

# The Promise of Power

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What nursing lacks today it will have tomorrow: a solid resource and power base upon which to move the profession forward.

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**M**OST nurses today are so preoccupied with their current professional lives that they generally give little thought to future conditions, for themselves or for their profession. Yet more than half of these nurses practicing in 1978 will probably still be active in nursing in the year 2003, and the face of nursing in that year will depend on the cumulation of decisions and events that take place between now and then. Consequently, an endeavor to scan the future and attempt to forecast the condition of American nursing just after the end of this century may offer helpful insights for directing progress.

## LOOKING AHEAD AND LOOKING BACKWARD

Time is a three-fold present: the present as the person experiences it, the past as the person's current memory, and the future as the person's present expectation. Obviously forecasting is not and can not be a purely objective exercise. The future does not exist; the forecaster must try to invent it. As she does so, her suppositions about what ought to happen are intertwined with assumptions about what will and what can happen. Existing or past trends do not always define the future, since a totally unexpected happening may create some new trend that is much more important than any now recognized. Would anyone in medicine, for instance, have predicted Pasteur's discovery of microbes twenty-five years before he detected them? Or physicists have predicted twenty-five years before Hiroshima that atomic fission would be achieved so soon? Yet these two developments are among the most significant occurrences of the past 150 years.

Without exceptionally powerful evidence pointing to a radical break between past and future, most forecasting is possible only through the projection into

future time of social phenomena which can be shown to exist somewhere in the present or past. A good parallel exists between the practicing nurse and the nurse who attempts to forecast the future. Just as the practicing nurse has to take into account the past health history of her patient, so the nurse forecaster has to take into account the past development of her profession.

Progress in any field is not a function of mere chronology. The earlier is not necessarily the lesser, nor the latest always the best; "modern" does not always connote the highest form of development. In the history of nursing, just as in the lives of individual nurses, there are moments or periods of great achievement, such as the establishment of the first Nightingale schools in 1873; and there are also moments or periods of decline, such as the proliferation in the early 1900s of hundreds of very weak nurse training schools, which existed almost solely to supply student nurse labor to hospitals. At various times in the future, nurses may strive to regain lost ground and may gain inspiration from certain bygone practice standards, such as the individualized "one patient-one nurse" care which characterized early private duty nursing. Thus, in speaking of progress in nursing, the forecaster is concerned not so much with the calendar as with the ongoing march of nursing toward the realization of the profession's fundamental values and potential.

In considering nursing's progress up to 2003, we are probing the principles of critical evaluation of nursing—past, present, and future. But what does "progress"

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mean? The word, coming from the Latin verb *progredior*, means "going forward." Now all going with nurses, as with other beings, is *not* going forward. Some crustaceans, for instance, move backward; crabs usually crawl sideways and can proceed in any direction without really turning. In the crab's philosophy of life, the term progress, in the sense of moving forward, would be confusing; forward and back, outward and in—all would be one to the crab. Many nurses, unfortunately, identify progress with vigorous movement. If the going is ceaseless and energetic, it is judged to be progressive, as with the nurse who "never lets up," or the nursing practice setting in which "something's doing every minute."

The least reflection should serve to dismiss the correlation of progress with mere energetic activity, for the most vigorous movement may be the most futile or ruinous if it is misdirected. Energetic activity and development are, of course, the means through which progress in nursing may be achieved. But to judge progress, one must judge the consequences of change: Toward what values do specific nursing activities tend?

The idea of progress emphasizing personal or collective fulfillment can be stated simply as change for the better in nursing care. American nursing in 1978 is in such a period of flux and there are so many diverse forces at work that it is often difficult to tell if the profession is moving forward, backward, or sideways.

#### ESTABLISHING A RESOURCE AND POWER BASE

The critical challenge facing nursing over the next twenty-five years will be to acquire a solid resource and power base upon which to move the profession forward. Ever since the beginning of the profession the absence of such a base has been the most crucially limiting force in nursing's march toward achieving its potential, and economic developments in the years leading up to 2003 will not make it easy to achieve such a base. For, by 2003, the United States will have moved away from the values of growth, extravagance, and exploitation toward sufficiency, frugality, and stewardship. In short, the principle of conservation will replace gain as the prime motive of economic life.

