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A Call To Create: Poetry As Healing and One Nurse's Self-Discovery

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A CALL TO CREATE:
POETRY AS HEALING AND ONE NURSE'S SELF-DISCOVERY

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DEDICATION

To Nurses wherever they may be found.

You are so broken by the traumas of the last two years.
Yet, you have marched in faith and with bravery.
Never abandoning your patients – even in their dying alone.
You have upheld your calling.

When it is time, tell us.
We will listen.

This work is dedicated to you.

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To Dr. Amy Hodges Hamilton,

You are intuitive spirit and intelligence, personified. With the clearest vision for what needs to be accomplished, I have remained in awe of these abilities as I have watched you demonstrate them with both grace and such compassion. You have given me purpose. Thank you.

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You opened the doors of my mind and heart, shining a light upon their dark, hidden spaces. You have given me tools for the healing of my life and the lives of others.

To my daughter Lauren,

You are my proudest moment. You are my best friend. You have given me joy.

To my son Mason,

My fierce warrior, your practicality kept me going until the end. You have given me pride.

To my husband Scott,

You have always been my phone call in the darkest of night. You have given me everything.

To my fellow traveler Brooke,

The brightness of your gentle encouraging light shines on every page of this work. You have given me endurance.

ABSTRACT

Florence Nightingale's vision for nursing has changed greatly in the past one hundred and fifty years, with nursing's identity replaced with an emphasis on science over caring. The fast-paced, technologically sophisticated environments, designed to meet the declining health of an American public, have resulted in nurses who are being pulled away from nurse-to-patient caring acts and the reasons they felt called to become nurses. These changes have had detrimental psychological and emotional effects on nurses and are especially evident in Intensive Care nurses. Expressive writing as poetry, autoethnography, and participation in vibrant writing communities offer nurses experiences for healing, voice, and empowerment, as evidenced in the personal work of the author.

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Introduction

Though it has been years since I opened the wide door of an intensive care unit to hear the alarms and regular “swoosh” of the ventilators or felt the woven tug of my scrub pants’ drawstring pulled and knotted tight around my waist, my memories of these moments remain as if those experiences were yesterday. I only have to close my eyes to feel the weight of my stethoscope looped around my neck or touch the cold metal smoothness of my bandage scissors within reach in my front right pocket. My muscles tense as I recall the physical rush of being in control of the hospital bed’s rolling weight, just as my heart’s epinephrine responds with thumping at the thought of an initiation of a Code Blue. No other role in my life has demanded such critical vigilance and minute attention to detail. So often, these memories and their experiences revisit me. For so long, I now realize, the worst of these experiences and their confessions lay silenced in an isolated space within me. I wish I could say that I had fully learned to live with them. It is only now, years removed from those events, that I have found the tools and the strength to open my heart and mind to face them. To expose those memories to the healing sun of words in such a way that I have been empowered to sculpt their memorials in words. I have done my best. Moreover, I have strived to live a life in sacred remembrance of these patients for whom I cared.

Nursing is defined by the American Nurses Association (ANA) as “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering though the diagnosis and treatment of human response, and advocacy

in the care of individuals, families, communities, and populations" (Nursing 7). Its practice was founded on the battlefields, inside the poorhouses, and was established during the Industrial revolution of the mid-1800's. Its practice rests its vision and principles on the foundational work of Florence Nightingale. For Nightingale, "nursing meant the care people gave each other and the care received by those who need help" (Karlsson 2). In the beginning, according to Nightingale, nursing's primary goal was simply creating the best conditions for enabling nature to heal the patient. In her seminal writings, however, Nightingale links poetry to the creation of those natural environments. Writing in *Notes on Nursing* (1860), Nightingale states that poetry aligns the nurse with "the ability to wholeheartedly engage with the feelings, no matter how different, of other people" (MacDuff 437). Poetry offers a tie to the natural world in a way that brings an openness and connection to others for healing.

Connecting poetry to the caring processes of nursing, Nightingale also viewed the grounding of nursing's role in science as essential. She is credited with establishing the science of nursing process. A contribution, whereby nurses formulate science-based care plans for patients with the means to execute and evaluate those plans, proved vital to both nursing's development and the patients' healing. Out of these practices evolved the principles of an evidence-based practice. Nightingale is further credited with establishing nursing's role as distinct from the work of physicians. A true visionary, she is also acknowledged for paving an educational and professional course for nurses to advance their development and creating a path far removed from nursing's austere beginnings.

Nursing practice, however, has not been without struggle. As long as I can remember, nursing has labored for an identity as a profession, attempting to balance the role of professional nursing as both a field of basic clinical science and as a calling and a caring art. In many academic and administrative medical conversations, nursing has been argued to be nothing more than a science-based technical field. This argument offers only glimpses of truth. Observing nurses adjusting dials on a kidney dialysis machine, reading electrocardiograms (EKG), or instilling an intravenous catheter (IV) in a vein for the purpose of running a bag of saline wide-open to sustain a patient's blood pressure are all admittedly technical. These snapshots, however, do not come close to fully capturing a portrait of the practice of nursing.

As long as I have been a nurse, nursing has worked to move beyond this technical perception into one of professionalism. This journey, like that of other fields, has sought to leverage a science-based practice as its foundation. To this end, preparatory training for nurses has moved from an apprenticed Nightingale model of nursing education towards situating nursing within the framework of higher education. Still deemed the best path for professionalism, this transition is a process that continues even today.

Despite repeated calls for the transformation in the education of nurses, three training entry levels still exist for the exact same licensed role (Benner 216). Anyone wanting to be a professional nurse has three different training options: a Nightingale-founded Diploma in Nursing (DIN; 3-years of apprenticed training); an Associate Degree in Nursing (ADN; 2-years of primarily community college classes and some clinical training); or a Bachelor of

Science in Nursing degree (BSN; 2-years of higher education prerequisites followed by 2-years of nursing-specific classes and clinical training). On each program's completion, these students take the exact same NCLEX-RN licensing exam and, after passing, receive the exact same licensed title of registered nurse (RN). Other than, perhaps, a slight differential in pay and opportunity, no other difference in perception exists.

In my experience, with the goal of becoming a nurse and preparing to finish high school, College Night nursing school representatives entered our conversations with one hugely significant question as I made my educational choice, "Do you want to be a nursing administrator or a bedside nurse?" This question reveals much about the issues I have described and the climate of those moments. My answer was (and still is), "A bedside nurse." Moreover, "Always a bedside nurse," I answer emphatically, even now, and declare this fact with emotion.

I earned my Diploma in Nursing in 1978. In its day, the Schools of Nursing (SON) offering Diplomas in Nursing were more numerous than any college-based nursing program. Apprenticed to Roanoke Memorial Hospital, I lived in a simple dormitory connected to my hospital's orthopedic wing. My nursing program called students to both a calling and a devotion. I wore white support hose and white leather nursing shoes. Leaving the hospital, I wore a dark blue nurse's cape with my school's initials embroidered in gold thread on my lapel and a starched white nursing cap. My cap was earned as the fulfillment of my first year of training. Pinned to the top of my head in a ceremony called, "The Capping Ceremony," I held a small ceramic lantern lit with a burning candle representing Nightingale's nurses

serving battlefields in the dark. Prior to being caped, in reverence to my calling I repeated the Nightingale Pledge and swore my oath to my practice.

For those three years, I schooled year-round with mere days between quarters and holidays. I ate all my meals in the hospital cafeteria. I lived, ate, slept, and breathed patient care 24/7. My school's strict academic code required a grade of at least eighty percent to remain in the program. Its strict honor code discharged many a nursing student. Each quarter I was required to pass an exam on drugs, dosages, and solutions without the aid of a calculator. I earned seventeen-credit-hours for each nursing specialty as I worked alongside physicians and staff in pediatrics, obstetrics, surgery, medical-surgical, and psychiatry – all the while, still schooling and preparing care plans to meet the needs of my assigned patients. My nursing school cohort was the first class with permission to marry and the first class to accept a male student.

Nowadays, BSN programs greatly outnumber Diploma nursing programs. As nursing continues to grapple with its identity, so much is happening. You only have to turn on the television to hear the raging medical debates about inequities, the uninsured, mask mandates, grave and ever increasing staff shortages, patient-nurse violence, and the rabid discussions about immunizations. Inside each of these conversations, you will find a nurse standing at their intersection representing their practice and offering patient care.

Currently, the stressors and demands placed on the shoulders of registered nurses are rising in concert to the changes in the overall health of Americans. The complexities and comorbidities of illness in modern-day patient populations appear in direct proportion to an

ever-advancing field of scientific knowledge required to meet the needs of modern medicine. The balance of nursing practice has tipped drastically away from nursing caring art towards a profession in the grips of science-based medical administrations. This move, pulling nurses away from the bedside toward a detached science-based practice, carries significant consequence for nurses. Distilling nursing into a practice of distance and algorithms has resulted in a community of nurses growing increasingly psychologically and emotionally depleted without a sense of calling or clear knowledge of why they entered nursing in the first place. Nurses desperately need personal tools to manage these growing distances from the art of caring and its experiences. Moreover, while practicing inside spaces of power and silence, nurses need practices to make their voices heard.

The nurse is the face that patients see most frequently at the bedside, and a nurse's frame of mind greatly impacts and influences the quality of care they receive. Recalling Nightingale earliest principles, the best environment for healing is a natural one filled with caring moments for patients, where patients trust in human transactions of caring rather than interactions with machines and monitors. More than ever, nursing needs support to push back against the pressure of science-based practice and give nurses permission to return to the art of caring into the balance of their beginning, exploring principles and theories that call nursing both to self-care and to reflect on why they chose the call to nursing in the first place. Also important, nurses need tools of empowerment and the elevation of their own voices to break their silences and share their stories for their own restoration and the benefit of the patients whom nurses serve. This quest has been and is my own. And although this path was

revealed to me in the later part of my life after being a nurse for many years, its effects are no less astonishing.

CHAPTER ONE: A CALL TO CARE

The Changing Face of Nursing

Throughout his memoir, *When Breath Becomes Air*, Dr. Paul Kalanithi calls his readers to remember two essential things. The first is that science can never be severed from the human spirit because the scientific process springs from the heart of human investigation. "Yet the paradox," Kalanithi writes, "is that scientific methodology is the product of human hands and thus cannot reach some permanent truth" (169). Secondly, as he writes transparently about his inoperable cancer and details the clinical signs of his approaching death, he reflects on the solemn truth that illness and death are inescapable aspects of humanity's life circle. "Death comes for all of us," he declares (114). With this profound inevitability, he pushes to explore life's worth and to question what humanity truly needs:

> Science may provide the most useful way to organize empirical reproducible data, but the power to do so is predicated on its inability to grasp the most central aspects of human life: hope, fear, love, hate, beauty, envy, honor, weakness, striving, suffering, virtue (170).

Nursing theorist Dr. Jean Watson speaks to this understanding and offers her own theories about the balance between science and caring art in nursing. As a distinguished professor emerita and dean emerita of the College of Nursing at the University of Colorado, Denver, she has spent her life examining the role and balance of these ideas in nursing practice. As early as the 1980's, Watson began discussing her ideas and highlighting issues she could see

evolving for the future health of nursing practice. Observing the detrimental effects of extolling a focus of science over nurse-patient relationships, she sought to redirect and restore to the nursing profession a balance of both.

Watson sees the act and art of caring as nursing's first call. Moreover, she views those interactions nurse-to-patient as sacred. Further, she believes the act and art of caring practice is not merely central to nursing practice, but nursing's saving grace. "More energy," Watson wrote to explain," is now expended on the acquisition of scientific knowledge than of understanding. Nursing tries to understand people and how they cope with health and illness" (Watson *Nursing* 2). Though written years prior to Kalanithi's memoir, Watson echoes his thoughts as she writes:

> Science lacks the capacity for humanistic learning because it is not concerned about human goals and values. Science is not concerned with individual experience. Science cannot be expected to keep alive a sense of common humanity (4).

Writing in response to what she had observed, she argues that caring acts in nursing had become secondary to the nature of busy overwhelmed nurses in settings surrounded by scientific technology. Watson highlighted their struggle:

> Nurses are torn between the human caring values and the 'calling' that attracted them to the profession, and the technologically, high paced, task-oriented biomedical practices and institutional demands, heavy patient load, and outdated industrial practice patterns" (Watson *Caring* 467).

