This chapter will emphasize the conditions and characteristics of a profession and the personal behavior that reflects the action of a profession, and it demonstrates membership in the professional body. Furthermore, the social mandate and characteristics of professionals will be outlined along with the tools and insights necessary to embed professionalism into the role of each professional person.

The Elements of the Professions

There are several components that define the unique character of a profession. Throughout history attributions and accolades have been generated to those who characterize wisdom or great knowledge. The notion of collective knowledge associated with an identified group has been a consistent theme throughout human history. The idea of a knowledge group morphed into the format of a profession generating from associating a particular arena of knowledge to a specific kind of practice (Bennet & Bennet, 2004). Professions were identified with not just having great knowledge but with doing something important with that knowledge that made a difference in the world. The practice or the use of particular knowledge is what can be associated with the emergence of professions.

CRITICAL THOUGHT

Being a member of a profession is not just a different way of doing work; it is a different way of being, an expression of the role and its relationship to the world, representing a social contract and reflecting high expectations for its exercise from those who will depend on it.

Professional Work Is Knowledge Work

The centrality of knowledge is critical to the existence of professions. In fact, knowledge is one of the characteristics that is an identifier or distinguishing feature of professions from other groups. A central assumption of a profession is that some unique body of knowledge must be obtained prior to becoming a member of the profession. The body of knowledge is specific and unique to the profession and is sanctioned by the profession as the foundation of the expression of its work in the world. All members of the profession are obligated to demonstrate in

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SCENARIO

Freda Smith, RN, always seems to sidestep any team or collective 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 shared governance, policy, defining best practices, advancing unit learning, resolving unit issues, and making practice decisions. The only problem with this is when decisions are made those who did not participate complain about the decisions and often struggle against making recommended changes.

Discussion Questions

1. Name three things that are occurring in this environment that do not represent a context for professional practice.
2. What 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. What 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, what 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 manager in reinforcing these decisions and ensuring these expectations are consistently met throughout the unit?

their own personal capacity the expression of this knowledge and demonstrate its application in all the work they do. In fact, membership is one of the critical elements of a profession and the particular professional knowledge that grounds it is one way of representing that membership. Membership is earned and the

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expectation of membership is fully exemplifying its knowledge and demonstrating participation in the life of the profession. It is 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 character of a profession, there is emphasis on the continuing relevance of the professional and that person's commitment to expanding the personal knowledge base and in participating in continuing the development of knowledge over the life of membership in the profession (Steiger & Steiger, 2008). This idea that knowledge development continues and grows for the professional supports the profession's commitment to those 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.

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 person, such that the profession becomes a part of the person and the person identifies 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. For the professional, his or her work is not simply a job. It is, instead, an expression of his or her identity, a representation of his or her ownership of the work and life of the profession that operates 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

CRITICAL THOUGHT

Professions are a social mandate and thus receive their power from the society they serve. For nursing, as with any licensed profession, it is against the law for institutions to unilaterally control the profession. 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 social mandate 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 must therefore express their accountabilities to the public, which empowers them, not just the institutions within which they practice.

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or an institutional position. Instead, the profession is something the professional occupies and lives 24/7/365. The professional understands that society expects him or her to represent their best interests at all times and will respond to their call for services any time the need arises.

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, are often a response to a social mandate or trust that provides a social good or fulfills a social obligation for their role. In this classification of the professional role, licensing regulations usually enumerate the conditions of membership and the statutory requisites for membership and practice (United States Congress, House Committee on Veterans' Affairs, Subcommittee on Economic Opportunity, 2011). The language usually enumerates the nature of the social mandate and the obligations that represents. For nurses and physicians the mandate usually includes language about the service that is provided, the necessary 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 usually also expresses penalties for nonperformance or professional wrongs. Because the expectation for contribution is so clearly enumerated and the failure to do so causes severe social deficits, the penalties are usually severe. 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 demonstrate responsiveness to the call for service in a way that minimizes risk and advances outcomes and fulfills the interests of the user (Roux & Halstead, 2009).

CRITICAL THOUGHT

If you are a professional, you may be an employee of an institution, but you are always a member of your profession.

