Macrotrends in Nursing Practice: What's in the Pipeline
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My involvement in health care and nursing largely limits me to a global perspective. But staff development educators, on the other hand, are making the critical analysis, the decisions, and the impact at the operations level. The partnership between us is necessary to forge the links between the two. In fact, it is my conviction that one of your two major functions in the workplace is to build bridges between the intense concentration of the institutional environment and the broad influences of the outside world, so that those inside “doing work” (for today) and those outside “doing science, and education, and policy” (for tomorrow) are connected and understand their relationship to one another. Your other essential function, as I see it, is to refresh the vital growing edge of human capital in the practice environment, through knowledge, skill, perspective, and motivation. All of this is in order for your facility to provide cost-effective, high-quality health care.

The following projections of the macrotrends, the big possibilities, the world view, are a combination of forecasts from professional futurists and personal observations (Figure 1). Within the next decade the nursing profession and the practice field will be bombarded by giant forces that are global, geopolitical, social, demographic, epidemiological, technological, political, and industrial in scope and nature. We are already squeezed by these pressures; but, what is different, I believe, is that some of these forces will intensify and, assuredly, some will shift direction.

The surest test of what we can predict is to look back to determine how much we have been able to foresee in the past. As one quick example, think back to 1980, only 12 years ago, to the pre-DRG, pre-AIDS, pre-plasticnost, pre-personal computer era. We probably would have done a poor job then of describing the work environment today, and today we would probably do a poor job of describing the work environment of the coming millennium. Why? Because the future is not a trend line projection. We can be moving in one direction when suddenly or gradually, individuals, singly and collectively, will change the course of events, as they have throughout history. Accordingly, we—you and I—can change the course of events within our sphere of interest and influence.

**THE BUTTERFLY EFFECT**
When the challenge to create or stimulate change seems overwhelming, think of the butterfly effect. Scientists have identified and described it. It is the cornerstone of my personal philosophy. The butterfly effect is defined as “sensitivity to initial conditions.” It is explained that the flapping of the wings of a butterfly in the South Pacific in December (i.e., the initial condition) gently sets off a chain of events leading to a violent hurricane in the Caribbean in July. If a butterfly can change the world’s weather, surely we can change nursing’s destiny. Where we don’t find macrotrends, we can initiate them; where we find them to be harmful, we can change their course.

**THE PIPELINE**
Within each of the pipelines—e.g., the political, social, or industrial pipelines—are one or two thrusts
most likely to affect us to a significant degree. I selectively mention only five forces, the last of the five integrating the others and serving as a vector guiding us into the 21st century.

In the political pipeline, health care reform is as inevitable as death and taxes. Current legislative initiatives constitute the third wave in slightly more than 25 years. First, we had Medicare and Medicaid introduced in 1965 with the programs of the Great Society. Access was the issue. On the second wave, DRGs were imposed less than 10 years ago. Cost was an issue. As we near the 21st century, crisis and collapse are the issues. Spiraling costs and neglect, a really strange combination if you think carefully about it, are jointly spinning out of control. As has been said so succinctly, Americans have the poorest access to the most expensive (and one might add "exotic") health care system in the world.

MACROTRENDS
Health Care Reform

The new wave of health care reform, depending on who has the upper hand in government, could tinker only with health care financing, or could make sweeping changes in health care priorities, policies, and systems of delivery. The possibilities that confront us range from a true single-payer national health plan, to adding some more patches to the already mind-boggling patchwork quilt. Odds are that the federal government will only deal with financing and will do so through cost-shifting or a pay-or-play employer-mandated system. And, odds are that the real shifts in health care priorities, e.g., expanding from cure to prevention, and from traditional to nontraditional sites and providers, will occur only in some states and through some private insurance or delivery schemes. Oregon’s systematic plan to rationalize rationing is one such development. Florida’s innovation in the use of schools as the center of the health care system for indigent children is one excellent example. We should hope this portends a macrotrend.

Increased regulation will go hand-in-hand with reform, despite the protests of the administration to the contrary. Regulations, of course, add to the burden of educating staff, changing behavior, and monitoring outcomes for health care facilities. Surely some of that burden will fall on your shoulders.

