THE HEALER’S ART

50 Stories for 50 Years

Brigham Young University
College of Nursing
50th Anniversary, 2002

Editors
A. Elaine Bond, APRN, DNSc, CCRN
Barbara Mandleco, RN, PhD
Myrna L. Warnick, RN, MS
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Preface

As we reflect on 50 years of Nursing at BYU, we have chosen 50 stories to reflect the experiences of graduates, faculty and students about their practice. We do so with nostalgia, awe, and personal satisfaction for all that has been accomplished. Our classrooms have changed in many ways: from a blackboard to Blackboard, from Netter=s drawings to PowerPoint and interactive videos, from practicing techniques on each other, to treating SAM, the Simulated Assisted Mannikin Practice. The clinical practice arena has also changed in many ways: from counting intravenous drops using the “sweep” second hand on our watches to using intricate IV pumps, from charting in black, green and red inks for each shift to monitoring patient progress through computerized information systems, and from simple administration of physician orders to completing complex assessments and using detailed protocols. The sites of practice have also moved from the hospital to both community and home settings, creating a need for a skilled, thinking nurse. However, commitment to excellence as we engage in evidence-based practice and in spiritual and emotional care, or the art of nursing, has remained constant.

As the College of Nursing moves into the next 50 years with great anticipation, we will continue to explore the depths of what it means to practice AThe Healer=s Art.@ When we celebrated the 40th Anniversary, the College commissioned a painting by Trevor Southey, entitled "The Healer's Art," based on the third verse of the hymn, “Lord, I Would Follow Thee”, (Hymns of The Church of Jesus Christ of Latter-day Saints, Hymn #220. 1985), which says, "I would be my brother's keeper; I would learn the healer's art." Those of us who were there felt the power of the painting as Mr. Southey described his experience with nurses who saved his life when he was a child. As we sang the hymn, a spiritual, enlightening commitment pervaded the celebration attendees, which is rekindled each time we hear it.

The author of the hymn, Susan Evans McCloud, has written two additional verses for the College=s 50th Anniversary Celebration. The poignant messages of the verses remind us that our underlying faith in the Savior helps us meet the needs of those we serve. We have arranged the stories in chapters, according to themes identified in each of the six verses of “Lord, I Would Follow Thee”. 

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As we celebrate 50 years of BYU College of Nursing and practicing The Healer's Art, these stories we have selected to publish reflect who we are as nurses. Many of our students, alumni, and faculty have shared moments in their practice. We had an overwhelming response to our request for stories; every story had a profound message. We regret we could not print them all. Those we selected seemed to capture the spirit of The Healer's Art.

No one can read them without being touched and without recalling similar experiences or emotions.

The Editors
Introduction

Elaine Sorensen Marshall, RN, PhD
Dean and Professor

The heritage of BYU College of Nursing began well before 1952. One hundred and ten years earlier, soon after the organization of the Relief Society of the Church of Jesus Christ of Latter-day Saints in 1842, the prophet Joseph Smith blessed and set apart Anoble and lofty women...to go about among the sick and minister to their wants1.

Four years after the first company of pioneers arrived in the Salt Lake Valley, sisters of the Church founded a Female Council of Health, representing nearly every ward in the Church, to teach courses on midwifery, child health, and women=s hygiene. In 1873, Linda Richards was the first nurse to graduate from a professional nursing education program in the United States. That same year, President Brigham Young requested that each ward in the Church support three women to study nursing2. Eliza R. Snow personally recruited students to local nursing classes Afor Zion=s sake3.

In 1898, the General Relief Society Nursing School graduated its first class under Emma A. Empey, who served as superintendent of the school and supervisor of charity nursing during its tenure. Tuition was $50 for the entire program. Graduates were set apart for their service, and honor bound to serve where needed and to charge no more than $6 per week4,8. By 1905, LDS (W. H. Groves) Hospital was established and eventually housed a school of nursing. By 1952 Brigham Young University College of Nursing was born.

What an honor for each of us to be here at Brigham Young University College of Nursing at this historic time! What a gift we have to celebrate 50 years of teaching, learning, and practicing The Healer=s Art. We are the beneficiaries of a marvelous heritage of courage, compassion, and faith. We serve at the pleasure of the divine master of healing.
The vision and purpose of learning the Healer=s Art continues. BYU nurses learn to recognize the hidden sorrow in the quiet heart, to provide skilled care based on the best science to the wounded and the weary, as they also learn to walk the path shown by the Savior. BYU nursing graduates are well prepared to serve in a world that cries for knowledge, skill, compassion, and sensitivity to the Spirit.

