Shared Governance

Shane D. Anderson RN, BSN, MDIV

November 2012
Abstract

For the past three decades, nursing leaders have promoted the promise of shared governance as one answer to many nursing challenges. Shared governance efforts have recently revived through the push by hospital systems to attain Magnet designation (Hess, 2011), which requires formal structures of self-governance for nurses within a hospital system. The promise of shared governance is that it serves as a vehicle for positive change, empowering professional, engaged nursing practice. But the past three decades of shared governance experience demonstrate it is “not a quick-fix” (Bamford-Wade & Spence, 2012). This paper contains an examination of the nursing literature surrounding shared governance, and offers a critical examination of the literature for issues, applications, and best practices that may assist nurses in developing, participating in, and revitalizing shared governance within hospital systems.
Shared Governance

The oft repeated call, taken up by the Institute of Medicine (2010), for nurses to work to the full extent of their education has yet to be substantially realized as nursing management practices have not engaged nurses to this potential (ANA, 2011). There are numerous restrictions on nurses’ autonomy over their own practice, and nurses continue to face a difficult social, political, and workplace environment, contributing to costly burnout and turnover (ANA, 2011; Fox & Abrahamson, 2009). For the past three decades, nursing leaders have promoted the concept of shared governance as one answer to these nursing challenges. Interest in shared governance has waxed and waned, but shared governance efforts have recently revived through the push by hospital systems to attain Magnet designation (Hess, 2011), which requires formal structures of self-governance for nurses within a hospital system. The promise of shared governance is that it serves as a vehicle for positive change, but the past three decades of shared governance experience demonstrate it is “not a quick-fix” (Bamford-Wade & Spence, 2012). This paper contains an examination of the nursing literature surrounding shared governance, and offers a critical examination of the literature for issues, applications, and best practices that may assist nurses in developing, participating in, and revitalizing shared governance within hospital systems.

**Review of Nursing Shared Governance Literature**

Using the search terms “shared governance” and “nursing,” 383 articles from the past twelve years were gathered from the CINAHL database. These articles were briefly reviewed for applicability, and articles that narrowly discussed the nature of shared governance in nursing were examined more closely for other articles that demonstrated the sources and progression of nursing knowledge about shared governance. This body of literature was studied for conceptual themes and unique contributions to understanding how nurses develop, engage in, and revitalize
shared governance as a positive force for professional nursing in the hospital setting. The history, definition, models, relationship to empowerment, and empirical outcomes of shared governance are discussed.

The History of Shared Governance

Shared governance as a concept was derived from broad theoretical sources: organizational, management, and sociological (Anthony, 2004). As Barden, Quinn-Griffin, Donahue, and Fitzpatrick (2011) state, “Shared governance has been an important management strategy for many years. Other disciplines including business, education, politics, and religion have implemented and benefited from the utilization of shared governance models” (p. 213). Christman (1976) was the first nurse to theorize about the concept in his early discussions of autonomous nursing organizations, where nurses would have a parallel influence to physicians within hospital systems. “The label of shared governance first appeared in nursing literature in Cleland’s 1978 adaptation of a university model of faculty governance. Cleland proposed a model that reconciled the interests of different organizational groups through the distribution of power to formulate policy” (Hess, 2004). Hess (2004) describes the emergence of shared governance within nursing as a way to give nurses “equal footing” with management and to make decision regarding their practice.

Tim Porter-O’Grady became a leading voice advocating for shared governance and writing extensively over the three decades through which shared governance has existed in nursing; His is one of the “most precisely articulated visions of shared governance” (Hess, 2004). The eighties and nineties saw the rapid expansion and promotion of shared governance models, but “as the last nursing shortage waned, shared governance … disappeared from many of the some 1000 health care institutions where it had thrived. Some programs were victims of mergers and acquisitions, others just sputtered out from exhaustion” (Hess, 2004). Yet, a new nursing
shortage (Buerhaus, Staiger, & Auerbach, 2009; ANA 2011) and the drive by health systems to gain and maintain Magnet recognition have renewed interest and efforts around shared governance (Barden, Quinn-Griffin, Donahue, & Fitzpatrick, 2011). Porter-O’Grady (2004) has consulted at hundreds of the health systems that have sought Magnet recognition, and he continues to influence the future direction of shared governance efforts and scholarship.