Economist Kenneth Boulding uses the concept "spaceman economy" to describe the future consequences of scarcity.<sup>1</sup> According to him, since our overpopulated globe is beginning to resemble more and more a spaceship of finite dimensions, with neither mines nor sewers, our welfare depends not upon increasing the rate of consumption or the number of consumers—both of these are potentially fatal—but on

the extent to which we can wring from a minimum of resources a maximum of richness and amenity. A good life will be possible, but "it will have to be combined with a curious parsimony"; in fact, "far from scarcity disappearing, it will be the most dominant aspect of the society; every grain of sand will have to be treasured, and the waste and profligacy of our own day will seem so horrible that our descendants will hardly be able to think about us."<sup>2</sup>

The health care industry, and specifically nursing, will feel the effects of this scarcity perhaps even more acutely than other components of society. Health services have always been scarce, even though the health care industry has been receiving an increasing share of the gross national product. And nursing services in particular have never been available in any great abundance—not even enough to meet society's basic nursing needs.

A static financial base will intensify these health care shortages and will force the industry to use its financial and manpower resources much more efficiently. The phenomenon of scarcity has momentous consequences, of which one of the most important is the utter inevitability of politics, defined as the art and science of government, and the need for government to distribute scarce resources in an orderly fashion. Assumptions about scarcity are absolutely central to future nursing practice, education, and research; and the relative scarcity or abundance of future health resources will have a substantial impact on the character of nursing standards.

Long before 2003, the nation will be forced by the current health care crisis to solve the disproportionate outlays for health services which take funds away from other parts of the economy. In 1978, health care costs will exceed \$185 billion. By 2003, unless drastic changes take place, the annual figure will be in the vicinity of \$1 trillion. Consequently, the questions about *who gets what, when, how, and why* in health care will be closely reexamined and answered anew during the next decade; by the year 2003, strict limits on the resources allotted to health care will undoubtedly be mandated.

The 1978 nurse is typically apolitical, largely because her socialization places political involvement outside the purview of professional nursing. The 2003 nurse, in contrast, will be operating within a health care system constrained by increasingly scarce resources, on the one hand, and burgeoning demands for quality nursing care, on the other. If nursing is to meet those demands, then nurses in 2003 will recognize the absolute necessity to become considerably involved in the



political process. They will know that nursing must acquire and maintain a fair share of the financial base available to the health care industry, today dominated almost entirely by physicians or medically-dominated institutions.

#### IMAGINATION AND POLITICAL AWARENESS

Nurses in 2003 will have at least two fundamental qualities which are generally underdeveloped in nurses today: creative imagination (the capacity for expressing their creative potential) and political awareness (in the wider sense of a determination to define the aims of the health care industry and to markedly influence the decision-making processes). They will have been prepared for such tasks through a broadened professional socialization directed toward the development of a full awareness of the complicated workings of the health care industry, knowledge of points of leverage in helping to shape the system, and a willingness to fight for principles in the face of competing forces which threaten to undermine or dilute quality nursing care. By 2003 a structural evolution will have occurred through the advance of socially committed nursing science, shedding light on decision-making mechanisms, defining individual and collective nursing projects, and transforming ideas, opinions, and attitudes into action.

While in 1978 many politicians are little aware of the so-called nurse vote but highly aware, for example, of the school teacher vote, in 2003 the vote of the nation's two million active nurses (double the number of active nurses in 1978) will constitute a potent force with which to contend. Like the National Education Association in 1978, which brings together the collective action and influence of teachers, the American Nurses' Association and the political arm of the organization, N-CAP, will be readily associated by the nation's policy makers with the advancement of health care. Several nurses will have been elected to Congress, and perhaps one will have won office as a state governor. Many candidates for state, local, and national office will seek endorsement from district and state nursing groups. Nurses will routinely work for the election of candidates who espouse their views.

As nursing in 2003 will be closely associated with health consumerism, politicians will find that advocacy of quality patient care and protection of patients' interests are effective means of garnering votes. Many local and state nursing groups will form coalitions with health consumer groups to elect public officials who are concerned with the welfare of nursing and health care recipients. From hospitals to public health agencies, to colleges and universities, to planning groups and regula-

tory agencies, nurses in 2003 will sit as members of boards of directors, will occupy positions as top level administrators, and will wield considerable power as policy makers.

Despite the overwhelming historical evidence for the rapid mortality of all institutional structures, we tend to think of the particular set of health care institutions that we have inherited and grown accustomed to as eternal, immutable, and, above all, right. They are not. Through a lack of critical reevaluation, some health care institutions and practices may persist long after the conditions that made them viable and socially useful have vanished.