To the BYU nurses of the next 50 years, we offer some advice: Find the courage to leap forward with greatness, to distinguish yourself by your competence and goodness. This will require thinking and doing differently than others. It will require more time, energy, and devotion than others may be willing to give. It will require more quiet, unheralded service than others may offer. It may require more gentle forgiveness than others are able to find. Nurses from Brigham Young University will continue to make a difference as they practice The Healer=s Art. On to the next 50 years!

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Chapter 1

Help and Lift Another

Savior, May I learn to love thee,
Walk the path that thou hast shown,
Pause to help and lift another,
Finding strength beyond my own
Savior, may I learn to love thee,
Lord, I would follow Thee.

The Church of Jesus Christ of Latter-day Saints, Hymn 220, verse 1
After graduating, I was not sure what I wanted to do with my nursing degree. All I knew is that I wanted to make a difference in people’s lives. After exploring all the hospital units and occupations a nurse could have, I decided to choose labor and delivery for my first place of employment. I quickly learned there is a lot more to nursing then the stuff you learn in books or even in nursing school.

There is definitely an art to nursing and I worked hard at my new job so my canvas looked as colorful as everyone else's. As I worked out my colors and got better at my brushstrokes, I realized Labor and delivery was the place for me! I was able to be a part of the most amazing experience in most people's lives. I helped people celebrate and care for their new baby.

My canvas was colorful, but I was missing one color. I did not learn the nursing art for death. I felt that maybe I chose labor and delivery because it was about life, not death. I knew that I would somehow have to learn to use the color black in my art of nursing, and I struggled with how to care for a family that was losing a baby.

I was still orienting when I took care of my first fetal demise. A beautiful young couple had been trying to have children for years. Just as they thought they had reached their goal, their baby's life ended before it had even begun. I cried that day, learning the pain that comes when there are no answers for what has happened. It was then that I realized what was sweet could also be very, very bitter. I did not understand what my role was for this couple; I could not celebrate the birth of this baby. I could not fix what so badly I wanted to fix. I left that day with questions of how I should feel as a nurse in this situation.

Several months after this experience, I was working a regular night shift. In report, we were told there was a woman who came in because her membranes had ruptured. During admission, she explained to the nurse that her baby was special. He was going to be born with a disorder that was incompatible with life, meaning he would die. I deliberately did not take that patient; I did not feel that I would give her the care she deserved. Later that night, I heard this little boy had been born. I did not hear a cry come from the room, just deafening silence. The father came out seeking someone who could help give his child a blessing before he died. We just happened to have a doctor who was a
bishop and he came to help give the baby a blessing. Not long after that, the nurse came out and said that the baby had died. I swallowed the pit that grew in my throat and said a little prayer for the family. It was about this time that the nurse asked if I could help her clean the room and change the linen.

At first, I was troubled, not sure I could handle seeing this disfigured family with their disfigured child. But, as I walked into the room, a great peace swept over me. The father was holding his son in his arms and he had a smile on his face. He walked over to me and said, "Look at my beautiful son." As I looked at this perfectly formed child dressed in a white tuxedo, I felt my Heavenly Father's love for this child. This infant had come to earth for only a brief moment, but he touched everyone who came into contact with him with Christ's love for all of us. I smiled and knew this birth needed to be celebrated. This son of our Heavenly Father had fulfilled the plan; he had gained his earthly body and earthly experience. I could only think he must have been one of the valiant ones who did not need the trials of this world to make it in the eternities.

As I left that room, I realized what it was that I was feeling. It was the same thing I felt every time I saw a child born; it was heaven. It is in these experiences, birth and death, that we get the closest to the veil of heaven that we will ever get. And at that moment, I knew what my role was-- to nurture life in all its forms and love as my Heavenly Father loves each of us, no matter the circumstance.

I did not have the answers for this family who had so many questions, but I did have the medical knowledge to help them understand what to do next. I could teach them how to take care of themselves and where to turn for help. Most importantly though, I could tell this family the feelings I had as I entered their room and saw their beautiful child. I did not leave that day with a bitter feeling, but with peace, knowing my Father in Heaven was embracing a little boy who made it back home. I felt honored to be a nurse and recognized the part I had to play when facing death.