**Definition of Shared Governance**

“Shared governance is a journey, not a destination. Organizations pursuing shared governance move incrementally from past orientations where the few rule to an orientation where many learn to make consensual decisions” (Hess, 2004). Hess, who like Porter-O’Grady has written extensively on shared governance, captures one of the themes in nursing literature when shared governance is defined: it is a journey, a process, an orientation and impulse. “Nursing shared governance is hard to define. Its structures and processes are different in every organization” (Hess, 2004). Porter-O’Grady simplifies: “Shared governance is, in short, simply a structural model through which nurses can express and manage their practice with a higher level of professional autonomy” (Porter-O’Grady, p. 251, 2003). Porter-O’Grady argues that this structural model is like a vehicle for partnership, accountability, equity, and ownership (Porter-O’Grady, 2004).

Anthony (2004) provides a helpful summary and reflection: “common characteristics exist [in the varying definitions]. These include autonomy and independence in practice, accountability, empowerment, participation, and collaboration in decisions that affect individual patient care, the more general practice environment, and group governance.” This emphasis on an autonomous and independent practice that engages the health system more broadly is also seen in Hess (1998): “Nursing shared governance is a managerial innovation that legitimizes nurses’ control over practice, while extending their influence into administrative areas previously
controlled only by managers.” O’May and Buchan, 1999, provide a thorough definition, stating that shared governance is:

- a decentralized approach which gives nurses greater authority and control over their practice and work environment; engenders a sense of responsibility and accountability;
- and allows active participation in the decision-making process, particularly in administrative areas from which they were excluded previously. The primary aim is to support the relationship between the service provider (nurse) and patient (client). It is not a one-time implementation process, with a concrete, set of rules, but rather an ongoing and fluid process, which requires continual assessment and revaluation to be flexible and adaptive to the environment. Shared governance is often misunderstood as ‘giving power to employees’, which oversimplifies the reality of outcomes claimed to be obtained by elective shared governance organizations, such as the release of expert knowledge, motivation and action at the point of service. Proponents of shared governance emphasize that it requires that all players understand the principles, processes, and behaviors of shared leadership and in shared governance, everyone is a player” (p. 281).

**Shared Governance Models**

“Structure is vital to shared governance” (Hess, 2004). This view is consistent throughout the surveyed nursing literature; shared governance is an operationalizing of the values of partnership, accountability, equity, and ownership (Porter-O’Grady, 2001). No one particular structure is argued for. In his article describing his work with shared governance in the emergency nursing setting, Ottens (2008) warns: “What I would caution is not to take any one model that you read about and think that you can drop it into your facility and make it work. Every hospital and every department are different.” Yet, while “shared governance can take a whole range of forms” (Porter-O’Grady, p. 251, 2003), a number of fairly similar models
have emerged in the nursing literature. Hess (2004) describes the three models for shared governance noted within nursing literature: councilor, administrative, and congressional. O’May and Buchan (1999) provide a helpful chart (Figure 1). One manager’s words of advice apply, “I would say that what works for one place may or may not be right for another, and all shared governance committees need to be tailored to the needs of the institution and department” (Ottens, 2008).

Figure 1 (O’May & Buchan, p.283, 1999)
*U.S. Shared governance models.*

<table>
<thead>
<tr>
<th>Unit-Based</th>
<th>Congressional</th>
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<tr>
<td>• Each unit establishes its own system</td>
<td>• All staff belong to a congress</td>
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<tr>
<td>• Multiple models may exist within one institution</td>
<td>• Similar in structure to federal government</td>
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<tr>
<td>• No department-wide co-ordinating activities</td>
<td>• Committees submit work to “cabinet” for action</td>
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<tr>
<th>Councillor</th>
<th>Administrative</th>
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<tr>
<td>• Co-ordinating council co-ordinates activities on department level</td>
<td>• Practice and management structures exist</td>
</tr>
<tr>
<td>• Unit councils reflect department councils</td>
<td>• Forum integrates work of councils</td>
</tr>
<tr>
<td>• Staff nurses accountable for clinical decision making</td>
<td>• Councils submit work to executive council for decisions</td>
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**Shared Governance and Empowerment**