Knowledge Work Always Changes

Besides establishing a knowledge foundation for the profession, an additional obligation for the profession is its ability to advance and change those expectations as new knowledge informs the actions of the professionals (Megill, 2004). This continual generation of knowledge is so critical to the professions that they

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invariably have mechanisms that take the professional beyond the foundation to demonstrate new levels of understanding and contemporary research that alters expectations and changes behaviors. This knowledge generation continually assures society that the professional continually fulfills the obligation to advance the interests 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 and is growing as the foundational frame of reference for the future of the clinical professions and the work they do.

Although it is not in the scope of this text, evidence-based practices in the evidentiary dynamics (referring to evidence as a system) upon which they are based are critical characteristics of the behavior of professionals. Ostensibly, professionals 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).

REFLECTIVE QUESTION

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

Every contemporary knowledge-based profession such as nursing needs to be able to demonstrate its commitment to fact and value-based choice making and clinical action. Whatever variety of approaches to evidence-based practice are used by the professional, the result must reflect the best evidence of what is both viable and effective in advancing the health and safety of the population that is

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served (Melnyk & Fineout-Overholt, 2010). Evidence-based practice is both a science and a discipline. In every approach to demonstrating the use of evidentiary dynamics there are 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 and gathering data regarding integrated and relevant evidence using a variety of information resources (general, filtered, and unfiltered). Officially sanctioned and integrated clinical systems databases must be used in order to ensure that officially sanctioned information is used that is relevant, comparable, and rigorous, such as those shown in the following table.

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	

3. Determining the validity of the data. This requires critical deliberation of the relevance of the data to the clinical situation and ensuring that the specific data to which practice is being compared is used as a reference source.

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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 particular or specific patient situation or clinical scenario.
5. Evaluating the impact of evidence-based choice(s). Evaluation questions relate to successful impact of the choice on 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 aggregate the database and inform future practice.

The reader is encouraged to pursue evidence-based practice principles in greater detail using the many other available resources. One of the lingering characteristics of good professional reflection, interaction, and communication is the ability to base the conversation 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 the nurse so that communication within the discipline and with other disciplines is 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 evidence represent the ground of professional practice.

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.

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

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unfold in a confident, informed, and rational manner. The ability to express this model of communication and the disciplines embedded in it projects a professional character of the nurse in relationship to those he or she communicates with and generates a sense of clarity, personal confidence, accuracy, and trust in the validity of the clinical, patient care content expressed in the conversation.

Such a discipline of these evidentiary dynamics (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 diminished to the extent that any of the elements of care have been poorly constructed or badly thought out or not expressed in a conscious, intentional, and scientific manner (Bennet & Bennet, 2010). It is unfortunate that this discipline of communication is not formalized in the classroom as a particular capacity of competence so the framework of the communication dynamic itself becomes the tool set with which the professional nurse demonstrates great skill and accuracy in presenting a perception of 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 yields effective response, trust, and value of both the informant and the information.

The Ethical Foundations of a Profession

Professions generally represent their trust with society in a strong code of ethics. This code generally assures others that their 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 and the personal and performance standards that represent what is best in the work of the profession. The code specifically spells out the role and relationship of the nurse with individual patients and with issues that advance the health needs of society as a whole. The code further defines the behavioral expectations of members of the nursing profession

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in terms that relate to who and how they serve the public and advance the social good.

The American Nurses Association (ANA) has historically enumerated the professional code of ethics and conduct for professional nurses in the United States (Hain, 2009). This code of ethics reflects a strong foundation in ethical theory and principles and in the establishment of a culture of virtue and value. The code of ethics focuses on the specific and individual role of the nurse as a professional and key provider and enumerates ethical foundations of the individual and collective action of the professional in relationship to patients' health and the health of the community. The code of ethics is promulgated on the understanding that the profession and the individual nurse will use the code as the foundation for ethical analysis, decision making, and professional behavior. There are nine specific provisions of the code of ethics, each with detailed explication of their interpretation in the application of related principles. The nine provisions of the ANA Code of Ethics for Nurses 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 optimum 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 health care 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

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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. (American Nurses Association, 2001)

SCENARIO

A young man was admitted to your nursing unit with severe infectious complications caused by acquired immune deficiency syndrome (AIDS). He was very sick with a broad 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 it clear about her religious and personal feelings related to AIDS and homosexuality, often stating that it 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 at the point of service by the professional nurse(s)?