As I added the black paint to my canvas, I realized that without the pain of losing a child, there could be no joy in having children live. As I look at my canvas now, I know the skills I have. I may not be able to fix the problems of the world, but I can use the art of nursing to help heal the body and the heart.
A nurse’s bedside manner impacts patients’ recovery and healing experiences. Choosing to make nursing an art is increasingly more challenging and easy to overlook as demands on nurses increase. With growing patient loads, it is easy to fall into the trap of simply passing medications and following doctors’ orders. Practicing artful nursing includes everything from being non-judgmental, to using therapeutic touch, to really listening to and advocating for the patient. The underlying concept is that patients can feel whether you have positive or negative energy towards them. This impacts their ability to heal. Although many conditions may be alleviated through therapeutic touch, one common ailment that benefits from therapeutic touch is pain.

A few years ago, I cared for a woman who complained that lower back pain kept her from being comfortable enough to rest. I felt I had tried everything I had ever been taught. I repositioned her on her side instead of her back and put pillows in between her legs and behind her back for support. I later let her watch a movie, hoping it would distract her from focusing on her back pain. We talked and I listened as she expressed her frustrations and fears of recovering and being discharged soon. She was in the hospital recovering from pneumonia, but had suffered from lower back pain for years.

Other nurses that I sought out for more ideas said things like, “She’s just like that, don’t worry too much about it,” or “Can you give her anymore pain meds?” She had already been given her maximum pain medication and still did not have enough relief. I felt frustrated. Despite any repositioning and comfort measures I provided, she was not comfortable and the nurses on the floor were out of ideas too.

Finally, it dawned on me to give her a massage, a form of therapeutic touch. At first, I think she became more tense, but within ten minutes her breaths became slow and deep and her body relaxed significantly. After twenty minutes, I knew she was asleep.

She rested peacefully for about two hours. When she woke up, her effect was very pleasant. Before, her eyebrows had been knit together; she just kept sighing, and would not hold very still. Now, she appeared calm and was very appreciative. She said she felt much better. I knew our nurse-patient relationship had deepened.
I was young at the time and relatively inexperienced. I often felt like my inexperience hindered building a strong nurse patient trust, but by the end of the day I felt she really trusted me. Her pain ratings on a scale of one to ten also decreased from the eight to nine range down to the four to five range following her nap; therefore her medication dosage decreased. This patient showed classic documented benefits from the therapeutic touch I provided.
Once in a while everyone has one of those incredible experiences, where one learns there is more to nursing than just the application of secular knowledge. I had the opportunity to experience such a moment in Argentina while working at a public maternity hospital. I learned to go beyond what I had learned in nursing school, and discovered something that cannot be taught. Seemingly forgotten, those babies in the "abandoned" section have taught me more than they'll ever know and will live on in my memory forever.

I had the privilege of going as a BYU nursing student to work in a maternity hospital in Argentina. The hospital was one like I had imagined it would be in a second or third world country. It had six or seven floors, old tile, broken windows, no toilet paper or soap for the patients or doctors, about one nurse for every forty-plus mothers, and one nurse for every sixteen-plus intensive care infants. There were no private rooms to rejoice in when the newborn was delivered into this world. There were no private rooms for mothers to grieve in when they experienced the loss of their creation.

I had worked in the labor room, the post partum floors, and on my last day, it was finally my turn to help in the NICU. I started feeding the babies and taking temperatures. When I was finished, a corner of the room caught my eye. I asked about the babies in this section, and learned they were there because they were sick and/or abandoned.

It was known as the abandoned section because many of the parents of the sick babies couldn't afford to pay for medical costs. Parents were left with no alternative but to leave their child there in the hands of the government who would then pay to have them treated, if they didn't die first. The price parents paid was to never be able to see their child again. Once they signed the paper, they weren't allowed to visit or care for their child. Unfortunately, if the mother was not there to take care of her baby, it was usually the last task of the day for the nurses. Their priority was in taking care of the babies who had parents who could pay for needed medical treatments, so these were the forgotten or "abandoned" ones.

The first one I came across was named Jose Ariel, and indeed he looked as though he had been forgotten. He had a heart abnormality and was lying in a little metal basket with a wet sheet, which reeked of emesis. He was not wearing any clothes and his diaper was overflowing.
I fed him, cleaned him up, and gave him one of the blankets and clothing articles which I brought from generous people back home. He loved the attention and was able to fall right to sleep.