Porter-O’Grady often refers to the struggle of nurses for empowerment, a struggle that parallels that of women in society. He laments: “It seems surreal at best to hear the same complaints and problems voiced today that I heard voiced 30 years ago when I entered the nursing profession” (Porter-O’Grady, p. 468, 2001). The history, definitions, and models of shared governance may lead one to believe that it would be an easy answer to this disempowered feeling among nurses, but in 2001, Porter-O’Grady, in his argument for the continued relevance of shared governance as a journey to help foster empowerment, challenged this sentiment saying: “Some nurses have the power that keeps others from getting it” (Porter-O’Grady, p. 468, 2001). Though the eighties and nineties continued to see individual nurses ascend the power structures
of hospital systems, the nursing profession as a whole was often let behind. Even where shared governance structures flourished, they often then languished, not only because of economic pressures but also due to apathy among staff:

Real and important decisions concerning hiring, budgeting, allocating, discipline, and policy remain in the hands of those the organization permits to control them (most often in the role of manager) where they always have been . . . Soon staff members stop making the decisions they are permitted to make because they learn quickly that it does not matter what they decide. The critical decisions are always made elsewhere and nothing for the staff ever changes.” (Porter-O’Grady, p. 468-469, 2001)

In contrast, Otten (2008) reflected on his successful formations and revitalizations of shared governance groups in the emergency setting. He writes, “I tell them over and over ‘it is a committee that allows your voice to be heard.’ They have to know that they will be able to make decisions that will change the way that the department operates” (Ottens, 2008).

Barden, Quinn-Griffin, Donahue, and Fitzpatrick (2011) studied the relationship between empowerment and shared governance and found “a positive relationship between a nurse’s perception of shared governance and empowerment” (p. 216). They argue for shared governance not as a costly extravagance in tough economic times, but as “an essential element” that promotes: “positive patient care outcomes, improved recruitment and retention, and provision of necessary support and resources” (p. 216).

Shared Governance Outcomes

O'May & Buchan (1999) argued for the need for more extensive research of shared governance outcomes, noting at that time that the data showed a mixed bag of results for shared governance, concluding “It is evident from the review of literature that shared governance is not a panacea.” This hesitancy to universally celebrate the accomplishments of shared governance is
seen elsewhere in the literature, for example, Anthony (2004) argues, “the organizational, work environment, and job satisfaction outcomes of shared governance have not consistently supported its anticipated benefits.” These weaknesses in the data are counterbalanced by a growing body of work that demonstrates good outcomes from shared governance approaches:

- “Nurses in the SG setting had significantly higher scores in overall governance, empowerment, and job satisfaction than nurses in the NSG setting” (Anderson, 2000).
- “…improved financial picture after implementing shared governance, resulting from either cost savings or cost reductions” (Anthony, 2004).
- “…budget successes, decreased turnaround times for patients, decreased turnover rates, and steadily improving patient satisfaction scores” (Ottens, 2008).
- “…patient care, increased patient satisfaction, improved work life, increased nurse retention, opportunities for all nurses to get involved with leadership, an open relationship with management, increased availability of information, and improved professional growth” (McDowell, Williams, Kautz, Madden, Heilig, & Thompson, 2010).
- “…increases nurse recruitment and retention and enhances their contributions to the patient care mission of the organization” (Scherb, Specht, Loes, & Reed, p. 175, 2011).
- “…increased job satisfaction and improved patient outcomes” (Barden, Quinn-Griffin, Donahue, & Fitzpatrick, p. 213, 2011).
- “…reinforces processes of professional excellence by empowering ownership of quality nursing practice and influencing both the work environment and administrative functions” … The study “demonstrate linkages between shared governance and nursing and patient outcomes” (Rheingans, p. 42, 2012).
• “...satisfaction outcomes and evidence of increased patient care quality in organizations that promote shared governance demonstrate that the model is back in vogue as a means of recruiting and retaining the most qualified, competent nurses.” (Brandt, Edwards, Cox-Sullivan, & Zehler, 2012).