A code 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 helps the individual apply this understanding to critical decision making. What differentiates a profession is that a code of ethics is considered as a part of the regulation of the profession. It outlines a defined frame for professional responsibility, guides critical thinking especially related to difficult decisions, and provides as clear a framework as possible regarding what behavior meets the criteria for ethical behavior guiding the individual or discipline to make a correct or right decision within a particular set of circumstances. From

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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 in trust for the society they serve, the social expectation that professionals maintain a high level of ethical behaviors is itself considerable. Adherence to a strong code of ethics exemplifies confidence by society with regard to personal trust toward the professional and the belief on the part of society that this individual will always act in the best interests of those they serve. 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. It is always expected when questions related to ethical nursing behaviors arise in the practice environment 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 the early vestiges of professional governance were outlined and applied to the institutional structures framing the professional practice of nursing (Allen, Calkin, & Peterson, 1988). Over that time within the principles of shared governance, many approaches have attempted 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) legitimately represent the principles grounding professional governance or not is the subject of much question, their claims notwithstanding.

The structures of professional governance are not much of a mystery. Law, medicine, engineering, architecture, academics, etc. have exhibited common characteristics of self-governance for generations, in spite of modifications reflecting professional and cultural differentiation. Notions of self-governance applied to nursing and nurses, on the other hand, have emerged more recently and have been approached more tenuously and with a level of reticence not generally experienced by 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 demonstrate at least as much influence:

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- Self-governance is historically a masculine exercise with no prevailing mechanisms for modification to a predominantly feminine application.
- Nursing has almost always been an employed profession; the nurse is generally an employee and therefore subordinated to traditional employment conditions and legal requisites.
- Historic power relationships in nursing are predominantly vertically derived and directed, while the historic power relationships in the major professions are much more classically horizontally delineated.
- Much of the social and legal framework for the traditional professions is designed to protect the public and the independence of the discipline to control 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 and to more carefully circumscribe nurses' practice boundaries and to limit its scope in a way that keeps it fully within defined parameters.
- The definitive character of the requirements of professional membership in the traditional professions is succinct, crisp, and definitive related to education, certification, and experience. In nursing, it is diffuse, often undifferentiated, and frequently broadly described and relative.

A Profession Is as a Profession Does

The journey of nursing to professional maturity has been slow and challenging. Unbundling its historic gender challenges has been a significant undertaking. Because of the social discomfort 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. As well, nurses have themselves been a great source of the problem in limiting the achievement of full professional delineation.

Constructing a Structure for Professional Practice

The initial purpose of implementing shared governance models within nursing was to provide a structural format for the profession to implement the more horizontal loci of control and practice power enablers so essential to professional self-governance (Figure 1-1). Taking into consideration the historic social and

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employment structures impacting the practice of nursing, shared governance provides a model where shared accountability serves as the frame for partnering practicing nurses with their institutions in ways that would provide for mutual obligation and advantage in the interest of advancing shared interests in patient care excellence. The four cornerstones of a profession's ownership and accountability—practice, quality, competence, and knowledge management—serve as the structural frame for the exercise of staff accountability over these professional requisites and the institutional partnership necessary to incorporate resource and institutional stewardship.

- 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.

Figure 1-1 Shared governance basic principles

Building the structural forms and constructing bylaws that enumerate them has provided much evidence of the success of such models to distribute ownership and enumerate accountability in the profession. Although there is little evidence that the power balancing necessary to true professional behavior has come anywhere near fruition, the infrastructure for it has certainly been well established. This, of course, raises the question, why has so little professional empowerment and interdependence emerged even in organizations where significant progress toward real professional status has been evidenced?

The Four Requisites in Professional Governance

Much contemporary leadership research now demonstrates the importance of differentiating the patterns of behaviors in knowledge workers from those of employee work groups. Although this is considerably more difficult for nursing and for the more historic and masculine traditional professions, work has progressed to make this possible. Since the early 1980s, considerable effort has been undertaken to challenge traditional organizational constructs and their legitimacy in light of constructing an organizational framework for professional behaviors. Much of the research has suggested that professional (knowledge

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work) behaviors can neither be obtained nor sustained in an employee work group structure where the expectations for performance are defined and controlled by the workplace and predominantly functional in orientation; where few peer-driven performance and evaluation processes operate; where work value is on volume, time, and motion determinants; and where work is highly subordinated to others and essentially management controlled and driven. In fact, these practices actually impede the occurrence of professional behaviors and prevent them from being demonstrated.