I then moved on to Ivan, who had hydrocephalus. He was three months old at the time and was scheduled to have a shunt placed within the next two days. The pressure that had built up was incredible. He had “sundowner's eyes” so severe that I could see only the whites of his eyes. His head weighed about twice as much as the rest of his body, and Ivan had not developed neck muscles strong enough to hold up his head.

I went over, picked him up and cradled him in my arms. I noticed the towel he'd been laying on was also wet, only it had no odor. I bathed him, clothed him and held him. I had also been watching his temperature and noticed there was a steady increase. It had gone up to 101.4. I spoke with some of the other student nurses who had been in there before, and they told me that a day or two before, the nurses had tried to relieve some of the pressure in Ivan's head by getting a little of the fluid out with a syringe needle, but they neglected to place a bandage on his head. It soon occurred to me that the sheet was wet with cerebral spinal fluid.

I notified the pediatrician and she said she'd be there when she finished making rounds. For me it seemed like an eternity. She confirmed that Ivan was leaking spinal fluid and most likely had an infection because his wound was left uncovered. Concerned about Ivan's upcoming surgery, I asked if it was likely they would go ahead and operate anyway. She replied it would be up to the surgeon.

When my arms grew tired of holding him, I tried to put him down, but he just cried uncontrollably. He loved being held, as if he had been starved for human contact. I had another student nurse hold him while I went to look for a bottle, which was no easy task. Returning about a half hour later, I held and fed him. He was ravenously hungry. I held him for hours and was able to feed him again before I left. I was the last to leave the unit and my fellow students waited for me in the van. No one came in to hurry me along, because there was an unspoken understanding.

While I held Ivan, I had plenty of time to think and reflect. I wondered what the future held for him. I watched as he lay complacently in my arms and wondered what kind of perfect spirit was inside his imperfect body. I played out in my mind the day I would be able to meet him in his perfect form after this life, and how happy I would be to see him, hug him, and talk to him. I reflected on how much I had been given
in my life and how much I therefore was obligated to give. I thought about the Savior and how He loves all of God's children.

I loved that I had the opportunity to help ease his great pain, if only for a day. The care I provided was not medical by definition; it was compassion and love. I loved that I was able to help the helpless. I know that if I had not been there as a student giving service, Ivan wouldn't have been held and comforted. I would not have had the opportunity to show him there was someone who cared. I would have missed the lesson of a lifetime. It reaffirmed to me that I was supposed to be a nurse. I know of no greater profession wherein lies the opportunity to help heal others, both physically and spiritually.

My heart and mind go back to that place often and wonder if he ever made it to surgery and through recovery. I have since made a commitment to myself and to those I serve, that I will serve them as the Savior would serve them if He were here in my place. I want to convey to them my concern for their well being whether it is medical, emotional, or otherwise. I want them to know they are important. I want to learn The Healer’s Art, and my journey has just begun.
Chapter 1          Help and Lift Another

Will You Sing Me a Song?
Angela Williams

As a beginning nursing student with no previous medical background, I was determined to learn the ins and outs of every procedure and do an absolutely perfect job at clinical. My first and second days of clinical went all right and I gained a little more confidence. During the second week of clinical, I was determined to get some new nursing skills down and spent the day concentrating on the new world I was discovering at the hospital.

I was assigned to a basic Med-Surg floor and had one patient, an elderly gentleman, who was recovering from surgery. He was doing well and my duties were not that difficult, now that I look back, but it was a whole new world to me at the time. I was so nervous about doing something wrong that I focused more on what I had to do than on the patient himself. Each time I left the room, I would ask the patient if there was anything I could do for him. He smiled and answered, "Can you sing me a song?"

I took his request as a joke because who in the world would really want to hear me sing? Smiling back at him, I would respond, "Now, you really don't want to make your ears sick too!"

He would smile at me and say nothing else as I went about my business. The next day the same gentleman was my patient. I went in and did my assessment as efficiently as possible, trying to concentrate on what I was supposed to be looking for and how exactly I would chart it. Again came the question, "Can you sing me a song?" and again the response, "You don't really want to hear me sing."

