

I never saw myself as a change agent
by Marie Manthey

In 1978, I left an executive position and became an independent consultant. The transition from an institution-based executive/professional mindset and self-identity to seeing myself as a solo-practice independent entrepreneur was very difficult and occurred slowly over a period of months and years.

I had never been interested in business and had consequently paid little attention to how a business operated. Every single decision in those early years was based on woefully inadequate information. I didn't know when to incorporate, what "intellectual property" meant, whether to copyright, trademark or service mark any idea or process I created.

Nevertheless, in small steps over time, we grew from a single-consultant, single-product company to a multifaceted, international company specializing in a wide variety of organizational development products and services marketed primarily to segments of the health care industry that deliver direct care to people. Our marketing strategy is two-pronged, focusing on both interdisciplinary caregivers and the nursing profession.

I am most associated with the development of our leading product, primary nursing. Primary nursing profoundly changed my thinking, the organization of hospitals, patient care and the practice of nursing worldwide and forever.

Primary nursing was a grass-roots miracle. Team nursing was still sacrosanct in 1968 when the organizational structure on Station 32 at the University of Minnesota Hospital shifted from the typical anonymous, authoritarian hierarchy to a decentralized framework.

This experiment yielded unparalleled and truly magical changes in the unit's culture when responsibility for patient care decisions was delegated down to the level of action at the patient's bedside. The paradigm shift was transformational, with implications that were not understood for years.

A Radical Idea

In the '60s, the University of Minnesota Hospital's Station 32 was an active 23-bed unit filled with patients referred for treatment of complex medical conditions. Hordes of students, inconsistent care planning and interdepartmental turf squabbles were daily norms. Any accomplishment required the negotiation skills of a diplomat, the wisdom of Job and the patience of a saint, qualities refined by only a few unique nurses. Meanwhile, whether "care coordination" qualified as a nursing function was hotly debated in ivory towers circles.

Nationally Paul Goodman (1965) described decentralization as a way to improve the social condition, and civil rights activists and war protesters challenged the establishment, questioned authority, and shouted "power to the people." Suddenly, the status quo in the hospital and in American society no longer had status. Against this backdrop, granting staff nurses the power and final authority for nursing care decisions was truly revolutionary.

Since grass-roots radicalism is not usual behavior for hospital staff nurses, that a miracle occurred on Station 32 at all is a miracle. Station 32 was slated for a trial of *unit management*, the "solution of the sixties" (Manthey, 1980) for coordinating non-nursing communications and activities. Although touted as an innovative way to "free nurses to nurse," experiences with unit management documented that actual time nurses spent with patients did not increase (Manthey, 1980). We abandoned unit management and refocused our attention on perfecting team nursing.

The alternative that we called Primary Nursing occurred because “coordinated, individualized and comprehensive” (Manthey, 1980) nursing care could not be achieved in a team system. Discarding this known care structure, a system based on shared responsibility and assigned tasks, was both radical and threatening. The change to primary nursing eliminated one level of nursing supervision, the traditional team leader, and flattened the well-worn hierarchical structure. Each registered nurse on Station 32 assumed 24-hour responsibility and accountability to plan nursing care for a small group of patients.

The results were positive, totally unplanned and nearly palpable. The staff nurse instantly earned, and claimed, the power to make nursing care decisions. Almost overnight, communication changed to a direct, person-to-person pattern; physicians discussed patients with the nurse caregiver, not the head or charge nurse. Dramatically, the noise and chaos that typified Station 32 turned to quiet calm.

Independent Thinking

Primary nursing is predicated on the organization theory of decentralization, a concept new to the authoritarian setting of hospital nursing. Decentralization is the pathway to personal and organizational health and presents a kaleidoscope of challenges that support human learning and growth. *Responsibility, authority* and *accountability* are the core principles that underlie the theory of decentralization. When applied to the work of the registered nurse, who is licensed to make independent decisions about care of the sick, these concepts clarify “professional” in ways never before applied to nursing.

Understanding the dynamic interplay among responsibility, authority and accountability is critically important to the success of primary nursing. Ignoring or manipulating that interplay results in abuse of power, victim-thinking and a dysfunctional workplace. Empowerment is the result. To me, it means striking a healthy balance between responsibility and authority. Responsible adulthood exemplifies empowerment.