Before you even catch your breath from implementation of the patient self-determination (medical directives) act, you, as architects of the connections to the outside world and as internal developers of human capital, will be playing a major role in building a new health care and work environment, the specifications of which have yet to be written. You will have no choice but to hold firm to your enduring mission, goals, values, and principles, and to apply them under changing circumstances.

As this third wave of reform rolls in, staff will need to know what is happening, how it will affect them and their work, how they can be proactive and involved in the changes, and how the best possible adaptations can be made. Through what programs are staff exposed to the major issues in health care, the issues that eventually impact on them and the care that they give? Do they support organized nursing’s agenda for health reform? Are they activists in the reform movement? And, the most fundamental question of all: Do they really believe that they can make a difference? Do they care?

Motivation of the Workforce

This brings me to a second major issue and possible trend in the industrial pipeline—the motivation of the American workforce. The remarks by Japanese officials regarding our workers have really struck a responsive chord in the heart of America, haven’t they? Our first inclination was to fight back with righteous indignation. Then, within a week, we began to shift the blame to management. Some people finally gave serious thought to the validity of the accusations. All three responses are probably appropriate. What about today’s nurseforce in your work environment?

We are told that successful, fulfilled people feel challenged, empowered, and significant. Do the nurses you know feel challenged, empowered, and significant (Figure 2)?

Would the staff you know say those things? Would you say those things about yourself and your job? If you answered “yes,” therein lies a happy, constructive, concrete, specific agenda for staff development in keeping those attitudes alive and well-nourished. If not, therein lies a deeper, less well-defined basic human need to be addressed through your good work. If there is a well of pessimism, apathy, and fatigue in the institution, then your mission is the critical one of transformation, not mere sustenance and reinforcement.

It seems to me that staff are best motivated and patients are best cared for in environments where there is a sense of community; that is, where there is a sense of common interest, personal bonding, and cooperative endeavor—where there is a sense of circles rather than lines and boxes. U.S. industry overall,
not just health care, needs to learn this lesson. The work environment should be a place where human problems are dealt with by human beings in a humane way. This is particularly necessary in settings such as health care, where “emotional labor” occurs. Emotional labor is the term used by economists to define any kind of work in which the employee’s feelings are in some way the tools of the trade. Preventing moral distress is our ethical obligation under these circumstances (Kerfoot, 1991).

To what extent is there a sense of community or even of microcommunities in your organization? How might such a spirit be engendered through your efforts?

Gender Issues

In the social pipeline we find long-simmering gender issues. The trends that will develop are difficult to predict, but they are important to observe or, even better, to influence.

My international experiences lead me to two generalizations. The first is that with some exceptions, to varying degrees, and with diverse manifestations, there is a global culture about women. The second generalization is a consequence of the first. Women are overworked and undervalued.

More and more, I am incensed about these realities. More and more, I suffer with my sisters around the globe and am determined that fundamental changes must be made, not just for the sake of women, but for the sake of society. To hold a mirror up to the face of woman is to see the reflection of civilization.

Gender discrimination manifests itself so differently around the world. Let’s begin with a “snapshot” of the planet. Consider these potent, telling indicators capturing the essence and magnitude and direction of the global gender gap. They come from a United Nations (UN) publication, entitled _The World’s Women 1970-1990: Trends and Statistics_ (1991), a valuable resource.

- Between 1970 and 1985, the number of the world’s illiterate women rose 10%, from 543 million in 1970, to 597 million in 1985, while the number of illiterate men rose only 1%, from 348 million to 352 million.
- Women work as much or more than men everywhere— as much as 13 hours more each week, on average, according to studies in Asia and Africa (UN, 1991). Yet, governments do not consider much of women’s work to be economically productive and thus do not count it in gross national product. (It is not even counted!) If women’s unpaid housework, family care, and subsistence agriculture were counted as productive outputs in national economies, measures of global output would increase 25% to 30%.
- Setting aside the fact that in many places women are relegated to low-paying, low-status jobs, even when they do the same job as men, they typically receive 30% to 40% less than men, on average, worldwide.
- Women hold only 10% to 20% of managerial and administrative jobs worldwide. Fewer than 10% of the members of the world’s parliamentary bodies (i.e., national legislatures) were women in 1987. Ironically, the highest representation, 28%, was behind the Iron Curtain in the Soviet Union and Eastern Europe, although these numbers have declined with the recent political changes. (So much for the influence of the “free” world!) Fifty UN member nations (close to 30%) have no women in any of the top echelons of government.
- Of 8,000 abortions performed in Bombay after parents learned the sex of the fetus through amniocentesis, 7,999 would have been females (UN, 1991).