Later, while I was concentrating on making sure his medication dosages were right and that he swallowed all the pills, came the question, "How about a song?" with only a smile at my response. The day continued like this until lunchtime, when another nursing student came with me to deliver his lunch tray and to do the midday assessment. As I focused on finding his pedal pulses and deciding whether to grade them as a 1+ or 2+ the same question came: "Do you have a song for me yet?"

But this time the response was different. As I was about to smile and laugh off his request, the other student nurse responded: "I think we can handle that. We'll get some of the other students so you can have a real choir and we'll sing you a song later this afternoon before we leave."
His smile grew and I kept thinking, "Can we really sing him a song? That doesn't seem very nurse-like."

During post conference my friend recruited several students to join us in singing my patient a hymn. We picked the song "I Need Thee Every Hour" and, armed with a couple of hymnbooks, we stood at the end of his bed and sang him his song:

I need thee every hour, In joy or pain.
Come quickly and abide, Or life is vain.
I need thee, oh, I need thee; 
Ev'ry hour I need thee!
Oh, bless me now, my Savior;
I come to thee!

(Church of Jesus Christ of Latter-day Saints, Hymn #98, 1985)

As the last note rang clear, we looked at each other and saw tears in everyone's eyes. The patient took a deep breath and said, "That's the best medicine I've gotten at this hospital yet."

I left the hospital that day with one of the greatest lessons I've learned in nursing school, and to my surprise, found that it had nothing to do with assessments, procedures, or medications. It was that I, as a nurse, could take the time to participate in the healing of someone's heart or soul. This is, unlike what I originally thought, part of the nurse's domain. The trick, I discovered, is to really listen to my patients. They may not know what they need on the medical level, but they will convey what they need from you on the spiritual level. I am grateful that my friend knew that already and was willing to listen to my patient when I was too focused on my own learning to do what he really needed. Being a new nursing student, I found myself focused more on my learning rather than on truly caring for my patient. My friend took the time to listen and gave me a true example of The Healer’s Art.
Our goal as health care providers is to do all we can to promote individual health and well-being. Through working as an RN, I have realized many aspects promote the healing process. In order to obtain a license, one must have the required skills and knowledge. I have also discovered many “extras” that a good nurse must also obtain in order to provide an optimal healing environment. Nursing skills and knowledge are vital to make a nurse, but compassion and caring are vital to make a great nurse!

A few months ago, I came on shift to care for a beautiful baby girl, Heather. Everything indicated a normal pregnancy, but when Heather was born, she was extremely sick. While in the womb she had aspirated meconium, which caused severe damage to her lungs. She was unable to breath on her own, her blood pressure and heart rate were unstable, and she was very unresponsive. She was taken to the NICU, placed on a ventilator, and given medication to help her lungs, blood pressure, and heart.

After I cared for Heather for a few days, I had the opportunity to learn more about the family. As I listened to each of them, I discovered information that helped me gear my nursing care toward their individual needs. The mother had lost a little sister when she was a young child. This situation in the hospital was very stressful for her because it brought back past memories. The thought of losing another loved one was more than she could handle.

One week before Heather was born, her mother went to her physician and said she had a feeling that Heather needed to be born right away. The doctor’s estimations of dates revealed that she was only 37 weeks and everything looked fine on the ultrasound. He therefore decided to induce the mom the following week. The mother expressed her concerns to me, wondering what would have happened had Heather been born a week earlier. Would she have aspirated meconium and had so many problems? Or would the infant have been just fine? This is a question whose answer we will never know. The physician did everything that was medically correct. The mother had an intuition, however, and no one listened.

Drawing upon the information I knew about the mother, I always tried to focus on the progress that Heather was making. I was always
honest about her present condition, but would try to focus on the day-to-day progress she made. I would encourage the mother to take care of herself with the proper rest, and to always feel comfortable calling the hospital whenever she was away.

Heather had lots of support from her family everyday. She received a priesthood blessing from her father and grandfather the day after her birth. Her parents, grandparents, aunt, and uncle would always try to come in and sit by her bedside. They became familiar with the monitors and equipment and learned about the baby’s clues that would tell them when she was stressed. They would call to check on her often when they couldn’t be there. They would participate in all of the care they could, including changing her diaper, taking her temperature, weighing her, and doing oral care. We encouraged their support and explained to them Heather knew they were there to show her they loved her.

Heather did remarkably well. She was weaned from dopamine and the ventilator within the first week. The second week was spent in learning how to eat. Heather went home a happy and healthy baby about two and a half weeks after her birth.