Nothing, Watson contended, should supersede nursing's primary call to acts of caring. These acts of caring, she argued, provide the power to replenish nurses to the wholeness of empathy. These empathetic interactions and an environment of care would bring about healing. Restoring nurses benefited both the nurse and the patient.

Witnessing the loss of caring's primacy, she forecast that the spirit of nursing and nursing would languish. Left without institutional permission toward personal empowerment and the validation of sacred moments of caring, nurses would be, "left hardened, brittle, worn down, and robot-like" (467). She argued that nurses must be allowed to give attention to acts of caring and given permission to uphold those sacred acts as an integral part of their nursing identity.

Watson, then, offered a directive to nurses. She called nurses to practice their own self-care as a means of spiritual renewal. Doing so, she argued, could restore nurses and prepare for profound experiences of empathy. Co-author of *Caring Science, Mindful Practice; Implementing Watson's Human Caring Theory*, Dr. Kathleen Sitzman elaborates on these self-caring benefits:

> As a nursing student, and then, a new nurse, I found that the realities of nursing education and then, professional practice sometimes blunted my ability to fully and wholistically care for myself and others. Watson's work has been a revelation and a comfort. It provides an outlet to immerse myself in the study of caring deliberately, productively, wholistically, and completely in nursing and in life (Sitzman & Watson 5).

Watson defined these profound experiences of empathy as "the ability to sense the inner world of another" and stressed the importance of, "requiring the nurse to be aware of his or her own inner world" (Clark 21). Further, she stressed that the self-care journey was continual. Speaking about herself as the embodiment of her theory, Watson writes:

> Here I teach what I continually need to learn. This journey is a process of evolving and honoring one's own inner needs, listening to the still small voice inside, connecting with our deepest source for awakening into our being and becoming ...without attending to and cultivating one's own spiritual growth, insight, mindfulness, and spiritual dimension of life, it is very difficult to be sensitive to self and other (Sitzman 65).

Encouraging nurses into a self-care practice as protection against the emotional and psychological depletion of a world weighed down by science-based nursing, she upheld, "the practice of caring in nursing has a social and human responsibility to promote higher ordered growth in oneself and others <…> the nurse must also be on his/her own healing journey (Clark 21). Those practices, she offered, as tools of self-discovery were found in the fullness of art, poetry, expressive arts, meditation, or other acts of mindfulness.

Echoing Kalanithi, Watson claimed that medical science is capable of curing disease; but no health can ever be obtained without acts of caring (Bayuo 142). These aspects of Watson's theories speak to me in a nursing language I can understand. Most importantly, her theories offer both insight as they are applied to my own journey and self-discovery as poetry in writing.

While Watson's theories were published and discussed several years after I graduated from nursing school, they are probably more relevant today than ever. Moreover, I see a space in our current national climate for her caring science to be relevant for anyone seeking to live a more empathetic, compassionate, and caring life or for anyone seeking a practice as an embodiment for profound experiences of empathy.

CHAPTER TWO: A CALL TO UNDERSTAND

The Effects of Science and Technology on Nurses

Describing the cost of caring, Kalanithi writes:

> "Before operating on a patient's brain, I realized, I must first understand his mind: his identity, his values, what makes life worth living, and what devastation must be

> reasonable to let life end. The cost of my dedication to succeed was high, and the ineluctable failures brought me near unbearable guilt. Those burdens are what makes medicine holy and wholly impossible: in taking up another's cross, one must sometimes get crushed by the weight (Kalanithi 98).

On April 14, 2021, most online news sources carried a story exposing the results of a research article published in a medical journal on the same day. Written by MA. Davis, BAY Cher, CR Friese, and JPW Bynum in the *Journal of the American Medical Association (JAMA Psychiatry)*, the article was entitled "Association of US Nurse and Physician Occupation with Risk of Suicide." These researchers reported the following:

> Before the pandemic began, suicide risk were twice as high among females nurses compared with American women as a whole, a new study shows. Even within the health care community itself, female nurses were found to be roughly seventy-percent more likely to die by suicide than female doctors (Davis et al 651-58).

In May 2021, it was estimated that 5 million adults in the United States suffer from the psychiatric disorder called post-traumatic stress disorder (PTSD) (Levi et al 224). PTSD was first observed clinically in soldiers returning from Vietnam. Its diagnosis so politically maligned at the time that it has taken approximately forty years to bring it into mainstream conversations. Its diagnosis is described in the Diagnostic and Statistical Manual of Mental Disorders (5^{th} ed; DSM-5; APA, 2013) as occurring in response to direct or indirect exposure to a single traumatic event or repetitive episodes resulting in symptoms and stress responses lasting over one month. Originally designated as an anxiety-disorder, the DSM-5 now classifies PTSD as a trauma-and-stressor disorder categorized into four clusters: the reexperiencing of traumas; avoidance of environments or representations of the trauma; the experiences of negative alterations in cognition or mood; and, finally, marked behavioral alterations in arousal and reactivity (APA 2013).

For reasons too many to discuss here, the diagnosis of PTSD for nurses is overlooked. All too often in nursing, because symptoms of PTSD are deemed "the cost of caring," nurses wear its symptoms as badges of caring. Additionally, nurses seek to appear strong in their clinical circles believing that symptoms of PTSD accompany their role. All these ideas lead to the avoidance of the diagnosis of PTSD. Rather, nurses' clinical symptoms become referred to with "softer" classifications of secondary PTSD, secondary trauma, compassion fatigue, or vicarious traumatization (Missouridou 110).

ICU nurses are at risk for PTSD due to stressful work environments, the complex high-acuity patients for whom they care, the traumas they witness, and the lack of support they receive amid those experiences from nursing leadership and healthcare organizations. They are forced to deal with quick changes in circumstances that are often beyond a nurses' usual scope of practice. Moreover, these nurses perform cardiopulmonary resuscitation and see patients die, despite their efforts.

In addition, ICU nurses confront suffering with expectant outcomes of death – yet nurses are still expected to perform physician-ordered care with the understanding that the care has deemed futile. Current studies reveal that approximately 33% of ICU nurses experience symptoms of PTSD, whereas 23% of nurses meet the American Psychiatric Association (APA) diagnostic criteria for PTSD. This number is higher than general nurses (18%) and extraordinarily higher than the general population (8%-10%) (Levi et al 224).

In her work, "Compassion fatigue in nursing: A concept analysis," Emily Peters frames the psychological and emotional factors producing PTSD symptoms in nursing. Nurses

enter the profession of nursing with a sense of pride and the expectation they will be valued by others as a provider of compassionate care. Moreover, nurses bring positive strengths to their roles: “Compassion, empathetic ability, high use of self, and maintaining composure in stressful situations are reasons nurses are excellent caregivers” (470). Nurses place a high value on the work they do with the devoted belief that their work matters and can make a difference.

Often, however, these feelings, expectations, and their associated experiences are minimized and even disparaged. As a result, nurses is silenced and, over time, begin to doubt their calling to nursing or their place in healthcare. Worn down and depleted by overworking, an overwhelming sense of fatigue and inability to keep up, an overwhelming sense of anxiety in the face of changing values as nurses spend less time at the bedside and experience depersonalization and the decline of empathy. All these features are coupled with overwhelming sense of hopelessness, the belief that institutions and coworkers do not care, and the observed perception that circumstances cannot and will not be improved.

Each of these features changes the face of the nurse interactions with patients and the quality of the care patients receive. Moreover, nurses understand this fact but cannot help their circumstances. Each factor affects nurses’ experience and result in clinical symptoms: diminished concentration and cognitive abilities causing errors that span from simple medication errors to patient deaths; deep apathy instead of empathy for patients causing delays in care or negligence to the detriment of patient healing; a sense of depersonalization wherein the caring connection between nurse-to-patient is irretrievably broken.

While I have observed depersonalization, describing its symptoms from my role as a nurse are difficult. Not because of the challenge to describe them, but because of the cynical and indifferent non-caring acts I have observed. Things become humorous when circumstances are anything but funny. Nicknames for medical issues and even patients become commonplace. The sensitivity and respect for patients and their care is hardened and absent. All of these things become enough for the nurse to question her personal values and create an overwhelming desire to quit nursing altogether (Peters 473).

CHAPTER THREE: A CALL TO LISTEN

The Power of Personal Narrative to Elevate Nurses' Voices

In "Language, Research and Nursing Practice," Kristin Bjornsdottir writes, "Language is not a neutral medium" (161). For nurses, in particular intensive care nurses, all clinical spaces of practice represent areas where language can be a space of uneven relationships of power. These forms of power flow from the top (institutional), through the middle (physicians), and even up from the bottom (patients and family members). From institutions, power comes in higher than safe nurse-patient ratios and the warning that walking off the job in fear of liability can result in criminal charges for endangering patient's lives. From physicians, verbal abuse and harassment can be rampant. Within this written space, I bear witness to my own experiences – a world where doctors acts inappropriately driven by the emotions of their situation: a patient is not doing well, or an error was made. Clinical spaces are governed by their own set of rules where a valuable surgeon or doctor is allowed behaviors unacceptable or even illegal. A space where sexual harassment is real, and so is violence (Valente 235; Potera 20).

I have observed physicians speak sexually and touch nurses as they wanted. I have also seen physicians aim surgical instruments to hit nurses (and nursing students) in frustration. In my own experience, I have been propositioned by a physician and then targeted and punished by the same using patient care as their means. Nurses making patient calls to awaken a physician in the night is among the worst examples. In fact, I can only remember a scant number of kind physicians in this regard; those physicians, more often than not, were married to nurses.

"Scientific knowledge is to develop true knowledge in the world and the relationships between phenomena" (Bjornsdottir 159). Thus, Bjornsdottir claims, nurses will silence themselves and choose scientific objective clinical data as primary language in order to find safe spaces to speak. Thus, the language of caring acts and spiritually intuitive spaces are hushed. This sense of silence within the use of scientific language is observed in particularly observed in nursing research. Scientific data and its quantitative power receive higher consideration and recognition than nurses' voices (161). For these reasons, the language of nursing remains embodied in an objective data-driven language of science over the consideration and recognition of qualitative narratives of empathetic caring as art.

Within the institution of medicine, language is power, and both its nurses and patients experience its silences. For those outside nursing, I recognize that it is difficult to imagine the paralyzing inability to raise your hand, much less your voice, to make a claim or to confront a physician or the medical establishment. Only the most self-actualized of physicians will take a moment to respectfully listen to an ICU nurse explain why she "feels" that something is going on

with a patient outside the clinical data to prove the situation is true. In "Silence, power, and communication in the operating room," Fauzia Gardezi et al writes:

> While speech is often equated with an active stance of self-determination and self-expression, silence is typically viewed as an indication of self-censorship, passivity, or quiescence. Therefore, explicit attention to silence may be seen as a way of attending to the voices of those with less power. To the extent that silence is revealing of dynamics of power and privilege, it is important to "listen" to silence (1391).

Further, these researchers demonstrate that nurses learn to modulate their voices according to their risks within the power structure. Gardezi et al found, in studies of nursing voices in operating rooms (OR), that nurses "speak quietly despite having institutional authority. To the extent that it plays a role in the lack of success of the speech act, speaking quietly may be perceived as a symptom of the traditional view of silence as a passive or quiescent stance" (1396). In contrast, they found that physician speak very loudly in the OR. Nurses' voices are soft and frequently ask for clarification rather than displaying confidence. Thus, the courage required for any type of confrontation is enormous.

Within medicine, the power from the bottom belongs to patients and family members. Though, more recently, patients and family members have faced criminal charges, nurses are often subjected to silence while suffering endangerments by patients and family members in the clinical area. In my years as a nurse, I have been bitten, kicked, grabbed, slapped, scratched, and punched by my patients; my experiences are not unusual (Dafny & Beccaria 3336). I would like to note, however, that, in my experience, the verbal and passive abuse by physicians ranks highest.

Autoethnography is a narrative form of qualitative inquiry with its foci on subjectivity, emotion, relationships with others, and epiphany (Dare 88). Writings offer an insider's view into a specific space and time. "Autoethnography is predicted on the assumption that – often oppressive – culture flows through self and vice versa, and that in all aspects of their lives people are ascribed within dialogic, socially shared linguistic and representational practices (89). The author, offering an autoethnographic example writes of the power of shared poetry as a tool for pedagogy in nursing, "…poetry touches readers in embodied rather than propositional and cognitive ways…poetry can provide nursing students with powerful insights, increased levels of empathy, and wider frames of conceptual and experiential understanding" (90).