CRITICAL THOUGHT

Professional delineation and job categories do not mix. In a professional environment job categorization for knowledge work is simply not an adequate delineation of both the requirements and the nature of the work. Position charters and role expectations serve as better tools for defining the accountabilities and obligations of professionals than do job descriptions that focus on tasks and functions.

These identified organizational characteristics have been entrenched in the healthcare system since its onset. Even currently, the long-held system of medical predominance in decision making is supported by a highly vertical, tightly structured organizational construct that has limited the professional growth and development of nursing in significant ways and created particular challenges to the development of a professional frame of reference for nursing practice. Even though contemporary nurses are academically grounded and the profession contains the largest number of bachelor of science in nursing degree and graduate educated women in health care, the traditional challenges to obtaining professional, social, and relational equity commonly achieved by academic parity have eluded nursing. The strongly hierarchical organizational framework for health care and the rigid control of the medical model in clinical decision making has served as a strong impediment to the emergence of the equity necessary to gain and advance comparable professional value for nursing and nurses.

Yet, much has changed over the past 2 decades that has shifted circumstances to create a stronger professional framework for nursing, laying the groundwork for equity, inclusion, and leadership. High levels of success related to advancing 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 create circumstances that have advanced the credibility and status of nurses across a broad range of the public sector. However,

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in hospitals and healthcare organizations where the majority of nurses 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) have done much to recalibrate the professional nurse's role in decisions affecting practice, education, quality of care, and the clinical decision making. Building a professional infrastructure for governing the profession's decision making and relationship to the organization has formed the foundations of a sustainable infrastructure that partners with organizations in a way that advances the interests of quality health care and the integrity and contribution of nursing professionals.

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 5 or 6 decades, or is the change specifically related to advancing women's education and its impact on nursing?

Personal Obligation for Participating in Governance

One of the basic obligations of members of 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 particular 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 will either advance or they will retreat 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.

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SCENARIO

The nursing staff on the medical unit has noticed that a wide variety of nursing beliefs and practices exist with regard to particular approaches to preventing pressure ulcers in long-term geriatric patients. 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. What 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?

Nursing has a tradition of 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 failed to engage 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 one becomes a member of the profession, it is a life circumstance, especially within the context of the notion that professional membership also implies social identification of the profession with the person. This "I am" character of professional identification enumerates 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 one seeks only job categorization that can be dropped or forgotten when done or left in the particular workplace, membership

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in a profession should not be pursued. Professional work can be neither done nor left. It accompanies the professional into every circumstance and activity every day he or she is a member of the profession. For the true professional, every activity he or she pursues represents membership in the profession. Everything the professional is and does is seen by others through the lens of membership in the profession, which therefore demonstrates in that moment whatever they will know of the character of that profession. At every given moment, the public's view of the profession is enumerated by what they see of the individual member and how that person represents the profession in everything he or she does. For that moment, the whole of the profession is on that professional's shoulders, and he or she is, in that moment, the only window others have of what the profession is or is not.

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 in the delivery of individual nursing care.

Participation in the life of the profession for the professional is not an invitation; instead, it is 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 it implies the capacity to opt out, to turn down the invitation. Far too often, given the option implied by invitation, nurses readily reject participation. Professions that behave consistently with their character 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, it is an expectation that they will engage in quality improvement activities that demonstrate the value of their practice.

Professional membership and the structures of governance require the discipline to delineate between expectations of membership and invitational occasions. Members of the nursing profession should be 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 a profession informing the functional work of the professional. Not

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participating in these active obligations of members in the nursing profession diminishes the professional character of nursing, limits the performance of its professional work, and presents an image to others of nonengagement, ultimately resulting in 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. Language is a more visible characteristic that suggests to both the speaker and the listener a particular kind of interaction (Figure 1-2). Language communication represents a specific kind of dialogue that characterizes both the circumstances and content of the dialogue. Language is important; others hear and perceive in it 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 demonstrates specific patterns of communication and interaction that represents 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 particular calibration of the discipline.