Throughout her stay in the NICU, each health care provider gave Heather their whole heart and soul to her and her family. The family was always appreciative, which only inspired everyone to do better. I looked forward to work because the family was so caring towards me. They knew my name, asked about my family, and were always so appreciative. Their appreciation and love for me helped me gain a closer bond and love for their baby and family.

Heather and her family came for a visit later, to show us how big and beautiful she was. As a four month old, she was doing very well. As I held her it was hard to imagine that this was the sick baby I had taken care of a few months earlier. I know we as nurses and health care providers have an important role in the art of healing. Those small, important “extras” not only improve the healing process, but also make the “ride” more harmonious and enjoyable.
Recently I was reading over my first year of nursing school journal entries and noticed the positive influence humor has had on my nursing experiences. Humor has always been important to me because it helps me relax in stressful situations and feel more comfortable in new environments. What better quality could a nurse have than humor? Humor alleviates stress and allows both nurses and patients to have a more enjoyable experience. In my own life humor does so much more than alleviate stress; it helps me remember experiences more vividly, it helps me teach people more effectively, and it helps me feel better about my life and myself.

One of my experiences involving humor occurred during the final week of rotations on the labor and delivery unit. I started out the day by showing up at 6:00 a.m. and having the privilege of being placed with an RN who was not too fond of mentoring students. She happened to be stationed in the Labor and delivery triage for the day, so she was the first nurse the new patients would meet while coming onto the unit. She informed me she could do a better and faster job if I did not become very engaged with any of the new patients. I became frustrated but decided to make the best of the situation and informed her I was bilingual and could help translate for any Spanish-speaking patients. It was a good thing that I do speak Spanish, because translating is what I ended up doing the rest of the day. I particularly remember one couple from Chile who came in because the wife was having an episode of hypertension. She was at thirty-nine weeks gestation, and this was her first pregnancy. Both the husband and the wife were nervous about the health of the baby. I became particularly embarrassed when I was translating a question about breast-feeding and inadvertently used the layman's term to refer to the breast instead of the proper medical term.

Upon translating incorrectly the couple looked at me oddly and said in unison, "What?" I quickly realized the mistake that I must have made and my face turned bright red. I then proceeded to give a quick explanation of how my Spanish speaking abilities were not the best and they began to chuckle under their breath until they were laughing out loud at my expense.

After having a comical time of translating the prenatal record questions, the wife's blood pressure dropped considerably. The RN
performed a blood draw for some lab work, and the family waited for the results in the triage room. All of the labs came back within normal limits. By this time the husband's mother and sister arrived to provide moral support and were informed of my translating abilities. They also had a good laugh! About an hour later the wife's water broke and the nurse admitted her into the unit to induce labor with Pitocin, by order of the doctor. I continued to aid with the admission and translating until the family was in the birthing room and had no more questions. Upon leaving, the family thanked me for having translated for them and making them feel much more comfortable during the admission. I in return thanked them for the opportunity to help them and wished them luck on their delivery.

Since that experience, I have often noticed that the majority of nurses joke with their patients, which appears to create a better teaching and caring atmosphere. Another thing I learned from my experience is that using humor improves the learning atmosphere, enabling patients to understand and remember instructions better.
On my last clinical day at the nursing home, I had many things to do. I felt heavy in my heart, afraid that I would not be able to accomplish everything, and I was running out of time. As I hurriedly passed a patient’s room, I heard quiet sobbing. I paused and glanced in the room. The crying patient was a lady whom I had cared for throughout my rotation. She was suffering from dementia. I walked into the room and asked her what was wrong. She cried more, saying that she felt so confused and just, “not herself.”

In frustration, with tears in her eyes, she told me that she could not find her grandson’s phone number. We looked all over her room and at the nurses’ station before we finally found it. I helped her dial the number and then began to gather my things and walk out of the room. After all, I had been nice and helpful already, and I had a lot of other things to do. As I approached the door, I heard her hang up the phone. I thought, “I really hope her grandson will visit, especially since she didn’t get to speak with him. She really needs someone to talk to.” As this thought crossed my mind, I froze. Who was I? What was my role? I turned around, leaving my worries about myself at the door. I walked back in and sat beside this wonderful person. As I did so, her eyes lit up.