Nursing voices are being acknowledged and elevated through autoethnography. Moreover, the telling of one's own story is gaining audience as a qualitative research tool. In "Research Methodology: Discussion Paper – Methodology: A case for the use of autoethnography in nursing research," Ashley Peterson writes: "Autoethnography is based on the assumption that reality is multifaceted, and the role of culture and context is crucial to understanding human experience" (Peterson 226). Its use, Peterson writes, has been underused in nursing but offers new insights in the examination of impact within nursing's personal and professional cultural identity in practice.

Moving the nurse from observer-critic to the position of participant forces the nurse into a vulnerable space that gives opportunity to new voices offering both insight and knowledge for readers (227). This type of research and writing offers opportunity to study a culture from the culture's point of view (Bishop 36). Further, Bishop underscores that ethnography offers "a

representation of the lived experience of a convened culture <…> The culture cannot be replicated or tested because it is experienced for a finite time though the researcher's participation and attention" (3). In this environment, the nurse's voice become central.

Peterson, addressing nursing as autoethnography, further claims that objective scientific data and qualitative analysis cannot and does not speak to the heart and hands of nurses. Rather, autoethnography offers a holistic full-hearted view empowering nurses to step out of the shadow of science and to speak and offer qualitative objectivity by sharing the power of their own stories. Their result is to engage readers through the evocation of emotion and the stimulation of reflection (Peterson 226). This sense of "audible authorship" offers new voices opportunities to challenge previous silences and to experience more dominant forms of representation (231). As nurses are enabled to offer their own narrative, they can yield insight to the entirety of the illness experience – offering readers a new understanding about nursing as well as those patients they treat.

CHAPTER FOUR: A CALL TO CONNECT

Expressive Writing as Poetry for Nurses' Healing

The use of words and poetry for healing is not new. Kalanithi asks his readers, "What kind of life exists without language?" (Kalanithi 109). These same words might have been spoken in the first century AD, by Soranus of Ephesus, a Greek physician, who reminded his patients of the healing found inside expressive arts. Soranus believed that his mentally ill patients would benefit from reading and discussion treatments; for the depressed and the manic, he

recommended theatre believing comedy offered benefit for his depressed patients, while tragedy offered benefit for mania. Greeks believed poetry and medicine to be so connected that both were placed under the dominion of Phoebus Apollo, their god of the sun.

In the United States, poem-therapy was used long before its current popularity. Offered as therapy in mental institutions in the early 20th century, the patient's expressive works were published in the hospital's newsletter. From its beginning, Dr. Jack Leedy, a psychiatrist in Pennsylvania, was its strongest advocate. "Poetry," Leedy wrote, "is one of the natural human resources for healing. In terms of human ecology poetry can be a constructive force in maintaining the balance of forces in human nature. Poetry helps people manage their feelings. It helps people stir up, release, or calm their feelings" (Leedy Healer ix). In 1969, Leedy would publish his first book, *Poetry Therapy: The Use of Poetry in the Treatment of Emotional Disorders*. This compilation of stories about poetry as therapy were written by experts in the mental health field. So successful, Leedy would follow that book with another in the same format, published in 1973, entitled *Poetry the Healer.*

Dr. James Pennebaker's 1997 seminal research on the health benefits of expressive writing brought poetry as therapy to the forefront. His research continues to be foundational to any work on expressive writing and therapy. Twenty-five years have passed since Pennebaker asked participants to write about their, "deepest thoughts and feelings about a trauma or and upsetting experience" (Sabo Mordecay et al 115). Pennebaker introduced his writing paradigm asking writing groups to write on assigned topics for three to five consecutive days for fifteen to thirty minutes. Surprised by his own outcomes, he was able to document both the effects and

benefits of creative expression/writing on physical symptomatology among college students. Pennebaker demonstrated that students spending as little as twenty minutes a day writing about emotional issues experienced positive life and health changes. Those benefits included grade improvement and fewer student health visits (Pennebaker Writing 162).

Initially, Pennebaker's positive outcomes were thought to be therapeutic due to the concepts of inhibition and disclosure in what was viewed as a common sense understanding that inhibition (the weight of holding secrets) could be proven to be linked to less rest, poorer attention spans and mental acuity, and, subsequently, poorer health or long-term negative outcomes. Further research has been unable to establish this connection; rather, it is the act of expressive writing – getting things out of the writer/poet and into writing – that creates the health benefits (Pennebaker and Smyth 151-156).

In expanded research, Pennebaker has explored his theory by employing the use of digital research technologies. These platforms have enabled the researcher to review negative and positive emotion words, causal words, and insight words inside writing samples over time. The conclusion, studied over the years in therapeutic arenas, has shown that while disclosure is, indeed, helpful, it is the mechanism of translating written experiences into language that has proven to be therapeutically relevant (Pennebaker Writing 165).

Pennebaker's initial research has continued to be tested and proven. In 2009, Jean Sexton et al published, "Care for the Caregiver: benefits of expressive writing for nurses in the United States," demonstrating that expressive writing offered therapeutic tools for nurses by creating opportunity for: 1) exposure – the means for exposing difficult emotions to make them more manageable; 2) cognitive restructuring – permitting new ways of thinking about upsetting

events; and 3) self-regulation – strengthening the nurse's ability to cope and regulate emotion (Sexton 311; Baikie 339).

In addition, this research, which included Pennebaker as a researcher, showed a decrease in missed days of work, reduced symptoms needing medication, improved self-image, and a decrease in symptoms of depression, as well as documented improvement in immune function with increases in immune responses to vaccines. (311;339). Also of note is that the subjects of many studies have demonstrated a host of continued health benefits to include reductions in health visits, increased healing blood markers in illness, better grade point averages, and self-reports of decreased physical symptoms and mental health complaints (Pennebaker Writing 163). Most interesting, those therapeutic benefits have lasted upwards of four years.

As more research has shown benefits, the application of Pennebaker's expressive writing paradigms has widened within medical specialties. Advancements in cognitive science, computer technology, and over twenty-four years of mental health research now allow theorists and practitioners to apply Pennebaker's writing paradigm in settings such as mental health, aging dementia, addiction, palliative care, human rights, and abuse (Baikie 342), using the paradigm to explore more specified realms of human illness and wellness. Sophie Nicolls states, "We are now in the position to take what we have learned from Pennebaker's influential paradigm and to move beyond it towards a greater understanding of writing and well-being, its range of uses, its applications, and how it can be helpful to us in both illness and health (Nicolls 178). Moreover, she writes:

> The process of expressive writing represents one phase in a longer more complex process of developmental expressive writing. <…> Critical approaches to health psychology may

> offer more detailed ways of understanding the mechanisms by which writing can be beneficial and how it might best be used" (178).

In Writing *and Healing: An Informed Practice*, Charles M. Anderson, and Marian M. MacCurdy offer, in my opinion, the best description of the benefits of writing:

> By writing about traumatic experiences, we discover and rediscover them, move them out of the ephemeral flow and space of talk onto a more permanent surface of the page, where they may be considered, reconsidered, left, and taken up again. Through the dual possibilities of permanence and revision, the chief effect of writing is thus to recover and to exert a measure of control over that which we can never control – the past (Anderson and MacCurdy 7).

Within my own personal experience within both writing and poetry writing groups, writing provides time and space for mindful reflection with subsequent opportunity to write, dissect, reconsider, and then, revise experiences and feelings. To move those experiences outside the mental travail of thoughts and feelings allowing for both close and distanced examination. It also offers the writer the opportunity to dwell in creative process and to touch all its emotions. Within this creative process – this open space – lies the opportunity to observe, to grieve, to reconsider events, and to come to terms with the narrative poured out onto the page.

For all these reasons, the use of poetry as expression offers therapeutic opportunity for nurses for a host of reasons. Nurses writing poetry affords opportunity for specific structure and an exactitude of language that extends personal and emotional control. Likewise, its openness empowers the bridging of emotional with the potential for empathic sharing by nurses across the clinical spectrum. The writing of poetry allows the nurse/poet the gift of finding language and meaning within their own words – to tell their own clinical stories.

Over five decades of poetry therapy have demonstrated the place for poetry written by others to have a place and be of use to clinicians in the treatment of patients and others (Leedy; Baikie; Rosenthal). However, writing poetry as a component of Pennebaker's expressive writing paradigm moves the writing of poetry into a healing practice. Self-authorship and the sharing of story and experience moves the therapeutic use of poetry far beyond the goal of seeking comfort or answers in another's poetic work. Rather, nurses using Pennebaker's paradigm offers self-care value when offers as a tool in alignment with the lens of Watson's caring science. Moreover, poetry – created by nurses – empowers nurses and elevates their voices for the healing of themselves and other nurses by offering a shared experience and creating therapeutic voice (Clancy 468).

In *Write a Poem, Save Your Life*, Heller describes poetry's transforming work as the ability to, "start out feeling hurt or angry, lost or confused, and as we write, we find ourselves on a journey. In naming and describing our feelings, especially the overwhelming ones, we write our way out of the chaos and into clarity" (Heller 13). Giving voice to feelings, the poem offers both language and space for healing. As the poet works, the narrative is reclaimed.

Gillie Bolton's article, "Every Poem Breaks a Silence that had to be Overcome," also explains, "The process of writing required of a poet takes the writer into hitherto unexpressed and unexplored areas of experience, in a way only very skilled psychotherapy/analyze or other art therapies can" (119). Poetry writing, Bolton reaffirms, uses word images to explicate and convey complex emotional and mental happenings and allows for healing processes to occur (128). The writing of poetry offers healing opportunities to the nurse/poet by offering engagement with those human experiences.

In “Poetry’s Company: When Medicine Leaves Us Alone,” Dr. Jed Meyers speaks of poetry’s use as the facilitator of caring moments experienced between caregivers, but also between nurses and patients, “It’s there where medicine leaves off. Poetry provides companionship in the presence of such losses, such that our sense of belonging in the human fold might be restored, sustained, even enhanced, as we endure our losses” (1744). Much like Watson’s theories on caring and the sacred connection between nurse and patient, he underscores the use of poetry as a therapeutic tool for the connection between both as a means to illuminate self-knowledge, human suffering, and human mortality.

“What is the meaning of a poem?” Dr. Lois Leveen asks healthcare workers. Her answer returns again to the effect of science and the mechanization of medicine, calling again for the work of poetry to offer balance for gifts of caring art and emotional transparency. She writes:

> As much of what physicians do becomes, ‘mechanized work, often menial, squeezed of human emotions, meaningful moments, and personal conversation,’ it behooves us to understand how discussing a poem facilitates emotional openness and meaning making through personal conversation, (1).

The concision of poetry can bring life and healing to the most dire and inexplicable of circumstances. In “Finding the Words to Say It: The Healing Power of Poetry,” Robert Carroll writes of the power of poetry to speak the unspeakable in medicine, “In mainstream culture, there are subjects we do not talk about. They are taboo. For example, even though each of us is going to die, we don’t talk about it. Instead, we avoid it. Even physicians are reluctant to talk with the terminally ill” (162). Within the space in which we live, within its strange twists and traumatic turns, poetry offers to both medicine and nursing the ability to concisely break down

walls and to open up the conversations. This poetry can find its place between nurses, between nurse and patient, and also, between the nurse and her own thoughts.

Poetry offers benefit to nurses for its brevity. In my own experience, walking away from a clinical situation, I have grabbed a blank Progress Note and began to write – tucking my work into my scrub pocket for later reflection. But, unlike many other expressive therapies, a poem's short lines can be transcribed on anything. For this thesis, my last poem, "For W.H.B." woke me up in the night. Reaching for my iPhone, I transcribed its majority into the NOTES application.

Poetry permits the nurse to explore their own experience and own the words within a specific therapeutic space. Then, should the nurse choose to share their poems with other nurses or another audience, the poetry is further empowered and creates a collective voice in its sharing. The poet's work, in fact, becomes an act of courageous sharing. This act gives both the nurse/poet and their reader/listener opportunity to see lives and experiences in a completely new way. To revisit those experiences at a distance. To touch the moments as a thing of completion and beauty.