We are a so-called enlightened, developed society in America. So, the culture of gender is acted out in more subtle ways. In the United States, many of us have been through the harsh realities of the women’s Lib movement and have experienced some of the beneficial effects, some of the overkill, some of the strategic errors, and some of the backlash. After gaining initial momentum and sensitizing the country to the inequities, we lost the battle for the Equal Rights Amendment in the 1970s and 1980s, and the movement stalled. Even some reversals were felt. In a study

![FIGURE 2](attachment:image.png)

**Figure 2**

Motivation of the Workforce

As to challenge, would they say:

- I want to keep on learning.
- I want different responsibilities.
- I want to take some risks.
- I want every day to be different.
- I want my job to be fun!

As to empowerment, would they say:

- I want to participate in important decisions.
- I want the opportunity to be creative.
- I want people to respect me.
- I don’t want to have to ask permission.
- I want to have to go by the book.
- I want to be responsible and accountable.
- I really care about what I’m doing and I’m one of the people who’s making it happen.

As to significance, would they say:

- I want to feel that I’ve made a difference.
- I want to believe that what I do is important.
- There’s a purpose to what I do.
- I’m doing something that others really appreciate.
- What I’m doing is significant. It makes a difference. I make a difference.
Health care reform, which will go hand-in-hand with increased regulation, is as inevitable as death and taxes.

reported in the San Francisco Chronicle, ("Schools Unfair," 1990), the American Association of University Women found that construction of the glass ceiling begins, not in the executive suite, but in kindergarten where, for example, teachers (mostly female) call on boys 80% more often than they call on girls.

Three sparks are rekindling the women's movement in the United States and seem to be sending it off this time in directions where there may be a more lasting and broader impact in the elective process. Those sparks, as I see them, are the Anita Hill incident, the Roe v. Wade discussion in the Supreme Court, and the exposure of the inequities in women's health.

Inequities taint both the image of medical practice, where women's complaints don't get as much attention, and the highly respectable scientific community, where female subjects have been excluded from research on major health problems (e.g., heart disease) and where women's problems (e.g., breast cancer) have been underrepresented and underfunded on the research agenda.

For those in our profession, men and women alike, this concern with respect to gender issues and trends must be threefold. We must apply our energies toward:

- women and health, i.e., our influence over health policy and health delivery;
- women in health, i.e., the nurseforce, its roles, its rewards; and
- women's health, i.e., our advocacy for this key dimension of health care within which the depths of discrimination have been so recently exposed.

So, I would ask: Are staff sensitized to these differences? How can their observations be effectively translated and projected upward into the institutional and public policy arenas? How can staff be helped to help themselves when they are the objects of discrimination? What is your role, as professionals, as staff development specialists, as responsible members of society, and as instruments of institutional change in the attempt to shift the trends regarding women and health, women in health, and women's health?

Quality Care and the Empowerment of the Consumer

The quality imperative and the empowerment of the consumer should be considered as twin macrotrends in the health care industry pipeline. I believe that we empower consumers in two ways. First, we enable them to negotiate the health care system and advocate for their own quality care. Second, we teach them to care for their own health. In other words, they must understand both their health and the health care system—what to do, what to expect, what to demand.

Toffler, the futurist, in his book, Powershift, analyzed three historical sources of power—knowledge, wealth, and violence:

... it is now indisputable that knowledge, the source of the highest-quality power of all, is gaining importance with every fleeting nanosecond (1990, p. 470).

As to the powers of government, Toffler distinguishes between "socially necessary order" and "surplus order." Necessary order is for the benefit of the society. Surplus or excess order is for the benefit of those who control the state. He predicts that, "the state with the lightest touch may accomplish the most, and enhance its own power in the process" (1990, p. 468-469).