Issues and Applications of Shared Governance Principles

Numerous nursing articles related to shared governance read like advertisements for various health systems, documenting their “journey” toward “excellence.” These articles follow cookie-cutter formats, describing a plan to implement shared governance, some minor problems, and some phenomenal outcomes. For example, Sanchez and Cralle (2012), end their article by glibly exclaiming: “Just recognized as a Pathway to Excellence institution, the future is bright for Midland Memorial Hospital!” This genre of nursing literature does little to advance nursing knowledge beyond repeating what is already known and may even be a distraction for nurses who are serious about implementing systems and shaping hospital cultures to support professional nursing.

Outside of these “promotional” articles, a critical reading of the nursing literature regarding shared governance finds an open and honest discussion of the positive and negative elements of shared governance. Shared governance, as Hess (2004) wrote, “is a journey, not a destination.” It emerged during the ascendency of nursing management and leadership as a discipline, and it has seen ebbs and flows for the past three decades. Anthony (2004) critiqued much of the research surrounding shared governance as lacking rigor and applicability yet pointed forward to avenues of research that may be more profitable. Some of these avenues are explored in the above literature review. Nurse researchers continue to explore the concept of shared governance and the corollary concepts Porter-O’Grady enumerated: partnership, accountability, equity, and ownership. The nurse who is interested in developing, engaging in, or
revitalizing shared governance is going to be faced with numerous challenges. These issues are described in the literature and some solutions are offered.

**A Need to be Oriented Toward Change**

Nurses who are involved in shared governance work describe the process of shared governance as requiring an orientation toward constant change. They see this as one of the key components of successful implementation of shared governance structures. “Our method of shared governance continues to thrive because of its commitment to change and professional development. Issues change and the senate strives to respond to those changes” (Malleo & Fusilero, p.36, 2009). This experience is described over and over in the literature (see Dunbar et al., 2007; Bretschneider, Eckhardt, Glenn-West, Green-Smolenski, & Richardson, 2010; Beglinger, Hauge, Krause, & Ziebarth, 2011). Ottens (2008) reports bluntly, “Once you have modified it and molded the structure the way you want, you will continually have to make changes as your organization changes and grows.” Dunbar et al. (2007) counsel:

…an ongoing process that will require continued commitment, vigilance, and flexibility to make changes as the need arises. Maintenance planning is vital in determining the final impact of shared governance. If the program does not have a maintenance plan, then it may not be in place for a long-term evaluation.

As nurses embrace this change orientation, they actually become more true to the original concept of shared governance as a process rather than a “thing.” As nurses seek to revitalize shared governance in established systems, they ought to remember that recognizing a need for change and a willingness to change can be a sign of a well-functioning environment. As Jacobs and Ward (2012) recount, “... the traditional shared governance structures didn’t meet the needs of our staff and believed that the recognition of the need for change was a sign of maturity.”

**The Costs and Benefits of Shared Governance**
As seen from the literature, shared governance involves new expenses (meetings, rooms, support staff), but promises new savings (nurse recruitment and retention, patient safety and care quality, efficiencies.) Nothing can change a work environment faster than a budget revision: “Just when we thought things were going well, our departmental level council was eliminated due to budget concerns” (Jacobs & Ward, 2012). Hess (2004) reported that a number of the initial 1000 plus hospital systems that had initially championed shared governance had at that time eliminated the concept due to budgetary concerns. “In an economically constrained health care system, it is a challenge to develop and maintain a professional practice model of nursing” (Barden, Quinn-Griffin, Donahue, & Fitzpatrick, 2011). The payroll costs of nursing hours are easily measured, but the savings are not. The nurse who believes in the concept of shared governance will have to be skilled in making the economic argument (Anthony, 2004). One potential argument is found in nurse retention:

Studies agree on one thing – shared governance costs money in terms of time and energy . . . In a worsening nursing shortage, money invested in shared governance can be a sound investment. Current estimates for replacing a staff nurse run from $50,000 to as high as $64,000 . . . As research strengthens the connection between shared governance and work satisfaction, the savings from a single retained nurse in a small hospital could provide a substantial reason for underwriting a program (Hess, 2004).