Empowering the nurse to write poems and engage in storytelling about authentic experiences has the potential to elevate nursing voices in research. In "Exploring an autoethnographic stance with poetry in children's nursing." Marie Clancy writes, "It has been said that poetry is one of the few media in academic research that can be trusted to represent honesty and authentic truth" (466). Thus, empowering nurses, autoethnographically, to write poetry as their truths provides an outlet for empowered voice to therapeutic sharing for better mental health and stronger nursing identity. In "Poetry as a way to express emotions in mental

health," Jose Marques Carvalho et al writes, "Poetic depiction of problems and complex thoughts is an innovative approach that facilitates introspective thinking and the building of self-identity" (139). Finally, poetry is capable of employing tools like intuition and emotional sensitivity to give support and power to the portrayal of human experiences.

With the potential of elevating nursing stories with poetic language, Clancy advocates for nursing to give poetry space inside nursing research. As a means to confront the power of scientific language in nursing research, she behooves nurses to include autoethnography and the writing of poetry as a means to broaden the ideas of nursing through writing, "The use of poetry in research has been seen as a powerful, evocative, and meaningful communication of data (467). She furthers advocates that poetry as research offers the opportunity to see nursing through a new lens. Allowing a nursing reader/audience to experience and perceive data in an alternative way. Thus, offering and creating a space whereby both nurse/poet and reader can engage with the written words in a broader, more humane, empathetic experience.

All these types of poetic engagement offer possibilities and potentials for nursing to experience healing and empathy. Clancy writes, "the emotive aspects when reading poetry helps the reader to engage with them empathetically and allows for the development of their own relationship by locating themselves inside the poem" (467). As the nurse/poet pulls the reader into the poem, the poem is empowered to offer personal identification with expressive storytelling in such a way to offer shared experience.

The reading of a poem, shared in safe spaces and communities opens the door wide to a sense of restoration as community identification occurs. Poems read aloud give witness to the

poet's experiences, their traumas, and their emotions. Within this space of responsive listening, caring communities – writing communities, planned poetic communities, or communities with shared experiences - allow each hearing witness to recall and verbally repeat powerful passages, lines, or words, spoken out to affirm to the poet. The poet understands that they have been heard. Moreover, as pieces of the poem are recalled and repeated to the poet, the poet experiences the affirmation that they have been understood. The poet understands that their experiences – placed inside language - have been accepted.

A written poem also includes further therapeutic opportunity. Not only the focus of word but even the words' therapeutic positioning on the page is considered important. This process includes the poem's line numbers, its punctuation, and its white spaces. As well, the creative process can take on a more tactile aspect – cutting out word shapes, using color, different fonts, or even creating text pictures: all aspects become therapeutic representations of the poet's thoughts and emotions embodied inside the poem. Each process engages the poet in a therapeutic and thoughtful mind work of revised narrative that opens the poet to the potential for revisiting emotions. Finally, the completion of this kind of work – the poem - can provide a sense of peace and personal wholeness. The poem empowers the poet with a sense of letting go and an acceptance about the past. Susan Wooldridge describes:

> Writing helps me connect with myself, name the feelings that threaten to consume me, pour myself into the deep and meticulous work of crafting a poem or song, and turn my pain into something meaningful. Poetry is a lifeline. Writing is the medicine that cleans out the wound and heals the hurt (Heller 6).

These healers, "share a common goal in their efforts to maintain light and order against the chaos of darkness and disease, and to create or restore the beauty and harmony of health; in

this quest, medicine serves the body, poetry the spirit" (Hudson Jones 275). Thus, within the writing of the poem, psychological and emotional balance can be restored. This letting go or acceptance does several things. Its experience equips the poet with tools and practice to call on for repeated therapeutic opportunity. As well, its experience offers the reopening of personal spaces previously occupied by unresolved experiences, pain, and traumas. "Working on a poem becomes a reason to live, something bigger than me, a way to channel my overwhelming feelings and make something tangible, make beauty from suffering" (Heller 2). Its experiences and its work results in the experience transformed into a thing of personal beauty.

CHAPTER FIVE: A CALL TO WITNESS

Writing in My Own Voice

In the spring of 2021, as COVID quarantine began to feel like a state of mind, I was invited to participate in an online writing Facebook group called Let's Write! At the same time, I had reached out to John Fox's Institute for Poetic Medicine (IPM). Speaking with and emailing representatives of his work, as well as engaging his beautifully expressive poetry partners, I signed up for several of their poetry workshops: Immigrant Youth Voices with Merna Hecht, Readings on Grieving and Loss with Mike Bernhardt, and finally, IPM's foundational work, Poetry as a Tool for Wellness with Kristin Thomas, and Athena McClendon. I smile at these remembrances, because John, while repeatedly offering his support (even sending me articles), continually offered support and encouragement, giving me the word, "Synchronicity." This word energized my work and offered a spiritual sense to our acquaintance and its occurrences. Offering the idea that things happen for reasons unknown in the moment; we have only to be mindful, to listen, and be ready.

At that time, if you had you asked me about expressive writing as healing or, better yet, poetry as healing, I would have offered you a clinical explanation based on my scientific research and my love of words. I might even have explained, at random moments of my life, that I had written poetry to express those experiences. And I could have told you about my lifelong need to put words on paper. But, even as a regular writer about personal experiences, with all honesty, I had no clue what was about to happen in my life.

Kalanithi writes, "I was searching for a vocabulary with which to make sense of death, to find a way to begin defining myself and inching forward again" (148). His words speak to me about my own attempts to understand my experiences in critical care. His words speak to me about transparency and the truths I uncovered as I created the poems. Moreover, they speak to me about grief's journey and the physical expressions of grief that dropped in for visits as I remembered and worked to create these poems. Kalanithi's words speak to me about my surprise at how incensed I often felt my silences, and, finally, his words speak to me about the overwhelming sense of peace that I felt as I finished each telling work of witness.

Poetry writing, for me, has always been the way I made sense of my experiences. For as long as I can remember, I have been inspired to write about the extraordinary happenings in my life and my world. Sad things. Hurt things. Lost things. Traumatic things. Experiences, when they occurred, that felt so dramatically out of place that words had to make a space for them. My writing was never the discipline of details; rather it was the surgical work of culling words on the page to make them speak to exactly how I was feeling.

Even before my career in nursing began, I kept voluminous steno-pads locked away inside a make-shift wooden box made by my father. Tucking those words away for the gift of returning to them when I needed them. As best I know, no one else in my family writes this way; thus, I cannot lay claim to having a parent or friend as a writer mentor or someone who encouraged my writing's growth.

Once, as an undergraduate at the University of Wyoming, I nervously submitted a response poem to a text I had read for an Honors Class in Political Theatre. The text's misogyny had made me angry – thus, a rapid-fire poem about the power of women to give life – something that men cannot physically do. My professor, Dr. Peter Parolin, was a perfect audience, a safe space. During Dr. McDowell's class on documentary poetry, I submitted poetry weekly about my readings. None of these experiences, however, work comes close to what happened when I was fulfilling my weekly expectations within my writing communities.

My writing work with both Let's Write! and IPM caught me completely off guard. Writing for both groups, my responsibility was to respond to the weekly prompts offered. With Let's Write! I initially had fun writing short stories. But, over the course of five weeks, suddenly poetry about my experiences in ICU began to erupt and then did not stop. Reflecting now, this experience is very much aligned with trauma theory and the way that memories are fragmented and recalled. Taking the group's prompt, I would let it settle in my mind, and then, listen for my mind's response.

I owe a heartfelt depth of gratitude to Virginia Watts, the Let's Write! creator and director, and the lovely women writers of this group. They formed a longsuffering group in the

listening of my memories. Despite the trauma expressed, they read my poems and then, allowed me to read them aloud during our Zoom time together (the group is based in California). While they were positive and encouraging as I read my poems of my traumas, I knew my work was not for the faint of heart. They never backed down though or relented to take a breath; I could watch the expressions on their faces via Zoom.

The experience of a prompted regular writing practice resulted in these poems. Opening up a thawing space to memories seeking their own words within these communities both enabled and empowered me to I lay claim to their experience. Prior to this experience, I could have expressed that poetry is healing. But I question myself every day after these experiences, did I really know poetry as healing? I absolutely did not. This poetry came from memories inspired in random (synchronicity!) prompts with one week to write it and to share.

My experiences with IPM taught me something completely different. IPM taught me how to appreciate a supportive poetry community. They also taught me how to support someone's poem and to carry that poem's embodiment as if we were all physically seated in a circle holding each other in care. They also reinforced to me that concept of the sacred and to hold up my poetry as such.

I offer a unique perspective to this work. I have a depth of nursing experience coupled with a love of words that runs, probably, deeper. Much of my creative writing efforts at Belmont University have, in fact, found their source in the traumas I experienced caring for patients in intensive care in my formative nursing years. Moreover, many of these poems are inspired by literal events and experiences that happened to me in ICU. It makes sense to me

that I would join the two richest experiences of my life and offer poetry up through my lens of medicine and healing.

To you, the reader, I offer a trigger warning. Many of my poems speak to the traumas of my experiences as a young idealistic ICU nurse with a huge heart and the belief that each patient deserved the best that I could be. While my poem, “Burnout” records a humorous way that we, as nurses, dealt with our stress, my other poems offer graphically painful images while my words are capable of inciting strong emotions.

POEM 1: SUPERHUMAN

So I begin with a poem that essentially breaks down what I just shared above. It is possible that most ICU nurses suffer with PTSD and other symptoms because others believe we are so much more than we really are. So many times, we hold life in our hands. Later, I will share my poem, “Out from Under,” that speaks of this struggle between the power of control within ICU and the power of faith to believe for healing.

But, to start, I will share some ICU humor: do you know that the heart monitor alarm that triggers when a heart slows down, develops a life-threatening rhythm, or stops sounds exactly like the sound of the alarm on the French fry fryer at McDonald’s fast food restaurant? You, my reader, would laugh if you knew how many times, upon hearing the fryer’s high-pitched alert, that ICU nurses experience an adrenaline rush just waiting in line for the pleasure of obtaining a Big Mac. I hope this story conveys what I hoped to share within this poem.

Trigger Warning: moral issues; nursing alcohol and drug use; patient trauma

I've never met anyone
not wide-eyed with admiration
with what
I do. You speak
of critical care
nurses like we are

cape-wearing Mother-Teresa champion superhuman feats of good.

Herein, though, lies a portion of our dilemma,
as we are human. Fragile, just
like you. Broken inside our own
hidden spaces. We stayed
in bed for days when
the cancer-ridden mother for three died,

leaving a generational vacancy filled with grief behind.

I know of a nurse
who tried to deliver
a baby while shit-faced drunk. Reported and
suspended from practice for a while,
has stayed in AA, and remains profoundly grateful

to this day that she never killed anyone.

We once had a nurse join our
unit. Nightshift. Bright. Fast.
Talented. Supernurse. We called him,
Doogie Houser after the lead in a popular medical TV show.
I was primary nurse for a patient with a surgical error
in devastated pain. 5mg Valium. 5mg Morphine,

given via IV on the hour and half-hour; yet I stayed confused over

how my patient wept in pain in the morning.
I hurt. I hurt. Please. Believe me, I hurt, he told me.
I'm so sorry, I said. Your narcotics are already
too strong, we cannot increase them.
I can try to reposition you, to

increase your comfort.

A profound unsuspected medical mystery until the shift Doogie disappeared.

Searching the unit, we found our bathroom door locked tight.
Security was called and our Doogie Houser
Supernurse was found seated
and passed out on the toilet.
A #20-gauge needled syringe still
inserted into his cephalic vein.

Doogie, removed from our unit to the ER, where no drug screen

was done; he was sent on his way.
Not to excuse any of this, I tell you, but
to show you how these cape-wearing Mother-Teresa superhuman
feats of good, we suffer just like you. How can we cope, you ask?
about the broken tragedies we see, carrying all that we
are called to do and the magnitude of what we represent.

I do not have the answers. Though, if I tell you, maybe you will hear me.

POEM 2: My Calling: Empathy

I am a nurse born of a line of Appalachia healers. My people are Scotch-Irish Appalachian settlers and Scandinavian and French fur-trappers who navigated the waters of the Mississippi long before the Revolutionary War. These Scotch-Irish people – the McConnells and the Kilgores – were my mother's people and settled the Appalachia region, because it reminded them of their Highland homes. This poem tells you much about my upbringing. Neither of my parents attended college. Moreover, I am not sure how much education my mother ever received; typical of the mountains, she was married off at an early age.