- Decentralized
- Team based
- Horizontal
- Inclusive
- Engaging
- Accountable
- Point-of-service based

Figure 1-2 Shared decisions

One of the challenges for nursing is the historic language of practice embedded in the traditional job-oriented categorization of organizational work. It is easy to see why the perceptions of nurses and nursing are informed by language that demonstrates the individual's own representations and perceptions of their 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 a more vocational or employee work

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group orientation of the individual. 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." Language frames such as these evidence the content of professional interaction and present the profession to others in a way that creates a perceptive model more closely representing a professional delineation.

For the professional, there are no accidental conversations. Every interaction contains the potential for perceptive reaction. The professional is careful to clearly reflect in her or his personal behavior 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 (Figure 1-3). Personal codes of dress, conversation, action, and expression play a critical role in the representation persons make about themselves to each other and those they relate to (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 for the demonstration of collateral and equitable behavior.

- 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

Figure 1-3 Personal character of the leader

There is evidence 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) (Figure 1-4). There rarely is an opportunity to redo these initial 3 minutes

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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 what specific image they want others to sustain about them over time.

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

Figure 1-4 The first 3 minutes last forever

The intention and clarity of the professional person with regard to codes of dress, conduct, communication, competence, relationship, and interaction are critical considerations for both 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 attitudes are egotistical or haughty, if interaction is hurried and dismissive, it will contribute to the observing individual's perception and it 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 purposeful and therefore must be carefully considered as the nurse operates within the context of her or his role, knowing that the reflection of these actions will be significant and lingering.

Interactions with Other Disciplines

Perhaps one of the most significant barriers to full professional recognition is the perceptions we create for others with whom we work that influences their view of us (Heuer, Geisler, Kamienski, Langevin, & O'Sullivan Maillet, 2010). If we all remember the basics of our psychiatric clinical studies, we will remember that all behavior has meaning. Also we will recall that in terms of personal identity we are each treated precisely as we expect to be treated and generally no different

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from that expectation. Although this understanding can be hotly debated, the intent here is to emphasize that how we as individuals clearly enumerate our expectations of self and others in a way that can be fully understood influences what behaviors toward us are expressed and how others generally and consistently relate to us because of those self-expectations.

Behavioral self-expectations need first to be clear to the individual before we can expect to see them in how others treat us. If we are unclear of what those behavioral expectations are within our own role and relationship, it is not surprising that others' perceive mixed messages with regard to what relationships and behaviors are acceptable, marginal, or completely unacceptable to us. Lack of clarity around expectations makes it impossible to determine correct and appropriate patterns of sustainable behavior and responses to each other, facilitating ambiguity and uncertainty that results in confusion and risk in practice and patient care.

On the other hand, in the absence of clearly congruent and well-defined behavioral expectations, others will often respond within the context of what they see regarding our behaviors. If, for example, I am consistently angry and acting out, whether I have defined the expected behaviors from others or not, their reaction to me will be predominantly a reaction to my consistent anger-based behavior. This holds true if I consistently act passively, childishly, aggressively, dependently, subsequently, or if I exhibit behaviors that denote fear, anxiety, uncertainty, lack of confidence, or subordinating, I should expect a direct response to those behaviors, not necessarily the equitable response I want. Without congruence between the behavior I define and the behavior I exhibit, the exhibited behavior will drive the foundation for response to me from others.

Clarity with regard to professional behavior and personal behavior that is congruent with such definitions is critical to ensuring consistent and appropriate interprofessional interaction. Much of my self-perception as a professional depends on having worked through my role and contribution within the profession, issues of equity related to my self-perception and in relationship with other professionals, and how well I demonstrate a clear delineation of expectation that I behave and perform equitably and will expect equitable respect and behavior in return.

Issues of poor self-image within the nursing profession have some notable foundations worth exploration, and they frame further discussion. Indeed, it is important for this discussion to unfold prior to beginning professional practice so that many of the impediments to equitable behavior among the professions can be addressed frankly and critically prior to beginning professional practice.
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This frank and open discussion between faculty and students should include

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 such changes indicating that there are several changes in both interdisciplinary interaction and particular discipline-specific clinical actions. There is much reaction to the written directive and some concerns 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 in 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 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?

conversations related to many, if not all, of the following issues affecting professional equity:

- Overcoming 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.