What are the lessons of powershifting for all of us who are committed to improving the health status of society through the education of health professionals? For me, the clear lesson is this: The "highest-quality power" to improve health care is that power gained from the dissemination and diffusion of knowledge about health throughout the population. Therefore, the technology of knowledge diffusion is the technology in which the greatest public resources should be invested. We empower consumers not by advocating for them, but by educating them. As nurses, we empower ourselves and the profession in the process.

The 1990s are the decade of practice parameters and outcome research in health care. While I disagree with former Surgeon-General Everett Koop on some matters of substance and style, overall, I think he is a man of some understanding and practical wisdom. He sees, for example, the need to put the power of outcome research into the hands of consumers. I believe that this movement (the flapping of the butterfly wings) could spark the true revolution in health care, could spark actual changes in medical practice. The results of outcome research must be transferred and translated to consumers. They must know all of the options available for preventing or treating a given condition, as well as the proven consequences of each of those options. Also, they must be aware of the variability in practice and results among geographic regions, among institutions, among providers. They must realize, for example, that there are 10 times the number of bypass surgeries in some cities than in others, and that the resulting morbidity and mortality for certain surgeons or facilities is highly variable; they must understand why there are such differences and how to assert their choices.
SIDEBAR
Ten Benchmarks of Successful Organizations

1. Hierarchy is out. Women executives tend to structure their organizations as a network or web of some sort, not as a hierarchy, and see their own position as being in the center reaching out, rather than reaching down or trying to climb up.

2. The organization is no longer the center of the universe. Organizations of the future will be conceived of only in relationship to outsiders of any size and form.

3. The team always comes before the star. High-performing, cross-functional teams that cut across traditional boundaries will do almost all of an organization’s day-to-day work.

4. The new job is never done. Constant improvement and change will be the central focus of organizational life, and employees of the future will see change as survival.

5. Process is at least as important as result. Emphasis on the long-term values will replace the focus on short-term outcomes. Relationships and partnerships will drive the most effective organizations.

6. Values dominate rules. In relationship-based environments, improving skills and willingness to almost daily change the shape of the task or organization will be a sign of a transforming organization. Long lists of rules and detailed procedures become counterproductive in such circumstances.

7. Voluntarism underpins the company’s pact with every employee. In the evolving brain-based economy, ‘value added’ comes from the head, or the collective heads. Bricks, mortar, and muscles are out—brains are in.

8. Employee empowerment determines managerial success. In a fluid world with little or no hierarchy, those closest to the action must have the support to get on with the job unsupervised. Managers with a great need for control are tomorrow’s dinosaurs.

9. Teamwork leads to success. Those with a talent for creating and participating in team-based tasks—almost all of which will cross old organizational boundaries and demand the breaking of old rules—will be highly valued.

10. Lovers of ambiguity shine. Those who can cope with ambiguity, or better yet, thrive on it, will make their mark (Peters, cited in O’Malley, 1991).

How do we teach consumers about standards of quality care? How do we make consumers QA experts? Let me give you one example. In 1990, I had the idea, which was published in a guest editorial in Nursing and Health Care, that professional associations and health care organizations should publish pamphlets translating standards of care into consumer language. Specifically, I outlined one for the hospitalized patient, entitled Ten Ways to Know If You Are Getting Good Nursing Care (Styles, 1990). I still think it has merit and would urge you to read it and perhaps try it in your own work setting.

If I were to suddenly develop entrepreneurial tendencies, I would teach health care consumer smarts. Specifically, I would set up a consulting and educational service assisting consumers to assume responsibility for their own health, combining the two aspects mentioned: that is, how to live healthy, and how to manage their own health care regimen in today’s highly complex, fragmented, and deeply flawed system. Personal experiences have persuaded me that patients are the case managers, not the providers.

What do you do in your work setting to empower consumers, both sick and well? What more could you do to capitalize on this trend? How could you help your institution to shift to consumer-smart, consumer-managed care?

Organizational Transformation
Organizational transformation is the macrotrend that becomes the focal point, the vector combining those that have preceded—health care reform, motivation of the workforce, gender issues, consumer empowerment—and many others, such as technological, demographic, and epidemiological factors that I have not specifically cited but that are very apparent to you. These forces all lead to the demand for organizational change and will, in combination, dictate the nature of the changes to be made.