Both my parents escaped the Appalachian region as young adults when my father joined the military. My mother enjoyed travel and left much of her children's upbringing to

the children themselves. During my senior year of high school, I moved away from home; we were stationed in Biloxi, Mississippi, and the racial environment was something I had never learned. I moved away to live with my only remaining living grandmother, Mabel Cornett; she had been a bride at fifteen and the mother of thirteen children – one of them, my father. I never recall being homesick – rather, I thought life was just supposed to be this way.

The summer before I left Mississippi for my senior year, at the request of a friend, I made the decision and signed up to volunteer as a candy-striper at our Keesler Air Force Base Medical Center. I had to walk through the airmen-student area to get to the hospital. Inside the medical center, I was assigned to both their Pediatric clinic and their Pediatric floor. Everyone in that hospital setting was gracious and helpful to me.

When the summer was finished, I knew I wanted to be a nurse. Ultimately, moving away to live with my grandmother, I would do my own college search and fill out my own applications. As mentioned in my introduction, as the nursing school representative asked me if I wanted to be a bedside nurse or a nursing administrator, I made my choice. Looking back to that night. I chose, unequivocally, to be a bedside nurse, and I never looked back.

When I told my mountain
momma that I wanted
to become a nurse; she
told me there
were much easier

ways to make money.

But then when I think
about it, she
also told me if
she had to give up

her children, she would give

us all away and keep my sister.

At sixteen, a friend convinced
me to become
a Red Cross Candy Striper,
our military medical center
two-and-a-half miles away.

So, in a red-and-white striped pinafore,

never knowing the option
of asking for a ride, I walked
in that blazing Mississippi
sun of a summer, across the base
and back again, volunteering

at the center's pediatric clinic and wing.

In that heat, I learned a nurses' speed,
loosening my hips
and stretching my gait to keep a
distance from airmen calling
out, but also, using that gait to rush back

to my clinic after dropping off lab specimens.

That summer, I did strep tests,
and held babies during sweat tests
diagnosing cystic fibrosis; learned
about itchy pin-wormed bottoms
growing in heated southern soil, and

watched ill children transformed by nurses' touch.

I asked my mountain momma,
how I would know what I was supposed to
do with my life; she told me
that I would know what to do
when I found it.

So, I did.

I moved away from home to
my Virginia grandmother's house in
my senior year.
Checking out nursing schools
all alone on college nights,

filling out my own applications.
After I left home, my mountain momma
told me the Red Cross called one day
telling me I had won a Candy Striper award. My
volunteer hours exceeding those
of the entire summer program.

Too much time had passed. I never picked it up.

POEM 3: My Name: For Ruby

My Mamaw – Ruby Kilgore Addington – was an Appalachian healer, and I write of her in my poem, "My Name." She was born in that region and was birthed without ever seeing her mother alive; she had died of a postpartum hemorrhage. Folk medicine dictates that this type of trauma gifted my Mamaw with healing abilities. She was a tiny woman who wore a child-sized shoe. She worked in her near-football-sized garden from dawn to dusk. She stoked a fire in the stove to warm her small house and hand beat any cake I ever saw her make. She used peculiar terms like "counterpane" (bedspread) and "davenport" (couch) – words that spoke of the proximity of her Scotch-Irish roots. Her healing inclination was the ability to cure babies of thrush – an overgrowth of oral yeast causing baby's tongues to turn patchy white. Thrush is painful and makes feeding difficult. Parents from all around her area would walk to bring their infants to see my Mamaw. She is the healer inside my poem, "My Name." As the parent held their infant, my Mamaw would breathe into their mouths. This cure took three days, so they brought the baby back each day.

I.
My name is
rooted
deep in the hills of Appalachia,
Wise County
Virginia
Dante
Kentucky,
seeded in the poverty
of mule and pick, broken backs,
of toiling.

My name is
alleged
to a Scot's Irish heritage with Cherokee
shadows,
penal shame, of inclinations
to ignorance,
illiteracy, clans
and hollers,
mountain music, changing loyalties,
of generational mysteries.

My name is
washed
pure clean by gritty Lava soap,
forced into blackened
skin creases alongside
a caged singing canary
in the mine, alive
amidst its
sooty inhaled blackness,
of coal dust.

My name is
held,
firmly among forest hardwoods,
by women
with small feet, who
scrubbed on their knees
for others, and
whose dirt-stained hands
fed their children

of rhubarb and blackberries.

II.
My name is
inscribed
among folklore
healers, wart-cures,
endowed women
who never
saw their mothers, of
babies with bleeding
geographic cottage-cheesy tongues,
of pained inability to suckle.

My name is
supplicant
for their healing, as
mountain mothers
walked along ridges for miles,
bringing their babies
to my Mamaw's door,
her, the cure for their crying,
of their cracked and hungry mouths.

My name is
transcribed
in DNA by my Mamaw's healer ways,
how she tenderly held those
screaming baby
mouths,
and blew her breath
for three straight days,
upon those painful infant tongues,
of healing and restoration.

POEM 4: The Cap I Forever Wear

Nursing caps have their origin in Florence Nightingale's religious foundations within the Anglican church. No longer worn, our caps were earned in the first year of our training.

Each cap was unique to its particular school of nursing. Thus, it was possible to go to a new hospital and discover fellow nurses by the caps they wore.

My unique memory is creating my cap. The cap, unstarched, was a simple piece of cotton fabric. In my case, a semi-circle with a wide cloth band sewn onto the straight side. In nursing school, evenings would find me on my knees at the end of my metal dormitory bed. Stay-Flo starch was purchased by the gallon; the simple cloth soaked into the blue-opaque liquid until dripping down my elbows, as I pressed the starch-soaked flimsy cotton fabric of my nurse's cap, pressing it onto the metal and smoothing out the air bubbles. In the morning, peeling the flat cotton sheet from the metal frame, I fashioned its stiffness into the nursing cap, which I then pinned onto my hair. This poem tries to encapsulate my nurse's cap, my nursing student life, the importance of vows, and how I have kept them.

The oath I stood to take
at
eighteen
asked
me to
practice my
profession

faithfully.

Me, in that moment,
hands wrapped around
a ceramic candle-lit lantern
promising to abstain
from the deleterious,
mischievous, and
never knowingly administer

any harmful drug.

Days before,
sitting cross-legged
on my dorm room floor,
young hands smoothing
and pushing blue air bubbles
from a small white
piece of cotton,

soaked in laundry starch.

My slippery hands
pressing the mere piece
onto the dorm bed's metal
frame to dry
as the blue starch dripped onto
my forearms and into
the floor.

Forming my first nurse's cap.

Once dry, my hands pulled
the starched board
from the frame as my
hands fashioned
the stiff and unyielding
piece into
its eight perfectly equal symbolic folds.

Love. Hope. Persistence.
Endurance. Patience.
Purity. Charity.
Loyalty.

Securing the cap
upon my head's crown,
my hands push its
small comb under
a square fold
of tissue held with
bobby-pins.

Have I carried this faith?

In devout remembrance,
as my old eyes dim
with tears
but smile, holding
the gracious
revelation,
understanding that

this eighteen-year-old

has practiced her life
faithfully
and upheld her
principles,
of that starched noble
form placed on her head.

The formative shape of an entire life.

POEM 5: Life

I was in my second year of training in obstetrical nursing when this event happened, and I have never forgotten it. This particular pathologist was the same doctor who performed the autopsies that nursing students were required to watch. I am sure he was less ghoulish than he made himself out to be, but he would appear to be respectful and to place a cloth over the face of our deceased patient.

After we had endured all the difficulties of observing the autopsy, at the very end, the pathologist would surprise us and yank the cloth off the patient's face. In that moment, humanity-joined-science and it all felt too real; many nursing students became faint or immediately left the theatre for air. Perhaps this story sheds a bit of light on my reaction when I was ordered to phone him.

Trigger Warning: pregnancy's labor; topics of death

Oh youth! Oh sheltered eyes that do not yet see.

A nursing student, I have been with a mother
laboring to give birth all day.
German-Baptist, it has taken us all, working
diligently to keep her head covering in place.
Me, documenting every laborious stage.
The execution of my exacting Labor Care Plan.

As she enters labor transition, her birth canal
begins to widen to the required 10cm.
And I painstakingly document the moment
when her body ceases possession of her mind,
and her body impulses explode
in an urge to push. I know this stage,

and furiously document its details,
that moment when all sense of reason appears
to have left the body. When suddenly,
women may threaten, blame, and often hit
their husbands. Promise abstinence
for the remainder of life. Or, like teens I have seen,

decide a literal exit door is the best choice.
Or, after all these working hours, simply decide to quit,
despite being so close to the end. “I can’t.”
“I’m tired.” “Don’t ask me again. I just can’t.”
All in blocking attempts to intervene against the power of
nature’s plan; I diligently document each and every moment.

On this day, though, my plan is abrupted.
“She’s in transition,” the Charge Nurse
confirms and points to me. “Call Forensic Medicine to notify
the pathologist now!” Never one to challenge an order,
I now defiantly stand my ground to implore, “What for? The pathologist?”
Then, I loudly blurt the obvious, “He performs autopsies!”

She looks at me, my youth and then, calmly gives me the order again.
I dutifully call and soon thereafter, see his deeply death-hallowed
face appear in the birthing’s viewing area. Making no sense,
at all, in confusion, I inquire again of the Charge Nurse.
“What’s he doing here?” My air of judgement, exuding.
She offers, quietly, “He asks to be called to come see all births.”

After all these years, I memorialize this moment. And know
that greater than my academic focus and my diligence to any finite end,
there exists somethings deeper in this world. Eye-opening moments of understanding.
How the most structured of plans can both break and surprise. How any life must be possessed of a balance. How new life cannot help but come, how grace must always
be extended in its call to give answers and to understand.

Oh youth, to understand.

POEM 6: Humanity's Memorial

After graduating from nursing school and deep contemplation, I chose the area of nursing that, so often, caused me the most anxiety and fear. Thus, as a graduate nurse awaiting my NCLEX-RN results, I began working in Neurological Intensive Care (Neuro-ICU) at Roanoke Memorial Hospital, the same hospital where I had trained. Our Neuro-ICU unit had eight beds and one isolation room. In the brief time I worked there, I saw traumatic accidents and gunshot wounds, mastered neurological assessment, and gave my first notification that a family member's patient was dying.

Of course, we never said, "dying" – rather, we always said, "Your family member has taken a turn for the worse." And, actually, I was not supposed to be the one delivering that message on that evening – the medical student accompanying me had been tasked to deliver the news. Walking down the hallway toward the waiting room, however, the pale and sweating medical student looked at me and said, "I've never done this before, and I don't think I can do this." Herein lies an important nursing secret: nurses save a doctor's bacon more times than any patient would ever want to know. Thus, I made the notification.

My poem, "Humanities' Memorial" is a remembrance to that Neuro-ICU. Its traumas were so tough, and I struggled to maintain humanity inside a system of assessment where it is so

easy to depersonalize based on what you are asked to perform. Neuro-ICU staff struggles with deep ethical issue such as flat-line EEGs and the legal definition of death. We combat the devastation of families who see their beautiful children on ventilators looking perfectly healthy, when only we know there is no real brain functioning inside - life would end save for the respiratory help of the ventilator.

Neuro-ICU provokes arguments about God and the ability of a spiritual entity to take or keep a body on Earth until that power decides it. We, the nurses, are the caregivers of patients and family. We stand in the gap of this discussion. We are the trusted ones ever present in these tragedies, as parents demand to keep their seemingly undamaged children alive/ventilated, while medicine advocates removing the ventilator to allow the patient to die.

In the thick of Neuro-ICU are nursing assessments performed with often-more-than-hourly frequency with the goal of arousing some type of response within the most deeply damaged brains. These assessments are not kind and more difficult to perform than I can explain here in detail.

These are nursing's moral injuries. In the beginning you are horrified by the things you must do; over time, however, you disengage your sense of what is humane and tell yourself that the most important things are the scientific facts of your assessment. An even deeper injury, though, is the truth of how you realize how easily you adjusted and no longer thought about it. If you are even remotely self-aware, you can hardly miss the personal injury of how you arrived at a point where these assessments stopped bothering your sense of the humane.