The United States, with its advanced technology, substantial financial resources, and highly developed acute care services, has the potential for the best health services in the world. That potential, however, is far from completely realized, since we lag behind many industrialized countries in caring for our citizens' health, as measured by vital health indices. More than two dozen other countries have a higher life expectancy for males, while about half this number rank above the United States in life expectancy for females. At least a dozen other countries have a lower infant mortality rate, and nearly a dozen have a lower maternal death rate. The same disparity is evident among population groups within the United States.

#### RESOLUTION OF THE HEALTH CARE CRISIS

Described as the "most rapidly growing failing United States industry" in 1978, health care faces a crisis of momentous proportions.<sup>3</sup> Millions of Americans now receive virtually no health care, and millions of others receive it only sporadically. Most health care is delivered at staggering financial costs and, in many cases, with unnecessary suffering. For millions of Americans—the poor and near poor who live in rural or inner city areas—the medical care system is not merely inadequate; it is almost nonexistent. On any measurable health index, the poor and racial minorities fare much worse than the rest of the population: higher mortality rates, greater incidence of major diseases, and lower availability of medical services.

It is clear that the United States cannot continue to tolerate this situation, wherein the availability of health services is too frequently determined by financial means or geographic location. Health care should be regarded not as a privilege, but as a basic human right for all citizens, and access to health care should be seen as a corollary to the right of life itself.

The present health care crisis, which will have to be resolved between now and 2003, comprises interacting

problems that exacerbate each other through various kinds of threshold, multiple, and combined effects. Thus, the complexity of managing the combination of problems has grown faster than any particular problem itself. Such a labyrinth is already taxing nurses' cognitive skills and will continue to do so through 2003, since a premium will be placed on analyses and evaluations of various courses of action and independent judgments in developing the most effective means of implementing quality nursing care within the shifting health care complex.

Nursing input into current efforts to solve health care problems is notably lacking, despite the fact that about one out of every 200 Americans (or 1 million) is an active registered nurse. Delays, failures of planning, and a general incapacity on the part of nurses to deal effectively with even the current range of health care problems are all too visible today. Nursing's ability to cope with large scale complexity will improve substantially by 2003, however.

Undoubtedly, a system of national health care, embracing cradle-to-grave health insurance, will develop on an incremental basis, building on Medicare and Medicaid as they exist in 1978, moving next to maternal-child care and then to comprehensive population coverage. This system will closely adhere to the principles of cost effectiveness.

Greater use of the services of nurses will occur as they will provide primary care to large parts of the population. Emphasis will be placed on prevention, and the major locus for health care will be ambulatory settings, not hospitals; thus, nurses in 2003 will provide much more care on an ambulatory basis than they do today. Physicians will be employed on a salary basis to provide specialized medical services, mostly of an acute care nature. Some physicians will still carry on a lucrative private practice by catering to the wealthy few who choose not to receive health care underwritten by the government.

#### EXPANDED NURSING PRACTICE

The expanded scope of nursing practice in 1978 already encompasses certain functions that have been traditionally performed by physicians. Nurses practicing in this new role have generally received specialized preparation beyond their basic or graduate programs. By 2003, these "expanded" functions will have become an integral part of the nursing role and of nurse preparation programs. The increased responsibility will be generally viewed, as it is today by some nurses, as an opportunity for the nurse to enlarge the informational base that serves her as professional foundation for

nursing assessments, diagnoses, and interventions.

Under a system of national health care, nurses will be considered cost effective by policy makers, not only because their salaries will be lower than physicians, but also because the preventive, wellness-oriented care that nurses offer can save millions of dollars in diseases prevented and can significantly upgrade the quality of life for millions of Americans. This type of care will be increasingly sought by consumers, in contrast to the biomedical model, which emphasizes the treatment of acute disease and explains disease solely in measurable biological terms. The biomedical model represents a rather recent view of illness—most people aren't aware that it is only about a century old—but it nevertheless forms the conceptual basis for most health care in America and has a tremendous impact on health policy.

Even though this model prevails, the word "health" is often used so imprecisely and inaccurately that it leads to misunderstanding and to false expectations. "Health center," "health examination," "health promotion," and "health insurance" are terms commonly misused today. In each instance, the activities encompassed by these designations are largely concerned with problems of disease. And the institutional frameworks within which nurses function today concentrate almost entirely on biomedical patient services and de-emphasize the supportive, preventive, and psychosocial tenets of nursing, which have been downplayed since they were espoused by Florence Nightingale.