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- Finding clarity around historic gender equity issues that provide the undercurrent for many interdisciplinary relationships. Exploration needs to include an accurate understanding of the role of women in human history; the unique contribution of women to the human experience; a full understanding of gender differentiation and its role in understanding equity; engaging cultural gender typing, which enumerates subordinating roles for women; the unique values women contribute to knowledge management; and critical thinking, knowledge translation, and decision processing.
- For nursing and nurses it is important to explore traditional and originating role characteristics; the journey from functional to professional delineation; the growing science 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.
- Explore issues related to how nurses 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 establishing a foundation for these behaviors upon which subsequent professional interactions can be built.
- Enumerate sociological, ethnographic, cultural, and economic forces influencing the character of self-perception and the framework for personal expression and interdisciplinary relationships. 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. Suggest strategies for accommodating such differentiations in the development of behavioral patterns that help the new nurse to adapt equitable behaviors that reflect personal resolution of inequitable circumstances.

Because of the long history of gender and cultural inequity long associated with women in the role of the nurse, it cannot be expected that individuals will automatically or on demand accommodate these prevailing realities and experientially adapt new behaviors to overcome them. A part of the work of nursing as a discipline is grappling with fundamental issues that reflect its history and

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inform contemporary challenges in building professional practice. This work must be intentional and incorporated into the development of the nurse. Rather than simply identifying courseware within which these contemporary issues will be embodied, it is more important to embed addressing these behaviors inside of the curriculum and clinical practice of the educational and developmental experience of the emerging professional nurse. In addition, faculty and practice leaders must also represent, in their own patterns of behavior, their having addressed and resolved many of these issues for themselves. They must do so in ways that serve to mentor the new nurse and demonstrate the continuing effort 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

One is always treated precisely as one expects to be treated, and no differently. The real question is, how do you enable or permit others to behave toward you, and how do they closely manifest your own expectations and self-treatment?

The Public and Policy Role of the Profession

All professions work in the public forum. If a profession is to be relevant, contemporary, and share in writing the script for the future, its members must commit to undertaking concerted and informed action in the public sector. Those things that influence a 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 are important to fully invest in so the profession can advance this effort (Finkelman, 2012).

Because nursing has both been a predominantly employed profession and generally driven by the characteristics of membership in an employee work group, it has been difficult to expand nurses' presence in important roles in the public arena. Physicians and other health professions have recognized the critical value for full participation in the life of the political and policy sector. As a result, this level of engagement has advanced the medical agenda, often created preferred roles and circumstances for physicians that are not always in the best interests of those they serve and society as a whole. Because much of this power and influence has not been equally countered by a fuller, more robust engagement of

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the public sector on the part of 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 principal action undertaken by governments. It usually involves political decision making and legislative action. Professional involvement in public policy ostensibly represents the profession's interest in advocating for those they serve through influence on 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 localities are more heavily impacted because all health service is essentially local.

Shaping public policy is generally 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 ways they think is best for themselves or others.

In the policy pursuit advocacy can take many forms and can represent a variety of interests. Advocacy can most easily be defined as the work to influence public policy through educating others, lobbying for specific interests, and working within the political system to make desired or needed change. Advocates suggest that the issues for which they are speaking are critical to the quality of life of those they represent. While it is controversial, many professionals and knowledge workers actively advocate for interests they feel they best represent as they seek to improve the circumstances of those they represent and serve. Questions are often raised, however, as to whether advocates best represent those they serve or if they, in fact, represent their own best interests.

Regardless of the discussion and challenges around advocacy and public policy involvement, it is generally assumed that professionals are interested in the welfare of those they serve. Professionals often link the welfare of the profession with the greater well-being of those the profession serves (Figure 1-5). Although this can be treacherous ground to walk, it is also representative of a strong ethical and moral effort to more clearly articulate the needs of those who are served and better organize public systems to meet those needs in a more effective manner. For good or for ill, policy and political advocates have played a critical role in the establishment of much in health care that 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.

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Nurses have historically held more advocacy positions than they have actively sought. Although nursing is the single largest health profession in the nation, its per capita representation in the political and legislative arena has not demonstrated the impact that such numbers would suggest. While advocacy for the health interests of the community is central to the role of the nurse, it is difficult to measure that commitment using a numbers count of nursing advocates who are active in the public forum (Jameson, 2009).