Kalanithi writes, "When there's no place for the scalpel, words are a surgeon's only tool" (87). This poem embodies my struggle. This poem is both my confession and my apology. My

hope is that it can also shine a light on how I tried. How even as a new graduate ICU nurse, I already battled against the critical care nurses' sense of depersonalization.

I confess, though, that this poem still grieves me. Grieves how young I was and grieves how I adjusted to do the things required of me – the things I had to do.

Trigger Warning: Graphic language references to the physical body; issues of death and dying; youth trauma; issues of parental grief and loss

No one prepares you
for the sacrifice of your humanity,
patient work inside NICU.
Not NICU like tiny
babies pushed onto earth too early
with frail thin fingers inside
an oxygenated rocket.

No, this is gritty.
Neurological ICU, just anything
but logical. Devastating. Robbing.
Traumatic brain and spine. Head smashed,
Gomers. Garden vegetables. Pupils fixed
and dilated. Without corneal reflex.
Brain death.

Neurological storms, when
brains' base no longer supports
Respiration. A chugging freight train.
Preeminent to absent cough reflex. And
burning bodies,
106 degrees on ice blankets
empowering ice packs to the arm pits and groin.

Measured with regularity, our
Glascow Coma Scale. Injury
classification. Spontaneous opening
of the eyes – rank of four points.
Inappropriate words, a whopping three points.
Motor response to deep pain – a mere two points, and
so, it goes.

Three points ready seeking of legal proof and the question
of organ retrieval.
Brain death. Nothing left.
No high-top tennis shoes
tied tight to the ankles
on the drunk teenager in the hopes
he might one day walk again.
No hand splints
to stop contractures of fingers
to squeeze, “I love you.”
Instead, the unit is silent but for the respirator,
taped above - a high school photo,
Lest you forget a youthful face when the
Breaking body begins to smell of sweat

And salmonella. Skin bruising from
deep sternal rubs to evoke
pain responses, the bucking of limbs.
Decorticate. Decerebrate.
To see if there is anything
left of the human ability
to respond. Of sequential flat lines on an EEG,
committing a legal definition of death.
Wailing parents. Screaming
a loss, like the
flashes of light into pupils,
eyes now so filled with blackness
that you cannot see
the sea of preexistent blue or green,
brown or hazel, centered now by
the broken storm,
a raging sea. Like the guilt you carry,

for things you had to do,
and how hard you tried
to hold sacred things.

Like the way you
cared, how you touched and soothed,
washed, spoke, and
combed, coaxing the memories you still carry,
clutching the things
that made you human,

to remain.

POEM 7: Out from Under

I had been in the Neuro-ICU for about six months when my husband and I moved to Charlotte, North Carolina. At Presbyterian Hospital, I could not work in ICU as a new graduate nurse for one year. Instead, I worked on their neurological step-down, surgical post-operative floor, and worked in their ambulatory surgery unit. I learned organizational skills that year. How to manage ten to fifteen patients many fresh post-operative patients. How the gastrointestinal system wakes up after anesthesia and how important respiratory care is when you are recovering from a surgery. How to do dressing changes and observe families deal with devastating cancer diagnoses. How the pain of hemorrhoid surgery can bring even the biggest and strongest man to his knees.

Even more important, I learned much about how, no matter how hard medicine works, the body still dies. And how that knowledge is no respecter of persons. And finally, most importantly, I learned that there is not enough prayer to get you out of a high-census/no-help backbreaking and risky nursing shift. Rather, your best advice to yourself is to take a big deep breath and keep moving.

One year later, my floor experience in tow, we moved again for my husband's education. He started Asbury Theological Seminary in Asbury, Kentucky. Stopping by the nursing office at Central Baptist Hospital in Lexington on our arrival into town, I was immediately hired and became the youngest nurse working in their only general Intensive Care unit (ICU). Inside that ICU we cared for everything from surgeries to traumas and received patients in crisis via

helicopter from all over the state. We had twelve beds – eight open ward beds and four beds in the back of the unit for isolation or situations when a patient would need a closed room.

So many of my poems come from this four-year experience. Working full-time, I learned to work fast and to orchestrate excellent care, but I also learned that a pint of chocolate milk grabbed in haste from the unit's small front fridge could quell the stress-induced burning in my stomach. Many nights I wished for roller skates. I reached out by phone to my husband many times; we had no cell phones then, but, in my youth, I perpetually believed that things would be better if I could just hear his voice.

At home, though, we often fought in a clash of values and ideas - his seminary schooling and my "boots on the ground" battle for the living and the dying in my intensive care. His answer to the embodied traumas of my patients was additional prayer for my patients, for myself, for my hospital and for my patient's families.

By this time in my life as a young ICU nurse, however, this simple answer was just not good enough. My husband would raise his voice and say, "God can heal!" I would shout back at him and say, "Death is the ultimate healing!" I saw people – still alive but suffering with every breath. I saw the young die while my elderly patients were not allowed the grace to die by families who fought hard to keep their family member alive.

I saw so much suffering. It made no sense. To me, something was very much skewed with this picture. And I knew in my heart that I could not "care" my way out of these moral dilemmas.

"I began to realize that coming in such close contact with my own mortality had changed both nothing and everything," Kalanithi writes (131). This poem reflects my own experience and my inner argument about these situations. About the traumatic work of facing these issues.

Ernie is a motorcycle accident victim whom I had cared for in the Neuro-ICU a year before. Severe neurological insults alter heart, temperature, and respiratory rates. Thus, an irregular pattern of breathing that will not adjust to the settings on the ventilator. The stress of his traumatic injuries left Ernie in a coma with a resulting inability for his blood to clot. His blood began to pour from every body orifice. He did not survive.

Trigger Warning: Graphic clinical experiences and language; youth trauma; issues of grief and loss; issues of faith and healing

Out from under
the belief that all illness
can and will be healed,
we are unexamined
nation with
unexamined rules.
An unexamined people who
choose suffering over freedom.

Out from under,
we argue long into the night -
death is the ultimate healing,
I scream.
My partner, the seminary student.
me, the critical care nurse,
as Ernie's blood
is dripping off the bedsheets

in my ICU because motorcycles
and pavement do not
mix. And now, Ernie's blood
will not clot. Me, on my knees,
placing white bedsheets
under his bed,

because I cannot keep up. White
makes it all look brighter.

Out from under
the decree that
a powerful god decides when the
body stops, and Ernie's ventilator is
bucking. We are at 100% now,
as his saline IV and three extras
RBC units are running
wide open with a Dopamine drip at 10μ.

Ernie wants to leave us.

His tired parents are trusting, and
making every visitation,
to hope and grieve.
Yes, we should pray for healing, my partner tells me.
Sometimes, out from under
the lies that we have been told,
we should pray for freedom

from suffering
from humanity
from pain
from gravity
from the affliction that mounts its charge

on this earth.

POEM 8: David

I worked in Central Baptist ICU for almost four years and faced everything from sexual harassment from a doctor to more trauma than I ever want to remember. In that unit, we practiced primary nursing. This meant that I was the appointed nurse for a selection of patients and coordinator for their care for the entire time they were in my unit.

Thus, I became close to my patients and their families. Research now shows that inexperienced and young nurses are at the highest risk for compassion fatigue (Kelley et al 439).

Moreover, primary nursing - being solely responsible to manage the care of specific patients for an extended period – increases the risk factors significantly for the stress-related nursing issues I will soon discuss (Peters 470).

And with that background, I would like to introduce you to David. "Words have a longevity I do not," Kalanithi reminds us (199). I was twenty-four when David rolled through the door of my ICU. He was eighteen and had participated in a shot-drinking game while skipping school on Senior Skip Day.

After drinking, David had no memory of getting his car and driving the back roads of Nicholasville, Kentucky, at a high rate of speed. The impact of his car accident caused the steering wheel to disengage and hit him square in the chest – breaking every single rib from his sternum. Without the supportive skeletal structure to breathe, his lungs had nothing upon which to base their physiological principles of air pressure and breathing.

David arrived in my unit on a ventilator and in Adult Respiratory Distress Syndrome. I was his primary nurse. From the first day until his last, David could not use his voice. He was either intubated or had a tracheostomy.

Instead, he wrote me. Pages and pages of notes about everything from girls at school to his accident, things he wished he could have done, and decisions he wished he had not made. As his primary nurse, he counted on me. He despised when I was off work. My other ICU nurses found him difficult; he would rattle his bed rails if they did not respond fast enough to his needs.

Of all the things I remember about David, two significant moments stand out for me. The first was an unbusy sunny weekend in my ICU when I offered him a wish. Just like David, he told me he wanted *two* wishes: the first, to get his hair washed and the second, to see the sun.

I remember feeling so caught off-guard. He had asked me for so little; he was eighteen and in the prime of his life's start. His small requests made me even more committed to making his wishes happen. Even now, his memory forces me to think about exactly what, in this life, is important. And what would we all do if we were young and relegated to a very public bed space and an inability to speak. What would you deem to be most important?

David's second significant thing for me came much later. He surprised me one day in the middle of our conversations. He wrote me to tell me that, if he ever got well enough to leave my unit, that he would never ever return. At first, I did not understand. But all too soon, I realized he was sending me a message. And he meant it. Yet, I still laughed and cast doubt on his message's meaning.

In my life, even after all these years, David still affects me. My children and husband know his name. You will soon meet him in my poem by his name. The way things happened for David – I was young – left me afraid his family would not want to see me at his funeral. So, other than sitting with him before the funeral home came to take his body, I never got to honor him with a formal good-bye.

Later, I remember searching the newspapers to see if I could find out where he had been buried in the hopes that I could visit him alone. I can still hear his mother's scream; she was such a nice lady. I live now with the wish that we…that I…could have done so much more. I have written about David in other classes during my time at Belmont, but it has taken poetry to give him a place of remembrance.

David's poem has become, as Philip Metres writes in *The Sound of Listening: Poetry as Refuge and Resistance,* "its own monument to this place, where no stone markers need to

commemorate…" (Metres 8). I cried over and over again as I sculpted this memorial to him. Working this poem as therapy was my first experience with creating a peaceful space for him to remain.

Please meet David. Imagine his tall willowy self with pale freckled skin and brown-black long curls. He has a tracheostomy tied by trach tape around his neck and thin fingers and hands from trauma-related weight loss. He is quick-witted, though, and extremely fast to write.

Trigger Warning: accident trauma; death and dying; ideas of suicide; grief and loss

You visit me.

I see you when my son drives his car.
In sunsets or
when I hear about the couple
who fell to their deaths taking a selfie
at Yosemite. Or imagine
the risks I take climbing

to the top
step of a ladder.

You visit me.

I see you, though forty-one earth cycles
have passed
since your teenage
body with its shattered rib cage,
impact of your steering wheel,
rolled into my intensive care unit.

Skipping school and drinking shots,
without any memory of the how or the why.

You visit me.

I see you and wish I had kept but
one of the hundreds of notes
you gave me. You, tracheotomy in place,

ventilated and unable to speak.
the two of us communicating like teenagers
with a desperate crush.

Pencil marks on notebook pages, pages, and pages
passed between your hospital bed rails.

You visit me.

I see you on your day of wishes,
my Saturday gift to you, your wish of a shampoo
and a wish to see the sun. Your first wish,
my hands rubbing your soapy head as handfuls of
your dark curls fell into my unit's
metal sink. I used my weight to hold you steady,

distracting you so you would not see, hiding your curls
with a towel. The curls I still cannot unsee.

You visit me.

I see you standing willowy tall, so pale,
by the brick wall of our hospital's sunroof,
your second wish to see the sun.
Your frail hand over mine, patting me gently
in stubborn refusal to leave when I got scared at your
weakness and wanted to take you back inside.

You visit me.

I see you at that brick wall, my seasoned warrior
of broken critical things with still-wet woven trach tape
under your curls. Your white-knuckled hands gripping brick,
as your face inhaled the sun,
letting go momentarily to lift those hands into the air
and to slowly sway. Your grateful dance.

Still pushing my hands away later, smiling weakly like a tired joke,
as you relented to get back in your wheelchair.

You visit me.

I see you, exhausted from that day of wishes,

but still. David. You wrote me that note. You know,
the one that still causes me to tear.
I would not listen that day, teased with you,
pretended I didn't understand.
You are telling me of how,

if you could ever successfully leave me,
escape my unit, you'd make sure you would never return.