Ultimately, the way an organization operates changes the way people behave—not the other way around. When a culture supports growth, people grow. When a culture values innovation, people innovate. The ability to thrive is directly proportional to the level of responsibility an individual nurse could accept and the cultural support within an institution.

Today, Senge (1994) echoes the importance of structure on function and creativity: “It is possible to change the organizational structure of work, but if the individuals are not able to function as responsible adults and if the culture doesn’t support thinking employees, the change process will fail.”

Global

The spread of primary nursing from Station 32 to the world is another miracle. Since 1968, primary nursing has been implemented and ignored, bastardized and internationalized, and in and out of vogue multiple times. The response by grass-roots segments of the nursing profession was strong and immediate, particularly from highly motivated staff nurses and risk-taking, forward-thinking nurse managers.

Meanwhile, educators and mainstream nurse administrators ignored the concept for years.

Throughout the 1970s, the grass-roots movements spread across the United States from unit to unit, primarily by word-of-mouth but also through obscure journals (Manthey and Kramer, 1970; Manthey et al., 1970) and the work of early researchers (Marram, 1974). By the early 1980s, the public relations and patient satisfaction benefits began to drive national interest in the

concept. Researchers studied cost, outcome and implementation issues. Today, in every developed country and many third world countries, nurses find ways to implement primary nursing. Research, curricula and literature and Internet searches all attest to the ongoing strength of the concept of primary nursing.

Granting autonomy to the bedside nurse has never been easy. Primary nursing became a platform to argue for staffing increases. This misconstrued belief that primary nursing required more nurses only complicates the concept and allows faculty, administrators, managers and staff nurses alike to sidestep the true challenges of primary nursing.

Primary nursing is designed to use available resources. Patient acuity and census determine only the necessary skill mix and number of staff. A lasting professional component for hospital-based nursing practice demands that decisions about nurse staffing levels become forever separate from the structure to deliver patient care (Manthey, 1991).

Primary nursing mandates a new, strong role for the registered nurse, one that many acclaim but few are prepared to fulfill. As I advanced in executive positions, I continued to learn about the deep cultural impact of primary nursing. While primary nursing seemed a popular solution to serious problems, often implementation was successful on only one or two units in a hospital before resistance developed.

Success is linked to high morale, a cohesive staff willing to become primary decision makers, and a strong, respected and non-controlling leader. Attempts to enact decentralized decision-making by management edict are appalling failures. Primary nursing is an organizational change that ripples through a system, changing relationships and perceptions of power and promoting self-determination, responsibility for professional nursing practice, and human, patient-focused care.

Throughout these years of serving patients through development of “relationship-based professional practice departments,” the goal of humanizing the care of people has guided our decisions—both in how to run the business and how to serve our clients. While many of our clients’ careers have taken them to four or five hospitals, they have contacted us each time for help establishing a professional practice model in their nursing departments. We have found it incredibly important to “walk the talk,” so we strive to incorporate all of our values into all of our transactions.

As you may imagine, this is a tall order. But we have found it pays off. Our reputation for integrity and value-oriented creativity is our most important commodity. Our clients know us by the quality of our relationships with them, and this focus on humanism is who we are as nurses and entrepreneurs.

References

- Goodman P.** (1965). *People or Personnel: Decentralizing and the Mixed System*. Toronto: Random House.
- Kramer M.** (1974). *Reality Shock*. St. Louis: Mosby.
- Manthey M, Cicke K, Robertson P, Harris I.** (1970). Primary Nursing. *Nursing Forum*, **9(1)**, 64-83.
- Manthey M and Kramer M.** (1970). A Dialogue on Primary Nursing. *Nursing Forum*, **9(4)**, 356-379.
- Manthey M.** (1980). *The Practice of Primary Nursing*. Boston: Blackwell, pp. xvii, 20-21, 30.
- Manthey M.** (1991). Delivery Systems and Practice Models: A Dynamic Balance. *Nursing Management*, **22(1)**, 28-30.

Senge P. (1994). *Fifth Discipline Fieldbook*. Boston: Doubleday/Currency.

Article originally appeared in *Reflections*, Second Quarter 1999.