- See the welfare of the community
- Link the profession to community
- Have an ethical obligation for health of all
- Ensure the healthcare system meets health needs
- Look for a fit between care and people
- Create a common vision for health

Figure 1-5 Public policy and advocacy

Membership in the profession assumes that a certain percentage of time spent in membership relates to working in the interests of the profession at some level of the public forum. Professionals recognize that policy, political, and legislative action is an important vehicle for advancing improved standards of health, clinical care, and community health. 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 professional can be expected to have an impact on the quality of life of the community:

- 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 the organization strengthens its capacity to speak 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

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contribute to the local level in a role that can have a broad impact on the quality of health and community.

- Testifying for boards, committees, and commissions regarding specific elements of care and service provides a notable and effective way of having an impact by educating and deepening understanding of specific issues, policies, or changes necessary to advance the health and quality-of-life issues of the community.

REFLECTIVE QUESTION

Does membership in the profession not also imply obligation to the community? Does that not mean that 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?

- Equally, serving on specific health-related boards, committees, and commissions can expand the option of the nurse to be able to influence policy and strengthen advocacy for particular health causes through the action of collective wisdom in a way that can strongly influence changes in policy, practice, and education.
- Serving in elective office provides a more definitive and specific process in 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.

In every level of professional life, from local agency advocacy to representation of broad-based political roles and legislation, nurses have an opportunity to significantly influence the quality of life of the community, the political and social role of the profession, and the passage of law and regulation that can 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 for addressing 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 each nurse serves. Such advocacy need not be widely publicized;

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instead, it can often be a quiet normative role contribution to making meaningful change in health care. Even the act 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, recognizing the essential obligation to have an impact on the public and the health of the community. As Florence Nightingale's life suggests, these are normative obligations for professional nurses and should not be seen as exceptional but, instead, normative functions congruent with the obligations of the profession and representative of its commitment to expanding health in the community it serves.

CRITICAL THOUGHT

For a professional, personal and professional identity act as one. As individuals become members of the profession, they are so 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.

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 him- 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 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 in mentoring, modeling, and contributing to the education and development of peers and, most importantly, making

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a difference in the individual and collective lives and health of the community. Each of these demonstrates the characteristics that make up a profession. Collectively they articulate what a profession does and who a professional is. They are the nonnegotiable foundations upon which a profession is built, and they are definitive requisites that form the foundation of professional life. Without them there is no profession. And without the full engagement, ownership, and investment in the activities associated with advancing these characteristics, one cannot claim membership in a professional community. As nursing moves into the adulthood of its professional life, these characteristics become the nonnegotiable characteristics to which each professional member commits in his or her personal behavior, interactions, and clinical performance.

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CHAPTER TEST QUESTIONS

WWW

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 predominently on principle, not simply 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 is a part of personal identity such that it is impossible to separate the person from the profession. True or false?
9. Language isn't 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 in order 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 worker. Because of their relative ignorance and lack of personal discipline and their willingness to escape the demands of work, it was 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 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