You visit me.

I see you on that day you promised,
and I was unable to imagine. My choice
was your complete recovery.
You were so young. I was young, too.
And even when the day came,
I was not ready.

I am still not ready. As your nurse, your friend.
I did not want you to go. Please.

You visit me.

I feel me running into your step-down room, to
find you clenching your teeth, capturing my gaze,
as you fought off the critical response team,
me begging you, you never letting go of my eyes,
refusing their airway, fighting away oxygen,
staring at me, shaking your head to remind me of
your blasted secret and how you sincerely meant it.
Me, holding your promise. Me, begging you to try to stay.

You visit me.

I see your oxygen-blown body behind the curtain.
Your face, curls smoothed back,
half-inflated with subcutaneous air, your blackened eye,
by-product of the trauma and our compressions.
David, your Code Blue
lasted over an hour.

From the waiting room, I can still hear your mom's scream.
I still hear me retching, my wounded heart,

hands clutching the porcelain sink of the
bathroom where I ran, locked the door, and hid
to escape this present world. My fingers
digging into the porcelain as I stared
at my pale-pained face, felt my embattled heart,
my reflection in the bathroom mirror.

Moving slowly, willing my feet to move, I returned
to your death bed. To sit. To cry. To hold your hand.

You visit me.

And after all this time, David, I
keep you alive. I write you
into my story, this story of my life.
All about knowing you, and I keep telling
and telling and telling, believing
that, just maybe, my words make you live.

All the while, keeping your secret inside me, and
spending my life trying to embrace your choice.

POEM 9: THE CHAPLAINS

"The fact of death is unsettling. Yet there is no other way to live," (Kalanithi 132). I want to confide and tell you though, that we, the nurses of critical care, found our own ways to cope under the weight of all we did. And our chaplains helped us. When we could not find time to eat, Chaplains MacGregor and Bailey would throw open our ICU door and roll in a hospital dining cart filled with hot trays from the kitchen. When I rebuffed the suggestive advances of a neurosurgeon early in my time in the ICU and that surgeon made my life difficult by turning every patient-related encounter into nasty conflict, the chaplains got involved when I got the courage to confront the surgeon and he blew up at me in front of my peers. I think of them so often, and I consider the physical and emotional cost of the burden of care that they carried.

Two chaplains were
assigned to the staff
and beds inside my ICU.

Chaplain Bailey,
burley freckled man with
laughing brown eyes.

Chaplain MacGregor,
the slimmer with grey eyes,
a quieter caring soul.

God's representatives, intervening
When tired and angry doctors
grew abusive.

God's representatives, bringing us
food when we were hungry
with no time to eat.

Chaplain MacGregor, in
a velour shirt, long-sleeved,
worn day-or-night,

so that when stress was high
or terrible things
happened, he was there

offering his arm that we could
touch and be comforted, into
the thick softness of his fabric. Sadly, these men died early.
Chaplain Bailey, a quick blood clot.
Chaplain MacGregor,

of a bad cancer. The continually shut
door of his hospital room carried a
sign, NO VISITORS ALLOWED.

POEM 10: The Hope

We lost two children in two different seasons during my time in Central Baptist ICU.

Both elementary-aged boys. The first one does not have a poem yet; but always, at this time of

year, as I write, I think of him. He was an elementary school student living in the most rural portion of Kentucky. He was trick-or-treating with friends when he stumbled and hit his head on a car bumper. Going home, enjoying his candy, he complained of a slight headache. He must have fallen asleep early, because when his parents went to awaken him – he was unresponsive.

By the time he was life-flighted to us, his pupils were fixed, dilated, and non-reactive to light; he was only breathing with the support of the ventilator. Unable to do anything for him but supportive care, we moved him to a room in the back of our ICU. That way, his parents and family could be with him until the medical decision could be made to disconnect his ventilator and to allow him to die.

Our second boy died in the spring. Playing kick ball with his friends, he ran out into the road from behind a series of parked cars. The driver never saw him. So silent and so small, it was only through female family members speaking broken English that we discovered this young boy was the only male survivor inside a family decimated by the Khmer Rouge – The Killing Fields.

Living through all the trauma of refugee camps, he was their one hope in their new country. He had straight thick black hair and the palest skin. He had a few scratches and a bump you could feel on his head. My strongest memory when I wrote this poem was how this boy's mother held my arm and over and over, cried out to me, "Please…please…save my boy." The sense of hopeless, I knew there was absolutely nothing we could do.

Trigger Warning: child trauma, parental grief, and loss

Nine-year-old Cambodian boy,
so tiny.
so quiet.
so, the size of distant traumas.

I lift your bed sheets
to search, my full assessment,
to find your brain, tragically sleeping.
to see your body's superficial wounds.

Superficial wounds, created running
into the car that never saw you.
into the street, chasing your ball
in play.

Deeply broken boy, twice.
the boy of promise.
the boy lone survivor of Khmer Rouge.
the boy sole future hope of family destiny.

Nine-year-old Cambodian boy,
now tragically sleeping, superficial wounds.
now leaving this country.
now dreaming of devas.

Nine-year-old Cambodian boy,
your momma needs you.
your momma weeps to me.
your momma begs me to salvage this beautiful promise.

All I am able, though,
is cleaning and placing
band aids upon your broken skin.
So, I do.

POEM 11: In Mente/In the Mind

One of my favorite times of year to work in ICU was Christmas. We decorated an artificial tree with lights and imaginary foil packages underneath. We hung fake (flame-retardant) foliage and decorated our large bed-sized door like a gigantic package. These decorations were for our patients – much like the televisions were rolled into strategic spaces within ICU for the purpose of playing the Kentucky Derby in the spring.

This poem is a Christmas memory about domestic violence. So often, your powers to control your environment inside ICU gives you a false sense of power to confront what is real. Split into two separate experiences, these experiences occurred in the exact same space and time. My young patient left our ICU to return to her abusive partner. My beautiful coworker and friend did not survive.

Trigger Warning: issues surrounding domestic violence; graphic images of abuse; issues of grief and loss

I

I remember twinkling unit Christmas lights,
and the rusty deep gouges down your back,
your buttocks, from the black iron poker
that pierced your flesh so deep and so hard,

to impact your kidneys causing them to begin to fail.

How your disempowered and plain human essence
created a mere shadow in my ICU Bed One,
the bed closest to those glittering tree lights.
The pale childlike-ness of your passive voice,

and how your mother cried as she watched you sleeping.

I remember how peaceful that tree looked
in the quiet of our holiday evening shifts, and how
your abuser sent hosts of stuffed animals.
Pastel animals plied to any emissary walking through the ICU entrance,

because we refused him access, your uncharged perpetrator.

I remember how you smiled at those soft animals; these, his supplication
for how he beat you. Beating, then leaving you alone.
Beating, then leaving you alone again.
Finally returning to use that black iron poker

to angrily prod your incapacitated self, “Get the fuck up, get up you hear me,”
as you lay defeated, the wounded animal,

face-down on a flight of stairs.
And I remember my own trauma at your whispered words,
as we nurses willed to empower you to press charges and leave him.

“He’s been under a lot of stress lately. See, we have two Jeep payments.”
So, you didn’t.

II

Mostly, though, I remember Barbara.
Your smart nursing skills and perfect heart-shaped face.
Your kind brown eyes and that mountainous auburn hair, three times more
than anyone needed, piled high upon your head.

I remember how I teased you and often called you, “Barbie.”

You were our strongest. Always quick to make a joke.
Smiling, a helpful team player perpetually wearing long-sleeved knit shirts
under your scrub top, always complaining our intensive care unit left you chilled. You made our nursing shifts run smoothly to get our care done.

I remember, for all those years, how we all

shared the exact same space, hours of closeness, as we shoulder-to-shoulder shared our end-of-shift reports. How you would be there, yet again, wearing your dark sunglasses with some funny children’s tale. “Corneal scratches. Light sensitive,” you’d shake your head and laugh.
Rambunctious children.

I remember the morning we all learned you had been killed in the night.

How your partner had beaten you until your beautiful body lay still,
and then, how he dragged your brokenness by that boundless auburn hair
into your family’s driveway with your children watching.
How he revved the truck engine to drive over your precious body again and again.

How can I live with this memory? How can I be justified?

How can we all consider the facts of what we saw
and never spoke? How not one of us, your meticulously
medically observant friends, ever questioned. Sat in blindness
at the bright warning lights before us, never offering claim to see.

How not one of us suspected or even ever inquired

to the reasons why. As we, now, attempt to forget our inaction
or the power we never claimed to own.

POEM 12: Burn Out

Thinking back upon my years there, when I consider all the professed backbiting that goes on in workplaces, we experienced extraordinarily little. We had no time for it. We needed each other. There is no way we could have gotten the job done without each other. We were proud of the care we provided. Humor did not happen often, but this poem, “Burn Out,” is about one of those moments.

This poem happened on a weekend of a particularly tough week of care. We had no patients in the last two rooms. Back there, we had a small table with chairs. A meeting place. Our scrub clothes were provided by the hospital and sat on metal shelves in our changing area. Completely spontaneous, this happened. The utter depth of its sacrilege still makes me smile.

Crispy critters,
too charred with empathy
to give another step. So, we
resort to gathering

into a burned-out
nursing collective
in the very
back of our unit.

With bandage scissors
in hand, we proceed
to wrestle
and laugh

wrestle

and
suddenly we begin
to

cut, cut, cut
cut, cut, cut
cut, cut, cut
cut, cut, cut

until our hospital
scrubs are in

ribbons and tatters.
With more flesh showing
than not, exhaustively laughing
and emotionally spent.

Then, we get up, dig new
hospital scrubs from
the shelf, hide our tatters
in the trash and get back
into the fight.

POEM 13: My Full Disclosure

Thinking about secondary trauma and compassion fatigue, my poem, "My Full Disclosure," tries to put into words the traumas surrounding nurses that I have previously addressed. Before the poem, however, I need to offer a bit of introduction. I would like to share something few people know about me. Are you ready?

Even after forty-plus years, I still carry fingernail scars on my inner forearms put there by a sexual predator. Over time, of course, the scars are now white, but I know they are there. And no, he never attacked me. I mean, I guess I can say he did not. Not technically, I mean. I was only his intensive care nurse.

This predator ended up in my unit (Bed 3) with a basilar skull fracture – sustained when his kidnapped female victim fought for her life inside his van and kicked him hard in the chest in an attempt to avert her rape. Her kick's force was strong enough to send him flying backwards toward the back of the van and, as his body weight forced the van doors open, onto the pavement of Kentucky's I-65 – back first – as the van traveled the interstate at 80 miles

Over and over, as I remember this event, I have played back the traumas in my head. I could not have been his victim. Could I? I am not sure. I mean, I lived; but so did she. And, even after all this time, I can describe him. He was white with a freckled ruddiness that comes from the Kentucky farmland. Medium-build and robust. He was in his thirties with a kind-of-curly red-brown facial hair.

And he had been drinking. Something cheap. The kind of bad alcohol that my college students drank too hard and ended up vomiting with toxicity in my unit. I could smell it on his breath every time I had to engage him for assessment.

My difficulties were made worse by his specific injury. The blunt force of his skull hitting the pavement broke the resting platform for his brain. This kind of trauma carries a specific set of behavioral responses. Combativeness. Rage. Near superhuman strength. Incoherence. Acting like a caged animal grabbing at anyone near his bed because his doctor ordered, for his safety, the placement of thick leather restraints. My patient fought so hard and with such strength he could move his ICU bed. And, if his hands could reach me, he grabbed me

so hard, digging his nails into my wrists and forearms that I struggled to get free every time I had to do his hourly neurological assessment.

I need to tell you the toughest part. It is how I could not do anything to protect or defend myself. This is defined as a moral injury. He was a rapist. And no matter what he had done to her or was doing to me, I had to keep caring for him. Showing him compassion. No matter how many bleeding scratches and bruises he gave me, I offered him the same care I gave to my sweet little surgical patient in Bed 1. As I dodged his attempts to kick and put Band-Aids on my wounds. I am an intensive care nurse, right? But I still remember him. And I still carry his scars.

You will meet this guy in "My Full Disclosure." You will also see how I wrestled with the moral injuries I suffered. To answer for silences, I held. To explain, to know the things I know and have experienced, it is important you know what you are asking.