The Requisite Culture Change

Nursing literature is full of warnings not to equate mere adoption of a shared governance model with successful shared governance (Dunbar et al., 2007). True to Port-O’Grady’s sage advice (2003), shared governance can take many forms, but must be true to its philosophical concepts: partnership, accountability, equity, and ownership. To do this, a culture change must take place in the organization: “reshaping the culture and maintaining the momentum of shared
governance is critical to ongoing acceptance, integration, and success of the process” (Dunbar et al., 2007). This culture change involves a mentoring of both nurses and managers:

A change in structure alone does not always result in a change in the distribution of authority nor guarantee nurse control over practice or shared decision making. There is a need to change both nurses’ attitudes and behaviors toward their role in decision-making and the culture of the organization. A socialization process related to shared governance for nurse managers is essential to assist them to adopt a leadership style that embraces shared decision making with staff nurses (Scherb, Specht, Loes, & Reed, p. 163, 2011).

One challenge is the difficult transition in authority patterns for the nurse manager: “the transition to coach and staff mentor while giving up comfortable authority patterns can be difficult. Managers often have the steepest learning curve…” (Ballard, 2010). Phillip Jullian, Nursing Leadership professor at ECU, comments,

Nurses willing to accept the accountability that accompanies Shared Governance is a fundamental cultural change in many organizations. We sometimes want others to tell us what we need to do rather than assert ourselves as professional health partners.

**Nursing Control of Resources and Personnel**

“Of course, nurses cannot effectively practice without the right resources – an appropriate amount and mix of caregivers, supplies, and supporting systems. To control practice, nurses must also have some influence over these resources” (Hess, 2004). While this seems to be an obvious component of health shared governance, “there are still limited examples in the literature of staff nurse involvement in administrative decisions (e.g., staff mix, staffing ratios) that have a great impact on clinical nursing practice” (Scherb, Specht, Loes, & Reed, p. 164, 2011). Scherb, Specht, Loes and Reed (p.174, 2011) found that staff nurses wanted more decisional authority over staffing, supplies, and education, and nurses felt that these decisions often had the greatest
impact on their practice. Unfortunately, “one of the most difficult areas of shared decision making for nurse managers is decisions about resources” (Scherb, Specht, Loes, & Reed, p. 164, 2011). Jullian (2012) notes that this is perhaps due to nursing education focusing primarily on “clinical” knowledge, leading to nurses who are “ill-prepared for the financial, resource, and policy aspects of care.” The nurse who is implementing shared governance or seeking to revitalize it will likely be challenged regarding who determines the distribution of resources, and if nurses are “not allowed” to impact these decisions they may become disillusioned with the shared governance process, believing “it does not matter what they decide. The critical decisions are always made elsewhere and nothing for the staff ever changes.” (Porter-O’Grady, p. 468-469, 2001)

**Best Practices in Shared Governance**

As described above, there are many exemplars in the literature of how various hospital systems have implemented shared governance, and a critical examination of the literature demonstrates the need, as Anthony (2004) noted, for nurse researchers to continue to develop knowledge of the various antecedents, forms, and outcomes of shared governance. As has also been demonstrated, the literature describes the challenges nurses are faced with as they seek to build and rebuild shared governance organizations. Within this body of literature, a number of best practices emerge. These may provide the nurse a good starting place for shared governance work.

Figure 2

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<td>Shared Governance and Nursing Autonomy</td>
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<td>Shared Governance and New Management Styles</td>
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Shared Governance Involved in Interviewing and Recruitment

“The most important factor in differentiating shared governance hospitals from traditional organizations was nurses’ ability to exercise control over personnel in such areas as hiring, transferring, promoting, and firing personnel; performance appraisals and disciplinary actions; salaries and benefits; and the creation of new positions” (Hess, 1998). The involvement of staff nurses in interviewing and recruiting new staff and managers for their unit was found to increase their sense of empowerment and their perception of shared governance (Scherb, Specht, Loes, & Reed, p. 166, 2011).