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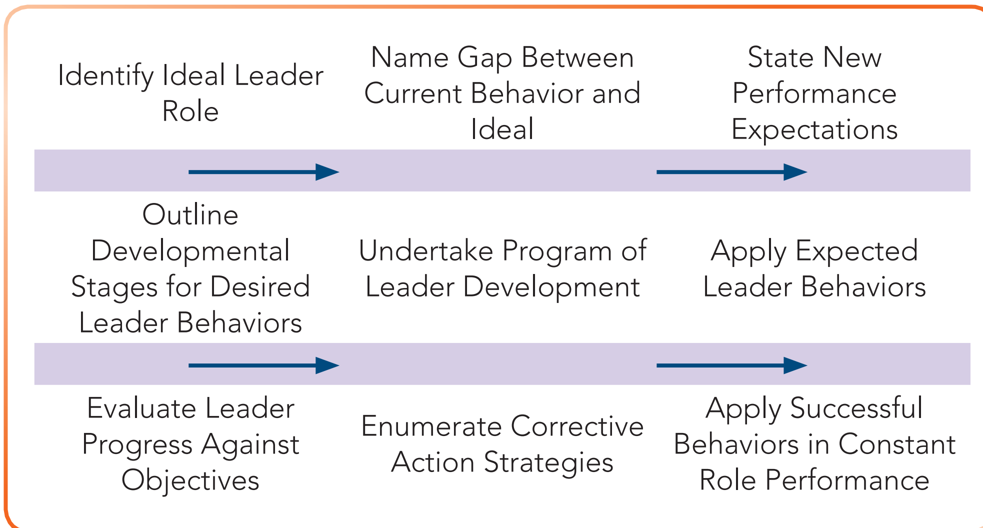
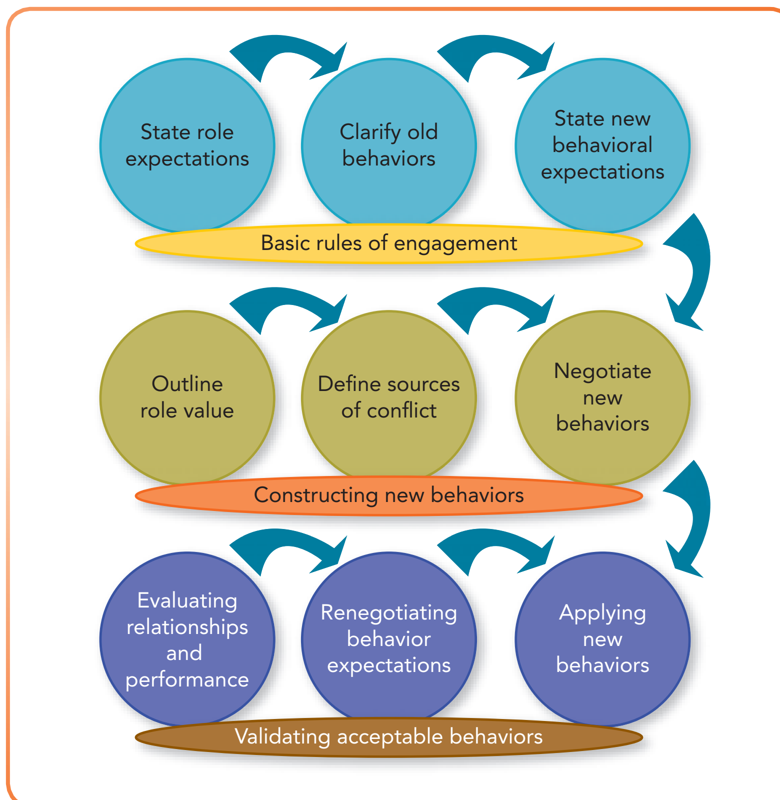


Leaders of the Profession Extinguish Parental Behaviors



Professionals Get Past Parent-Child Behaviors

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NOTE

No one should expect to be invited to the full expression of partnership in the work of the organization. That invitation occurred when one 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.

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.

An invitation to play the full role and 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 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 they begin the role isn't going to be expressive of 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 for 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 and reduces the net value of the work of all and pulls energy away from the collective effort to add value and produce good outcomes.

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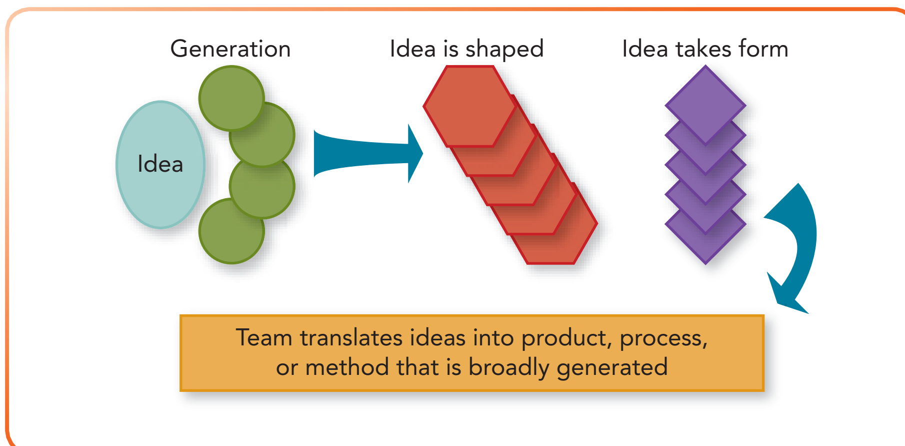
Appendix B

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 generate from individuals or teams but must be shared in order 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 or it dies.



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