This poem is my personal attempt to begin to wrestle with my intensive care experiences as I imagined someone looking inside me. This poem comes out of that work. I remember him. And I still carry his scars.

Trigger Warning: graphic physical images; violence; drunk driver; adult trauma; infant trauma; rape; failed suicide; burn victims; moral injury

Nurses are taught
to observe closely
and to document
meticulously.

A sacred skill of competence.

I hold now that a space of
disclosure must exist,
between my intensity
of observation

and my pen's willingness to transcribe.

Or else, how can I explain
the gaping fleshed wound of a shotgun
to the face. Teeth on the pillow.
Failed suicide.

Or a predator's skull hitting highway asphalt by a victim's kicking feet.

Explain my hands sunk inches deep
into the gelatinous soggy softness of a burned skull,
blinding opaque-blue corneas. How I prayed that shift
to be spared nightmares; how the wooden fingers snapped,

torched by the matches' lighting of the kerosene heater.

You must understand if I write the risks to know
what I saw. About the sorrow, my anger, the invasive
and violated shame of the damaged. My recognition of
loss and destroyed dreams. How in the end,

men cried out in pain for their mommies.

And how the brain-damaged baby screamed
in the crib beside the superficial scratches on the drunken driver.
"Can't you shut that fucking baby up?"
And you found out I never answered a
solitary word to the accountable.

POEM 14: Nursing Shift

As my world of traumatic memories opened while participating in my online writing groups, I worked diligently on the personal work and word prompts that were offered. Over the week, I would unearth a poem based on my nursing experience and offer that poem into the

Facebook file or email drobox for reading. Then, when we met, we would take turns sharing and reading aloud.

Weekly, as I opened my memories inside my writing groups, I watched their faces as I shared. While I cannot say enough about their support and the affirmation that they offered for my work, it would be negligent to believe they were untouched.

As I reflected on their faces, I questioned myself. “Why are my poems so filled with such graphic dark memories?” My answers lie in trauma theory and how traumatic experiences are not processed inside the brain in the same manner as healthy experiences. Moreover, my answer speaks to the nurses’ struggle with clinical objectivity and personal nursing experience. These contrasts remain impressed on my brain.

Most of the poems written here struggle with the idea of nursing practice objectively distanced, yet so graphically and emotionally close as to make these contrasts so significant that the experiences remained imprinted in my brain. This poem is my own answer to the “Why” in my poetry’s disclosures.

Trigger: grief and loss

This worded work I lay before you,
solemnly taking your questions while listening
to defend. You must understand, in fact,
that throngs of my patients lived and thrived.

Coughed when they were asked.
Accepted suctioning when they didn’t.
Asked for bedpans, when necessary,
and never pulled out a tube.

They mustered the strength,
to grasp bedrails at every two-hour turn.

Squeezed my hands tight and
wiggled their toes, all upon my command.

They didn't complain too much,
when made to sit up for hours.
Accepted my stern authoritarian command
to stand up straight and walk.

They breathed deeply, permitting
my cupped hands to percuss their
chests in search of phlegm, and lay
stoically silent during enemas' invasion.

They managed their pain, never
begging for more than their fair share.
They trusted, trying, adhering and
complying to hold hope in healing's journey.

Hear me: This work is not theirs.

Their names are now denoted
among the living. Memories erased,
they decline persistent attempts to prod me weekly,
now, even over forty-years past.

Rather, this worded work speaks of
those patients who fought valiantly and failed,
whose tortuous defeat haunts and returns to me again
and again. Their lives are the stories I tell my family.

Of those strong patients, we listen.

POEM 15: $500

This poem almost needs no introduction. Writing it made me remember and imagine the helplessness of this son in the face of his loss. What I remember is his honest desire to understand what was going to happen to his mother. My caring acts toward him were so simple. I imagine him trying to think of a way to say, "Thank you," and making the decision that sending

me money was the best way to do it. We learn early in our nursing education that gifts of any kind are not to be accepted. I can close my eyes and remember writing my own “thank you” note to him in this acceptance.

Trigger: death, grief, and loss

A son gifted me with $500 once.
His mother lay dying in my ICU.
Her illness and her wishes, DNR.
Do.Not. Resuscitate.

He was a kind undemanding guy,
his biggest fear, not knowing
what dying looked like,
or what would happen next.

I offered my presence. Spent time
to explain to him her most probable
steps. Promising him I would be
there. I updated him

throughout my day.
privately, asking my ward clerk to page me over
the hospital intercom if I happened to be
off my unit as things began.

I bent our unit visiting policy;
we had such restricted hours,
and had her bed moved to an empty room
in the back of our ICU. A quieter space,

because I told him the hearing
is the last sense to leave. That way, he could speak
to her, though, by this time, she no longer appeared
aware. I got my page at lunch. Bounding up

the linoleum hospital stairs, I fulfilled my promise.

His gift was so unexpected. A written card
thanking me for all I had done. Humbled,

just presence. Such small things. In medicine,
however, private gratuities cannot be accepted.

I wrote him a note of thanks,
and explained his gift would be
used to update our unit's audio
system; telling him we always listened to music.

POEM 16: We Cannot Go Long

I am not sure what people always want to know what ICU nurses see and experience. My family carries many of my memories and know them by name. In all the years I have been a nurse, Kathy was the only one of my patients to appear to have an afterlife experience. As I was still practicing primary care nursing, we became close. She is the only patient I saw outside the hospital when she recovered.

Trigger: adult trauma, infant death; infant delivery after death; issues of death and dying

Intensive care nurses cannot go
long without someone
asking how much death
we have seen or if we know any
death to life experiences. I know one.

My twenty-one-year-old female patient admitted
one night, after experiencing an intrauterine infant death
at 6 months gestation. Life Flight.
What stands out to me about her admission is

how the deep blue cyanosis of her pale eyelids looked like bad makeup.

In acute respiratory distress. Diagnosis:
Adult Respiratory Distress Syndrome.
Intubated. Ventilated. Soon, possessing bilateral chest tubes.
Maximum positive-End-Expiratory-Pressure,

to hold lungs open to oxygen. Only absolutely nothing helped.

In medical desperation the joint decision was made
to induce her labor and to take her dead infant.
This determination made only after my patient Coded at shift change.
Revived, she was now so catastrophically ill that she never felt her

sweet slippery fully formed infant slide between her legs into the bedpan.

"Crying in the soup!" her
doctor yelled at me into the
phone a morning later when I called to tell him her
post-delivery cultures had revealed a particularly nasty anerobic infection.

Requiring isolation, my patient and me, her primary nurse, relocated into a closed back room.

Isolated, the monitors and her ventilator sounds, I will describe as cacophonous.
Then, one morning, as I bathed her over the sounds, her eyes opened;
she began to cry with such pressure that the ventilator alarms became sirens.
Motioning for paper and pencil, her shaking hands writing,

Why oh why did you bring me back? Why?
Why?? Why? I was in the light. The peace.
The beautiful water. I was there. Please I want to go back there.

Not long after, my patient recovered. And that is my only story.
She left her husband and lived a wild life on the edge.
I met her once outside of my intensive care unit. Hair bleached blond
with new tattoos and no memory at all of that time we shared together.

POEM 17: For W.H.B.

This poem, the one below these sentences, was the most difficult poem for me to write. I knew that it belonged inside this work, but I was too ashamed to write it. This poem speaks to the power inside medicine that I have both explored and described. This experience haunts me. This poem comes from no other prompt but my own voice in my head. "Show them about the silence. Tell them what happened."

Trigger Warning: institutional silence; institutional power; youth trauma; grief and loss; moral injury

(Silenced).

I searched for you online today,
and know you are still in practice.
Rock band playing. Sexual harassing,
I am still thankful for the Chaplains

and how they protected me by
speaking with you.

(Silenced).

But this poem is not about
me, or is it? Maybe it's about us
all, the women. The nurses. Those of us
with only the power to care.

You told me to come with you,
pulling the curtain around the bed

(Silenced).

of the beautiful Botticelli painting
except for her traumatic brain injury
and its rocketing intracranial pressures
we could not control.

I watched you take your hands and separate
the breathing tube from the ventilator. Frozen, I stood

(Silenced).

with you to wait. Watching her
heart rate begin its descent, you watching me.
Waiting. Slowing. Slowing.
And when her beautiful heart was its slowest,

you reconnected the machine and gave me
a verbal order. Go. Go tell her family that she has

(Silenced).

taken a turn for the worse. Then you left. So

I did it. I told them and supported them,
to grieve and say goodbye. But even today, I
struggle with what you did. I understand you saved

them from a tortured life of coma caring. And I know
that you saved her, too. But you took away their choice.

(Silenced).

And you left me all these years self-battling
to understand the frozen of my inaction
and the indenture of my silence. And memory's burden
because I carry one.

And believe me, I know this beautiful girl is in a
better place. But it was wrong. Wrong to do this to us.

(Silenced).

CHAPTER SIX: A CALL TO RESPOND

The Strength of Writing and Poetry for Nurses' Healing

"You have to find out what's most important to you," Kalanithi writes as he faces death (165). Later, after his death, his wife, Lucy, tells his readers, "Writing this book was a chance for a courageous seer to be a sayer, to teach us…" (216). Kalanithi's body of work, his expressive telling and showing as a physician being felled by death, fills me with humility, and I hope that I have offered but a small portion of the same. Connecting with his writing as an intensive care nurse, I view his reaching down inside himself to connect with his readers, all the while exposing his dwindling health and fragile humanity, as the bravest act of human caring and connection.

The nursing vision of Florence Nightingale has changed greatly in the past one hundred and fifty years. Nursing's struggle for professional identity has grounded its practice in technologically science-based methods; these methods have pulled nursing away from its original calling and devotion to nurses' psychological and emotional detriment. The loss of patient contact

in acts of caring has resulted in a host of mental and emotional health issues, including PTSD, which particularly impacts ICU nurses due to their experiences. Adding to this trauma, nurses are silenced within the institutional power structures of medicine. Nurses thus need tools to elevate and empower their voices. Autoethnography and poetry have great potential to be these tools.

The work of expressive written form – in particular, poetry - is a valid, therapeutically beneficial tool for emotional and psychological healing as well as a reconnection to both personal and clinical empathy. Whether nurse-to-nurse, nurse-to-patient, or the ability to self-study and healing, this creative tool empowers its creator to touch again specific, often traumatic, clinical experiences and its resulting thoughts, traumas, or feelings. Using written language, poetry enables nurses, patients, and care providers to creatively sculpt those clinical experiences and construct a healing place marker of remembrance dedicated to them.

In his memoir, Kalanithi reminds us, "Words have a longevity I do not" (199). I consider the power of words as I conclude this thesis. The therapies of expressive writing amplify the importance of words in an entirely new light. Prior to my work with Let's Write! and the IPM, I understood poetry as therapy. I did not.

As an ICU nurse for many years, I never knew I carried all these experiences inside until experiencing their release through the experience of regular expressive writing. Writing poetry to prompts has offered me to the work and privilege of giving shape to my memories. These writings have given voice and permission to express emotion; I have entrusted those traumatic memories into a safe space.

Writing poems about these memories within supportive communities has allowed me to relive the experiences in an environment of acceptance and safety. Many times, I apologized for the things I wrote and then, read aloud because of the traumas written inside the poems. Every time, my community both supported and affirmed for sharing my narrative, giving me open-armed permission to move my traumatic memories from my heart and mind into a safe space. These opportunities provided empowerment and energy to create markers of remembrance to my heritage, my training, and more importantly, my patients and our experiences together.

Writing poetry as expressive therapy offers healing opportunity to all nurses, but I imagine ICU nurses would benefit the most. In offering colleagues and coworkers opportunity to read my poetry aloud for the purpose of creating a video for a digital rhetoric assignment, not one of my colleagues reached out. In this silence, I perceive that nurse are more broken and brittle than Watson ever imagined during times such as we find ourselves in today.

And while I understand that poetry will not fix a nursing shortage or hold at bay a pandemic, I do believe in its therapeutic effects. Thus, it is with gratitude that I consider my years within Belmont University's English department and credit this environment as opening the doors and providing a foundation for this type of sharing. Supporting me with confidence to find my voice and the power to open up and provide me with the initial sacred safe spaces. Moreover, I am grateful to my experiences in my writing group, Let's Write! and the support and welcome of my expressive work within IPM, and how they have assisted me in this journey.

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