Think of a magnifying glass, and how, as children, we used to manipulate such a lens to scorch and ignite paper under the hot sun. These macrotrends or forces in the environment focus their intense rays upon the organization. The organization will, I believe, in turn focus its intensity upon you, the developers of its human capital, to assist in the transformation.

Gender advantage and unprecedented nursing leadership opportunities are excellent examples to consider. “The challenge for health care is to discover new leadership . . . that is both visionary and innovative . . . yet realistic and pragmatic” (O’Malley, 1991, p. 3). Tom Peters, the organizational guru, suggests that women will emerge in the 1990s as best-suited to manage organizational transformations in the new business environment. He correlates 10 benchmarks of successful organizations with inherent female strengths (Sidebar).

Does this list constitute normal practice in most hospitals today? Perhaps not. But, it is no fanciful version of successful organizations. What can you do to develop these transforming qualities in yourselves as well as throughout all levels of the organization?

Governance and care management models are evolving with each passing day. What do you read about in
Do the nurses you know feel challenged, empowered, and significant?

the literature and what are you experimenting with in your workplace? For example, we read that, with respect to unit-based models, shared governance in nursing is evolving to integrated patient care teams (Kerfoot, 1991). Ad hocracy, flexibility, and problem-solving centers are said to be the wave of the future.

Will staff development itself be decentralized to staff circles? If so, what are the effects of such a trend? How can it be most useful? Keep in mind that decentralization is one thing, but integration may be quite another. As with mental health and community content in school curricula, we have seen that integration sometimes leads to disintegration. This must not happen to staff development.

There are three trends or demands—not necessarily consistent with one another—that I am aware of that clearly impinge upon you: cross-training of personnel, increasing utilization of assistant personnel, and the emergence of new breeds of workers related to specific technical tasks or to specific roles.

As a member of the American Nurses Association and as a member of the California Board of Nursing, I am aware of issues arising regarding the scope of practice of unlicensed assistant personnel and the training and regulation of emerging technology-specific technicians, such as perfusionists. You must be doubly involved in addressing these issues, first as a professional and secondly as an institutional employee. Are you experiencing conflict between your professional and institutional loyalties? Have you been forced to reexamine your values and to negotiate compromises? Does this conflict lead to a sense of burnout and isolation? What resistance, ethical dilemmas, and other difficulties, if any, are introduced in implementing cross-training initiatives and in the use of assistant personnel? And, how do you carry out your responsibilities for preparing nursing assistants? Is this the sort of project in which you should be joining forces with community colleges? And, what must you do to support nurses in their development of health care team attitudes and behaviors and skills and in assuming new roles, such as that of case management? How do clinical nurse specialists fit into the transformation? What roles are emerging for nurse practitioners?

Another factor, cultural diversity, also demands organizational change, both from the consumer and provider standpoint. How does the assimilation of foreign-educated nurses and other employees affect the character of the institution and your responsibilities as staff development educators? How does providing services to an increasingly diverse patient population, or having staff and patients of different languages and cultures affect you and your institution?

The changing character of American business, staff mix, new roles, new technologies, and cultural diversity are some of the ingredients in organizational transformation. All focus upon you, the builders of bridges to the outside world of powerful influences and the developers of human capital within the institution.

What must the successful staff development programs of the future look like? From my perspective, it seems that they must be made up of flexible, multitalented teams of educators, who, in turn, must encourage the development of flexible, multitalented teams of caregivers who appreciate that the team is made up of diverse providers and consumers and that power shared is power gained.

Think about your charge within the profound, eloquent framework of James McGregor Burns in his theory and book on "Leadership" (1978). Burns has identified two types of leadership behavior. There is transforming leadership, which raises the sights, the expectations, and the performance of a group; and there is transactional leadership, which negotiates the day-to-day business of getting things done. Both types are needed to achieve organizational and professional goals. Neither, either, or both may exist in one individual from time to time. But, isn’t it true that, as these factors, these macrotrends create the vector toward the new millennium, you really have no choice? You must transact each day. You must transform overall.

REFERENCES