#### TECHNOLOGICAL INFLUENCES

Biomedical technology is growing rapidly, but it will have become obvious by 2003 or before that medical technology cannot be improved indefinitely without encountering limits of scale beyond which further improvement is of no practical value. Some technologies in medicine are already near this point and the rest soon will be, for the expensive substitution of one ever more efficient form of technology for another simply cannot continue forever.

In effect, the better the existing technology is, the harder it is to improve upon. How much further will the current thrust in biomedical technology run? It can hardly continue indefinitely if the past is any guide. Trends at some point begin to reach a limit, and turn into the common S-shaped curve which has its kinetic analogue in the motion of a pendulum.

Although a condition of diminishing returns will prevail, some significant technological breakthroughs will continue. By 2003, transplants will have become very popular with the hundreds of thousands of debili-



tated people needing new limbs, hearts, lungs, and other organs. Spare-parts surgery will be limited only by cost, the number of surgical teams available, and the supply of spare parts.

At the same time, such surgery will give rise to difficult moral and legal problems that the nurse will be expected to help resolve. Which of the many patients in need should receive a new organ? Should there be an open market for kidneys? Or just a black market? Should an individual be free to decide whether his organs can be transplanted at death? Or should relatives be allowed to make money by selling his heart and lungs? Other new technologies by 2003 may include:

- artificial hearts, perhaps as common as artificial limbs are today.
- synthetic skin for burn injuries.
- regeneration of bone and eventually of vital organs.
- laboratory-synthesized whole blood substitute for emergency transfusions.
- implantable brain-stimulation devices to control appetite, induce sleep, and relieve headaches.

Diminishing returns will clearly be seen, however, for the more scientific work that is done, the more likely it is that new theories will be corrections or refinements of previous ones, necessarily leaving most of the old structure of knowledge intact. Thus, new knowledge may not be translatable into new technology. By 2003, some additional advances will have been made against mental illness, arthritis, degenerative vascular disease, and some cancers; but the billions of biomedical research dollars will have yielded so few practical, cost-effective breakthroughs that biomedical, disease-oriented research will have given way to prevention as the major research and development focus.

Nurses will logically play a pivotal role in conducting this research. This is not to say that an ongoing program of biomedical research will not exist but rather that a far greater share of research resources will have to be allocated to preventive and psychosocial solutions.

#### THE NURSE HERSELF

The personal characteristics of the nurse will also undergo marked change. In 1978, the *majority* of nurses are still characterized as submissive, dependent, malleable, conforming, and "mild-mannered." By 2003, the typical nurse will be described as confident, independent, autonomous, and even assertive. Nurses will be regarded as health professionals in their own right, who are as valuable to society for their unique contributions as physicians are for theirs. Nurses will be much more willing to accept responsibility and accountability for

their performance than they are today and will engage in independent practice as well as in cooperative decision-making with physicians and other health care providers.

Unfortunately, some physicians will still resist the nurse's egalitarian role on the health care team. The years between 1978 and 2003 will be characterized by some degree of conflict between physicians and nurses as health care roles are realigned. Government guidelines for health care providers will help in the resolution of differences. Nurses' involvement in institutional politics and their ability to tolerate the anxiety associated with confrontation will, of necessity, greatly increase.

#### A MAJOR CHALLENGE

We confront a major challenge during the next twenty-five years, and we should not deceive ourselves about the magnitude and duration of the task. No one nurse, no one development, no one invention can supply more than a small piece of the eventual solution; the final result will be a mosaic of mini-elements, some designed by nurses, others fashioned by the accidents of history. Progress in nursing has been and will continue to be a zig-zag. No sooner has one obstacle to professional fulfillment been removed (such as large scale exploitation of student nurse labor), than others have loomed up (such as access to third party payments). Any satisfaction that is gained will always release new needs so that the unending battle will have to be joined again and again.

Only by postulating goals and understanding why we select those goals rather than others can we assess the ways in which change in nursing interacts with change in society—whether the change be large scale, such as a radical revamping of the health care system, or small, such as a new nursing intervention for a particular type of patient. Of necessity, an assessment of our goals involves forecasting. We want to know just how the change will or will not fulfill our postulated goals, not only now but also into the future—for one, two, or even three generations. To do this requires some exercise of the imagination, some movement out of the quantifiable into the unknown. □

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