Clear Methods of Communication

In their study of autonomous work groups, Ingvaldsen and Rolfsen (2012), found that “inter-group coordination becomes a major challenge when groups enjoy high levels of autonomy.” While this challenge is compounded by the complexity of a hospital system, it is not insurmountable. Ballard (2010) reminds leaders of the importance of information flow: “Data important to decision making should be identified along with mechanisms to obtain data formatted for ease of use by staff. A process for regular reporting is important in promoting staff appreciation of accountability for outcomes and quality.” Additionally, inter-organizational communication structures that connect councils, staff, leadership, and other councils need to be identified, implemented, and regularly evaluated (Ballard, 2010). Whitt, Baird, Wilbanks, and Esmail (2011) argue for the use of formal decision tracking tools so that accountability for implementation of decisions and outcomes of decisions become “experienced” by the nurses who make the decisions.

Shared Governance as a Means of Retention and Professional Growth

Nurse researchers and leaders echo the same refrain: shared governance is a power approach to engage, develop, and keep nurses. “The opportunities include getting noticed and
nudged, developing an understanding of the big picture, developing a results orientation, and substantial skill acquisition” (Beglinger, Hauge, Krause, & Ziebarth, 2011). The nursing shortage is not only a matter of needing more nurses, but also needing nurses who can function to the full extent of their scope to address the complex health needs of society. Nursing shortages ought to be an argument for shared governance not against it (McDowell, Williams, Kautz, Madden, Heilig, & Thompson, 2010). Shared governance ought to be integrated with clinical and professional development (Rheingans, p. 41, 2012) to retain and grow nurses as leaders both at the bedside in the boardroom (Pennington-Caraviello, 2011). While integration of shared governance with clinical ladders and leadership roles is one way to do this, it also requires a cultural shift in the organization: “These workers are not amenable to staying in a setting that does not honor their unique contribution and avoid a setting that assumes it owns both the worker and the work he or she does” (Porter-O’Grady, p. 470, 2001).

**Shared Governance Ought to Include Everyone**

Hess (2004) argues that nursing must embrace the whole of the health care organization, including everyone’s voice in shared governance, including patients: “Shared governance models that include only nurses can become exclusionary and eventually ineffectual by focusing on the goals of a single profession, instead of the organization as a whole.”

**Shared Governance and Nursing Autonomy**

“What shared governance represents in all its forms is a format for the expression of the necessary autonomy that any professional body needs to make a vibrant and living contribution to those its serves” (Porter-O’Grady, p.251, 2003). When nursing shared governance becomes simply a way to enforce organizational imperatives from the top-down, the spirit of shared governance has died. It is important for nurses at every level to facilitate meetings in a way that listens, allows for group decision-making, and upholds communal accountability (Seguin, 2003).
While this may be uncomfortable in corporate-modeled health systems, “Nursing shared governance models have always focused on nurses controlling their professional practice” (Hess, 2004).

**Shared Governance and New Management Styles**

Shared governance not only requires new skills of the nurses who are involved in it (Reeves, 1991), it also requires managers to learn new skills, give up control, and lead in new ways. “Organizations will need to assist and support nurse managers to develop the style, comfort, and skills that enable shared decision making with staff nurses” (Scherb, Specht, Loes, & Reed, p. 175, 2011). Bamford-Wade and Spence (2012), capture the essence of the approach managers must embrace:

Working with the structure and processes of shared governance, as a vehicle for change, requires a different style of leadership. It requires collaborative leadership based on the principles of partnership, equity, accountability and ownership. Relationship building and shared decision-making are integral to collaboration. This requires spending time together to develop goals, plan and make decisions. As leaders we try to model collaboration and cooperation rather than individualism and competition yet at the same time we must also recognize and value individual effort and achievement. Creating an environment of innovation and working within a shared governance model is not a ‘quick fix’. Nor can it be achieved by any one person.

**Conclusion**

Shared governance is often complex in its application, but it is profoundly simple in its essence. “Shared governance is, in short, simply a structural model through which nurses can express and manage their practice with a higher level of professional autonomy” (Porter-O’Grady, p. 251, 2003) Shared governance is a compelling means by which nurses and hospital
administrators come together to create empowered organizations that value partnership, accountability, equity, and ownership. Three decades of shared governance experience have revealed challenges, best practices, and significant results for patients and nurses. In the context of rapid change and immense challenges facing patients and the nursing profession, “building a structure for empowerment (shared governance) is not only relevant, it is essential” (Porter-O’Grady, p.473, 2001).
References