Later, as I left her room, my heart was filled with joy from this simple act of service. I learned an important lesson that day. My life was blessed as I took the time to go beyond being “nice” and to truly care for this sister. Suddenly my worries were forgotten and my burdens were lifted. I learned that nursing is more than clinical skills or fulfilling assignments. It is indeed about learning The Healer’s Art.
As a nursing student, I spent hundreds of hours learning how to be a nurse. From my very first day as a student, I was determined to perfect my "skills", so that I could be competent when I graduated. The nearly one thousand hours spent in the clinical setting have taught me how to proficiently care for patients. I do not believe however, that learning nursing skills are what makes someone a nurse. Nursing is about caring, and caring is not taught, but is inherent in each one of us. It is the spirit of Christ, given to each of us as a gift to bless God's children. When we learn to love as Jesus Christ loved, we supercede our own level of nursing skill and tap into His power of healing.

I recall an experience I had as a new student that forever etched in my heart what it meant to be a nurse. It came during my very first rotation on the surgical floor. I had few of the "skills" one would expect a nurse to have in order to care for a patient. In fact, the only real expectation of me was to get to know the patient, and follow her throughout the entire surgical process. I did not feel in any way competent to call myself a nurse. Nevertheless, I introduced myself to my patient and her family as one of the nurses who would be caring for her that day.

She was preparing to have her second kidney transplant. Her first one had failed after only nine months. I spent about thirty minutes that morning talking to my patient and her family in the waiting room. They asked me all kinds of questions about the procedure, of which I knew little. I felt incompetent, and remember thinking to myself, "How does my teacher actually expect me to do anything good for this patient?" I would soon learn however, that nursing is much more than knowledge and skill.

My patient had been called back to the operating room for her surgery, but due to some complications with the kidney donor, there was a delay for nearly an hour and a half. Her family had been left behind in the waiting room, so for awhile, I was really all that she had. She was obviously scared, and having to wait only made things harder. That delay however, turned out to be a blessing for both of us. For the next hour and a half, we sat together and talked. We talked about the surgery, we talked about her family and mine, and we also just talked about fun stuff that made us laugh. She cried at times, and I held her hand without saying anything. I did my best to listen, and to let her know I cared and that
everything would be all right. There was so much going on around us, but she and I were in our own little world, and it was special.

Eventually, our time together ended as she was taken to surgery. Before she left she squeezed my hand and smiled at me. The connection between us was without words, but I knew what her heart was saying. She was grateful. As the surgeons took over, my responsibilities for her were transferred to them. My responsibility as a nurse however, did not end. I left the OR and went back to the waiting room to a worried family. There, I related to them the conversation that I had shared with their loved one, and let them know she was all right. It was a simple thing, but I realized how much it meant to them, and how grateful they were to be comforted.

This small experience has been huge in shaping the way I view nursing. A patient is more than just a broken arm, or fluid-filled lung that needs fixing. The cornerstone of caring evolves not only around the illness, but around the patient's entire well being-- physical, mental and spiritual. Often it means taking a little extra time to show you care.

I am reminded of the story of the Savior on his way to the house of Jairus. He had been summoned by Jairus to heal his daughter, who lay near death. There was a great multitude thronging about him as he made his way to the house. Many feared that if he did not hurry, the young girl would surely die. The urgency of the moment, however, did not keep the Savior from noticing the plight of a suffering woman, who had touched his robe in faith, that she might be healed. The swarming of the crowd did not keep him from noticing the slightest touch of the one. He stopped and patiently sought out the woman who had touched him. And then, acting as if he was in no hurry at all, gently spoke to the woman and healed her suffering.

Jesus Christ was, and is, the Master Healer. He is the Master not only because he held the power to heal, but because he took the time to show his love to the ones he served. He took time to teach them, and healed them in the process. That same spirit of love and caring is what nursing should encompass. Nurses too can be healers and teachers. It makes a world of difference what we do. Holding a patient's hand or wiping a fevered brow can make all the difference. A cloth across a forehead: it couldn't be simpler. Yet that simple act connotes comfort, caring and human bonding. Kindness is the key; caring is the added element that makes nursing the noble profession that it is.

I once thought I needed "skills" to be a great nurse. I have learned however, that far more important than what expertise I possess,
is the time and love I am willing to give away. The true spirit of caring lives in our hearts, our dreams, and will always live in our memories. It often happens in a single moment, but it changes lives and lifts the soul. It is nursing. It is The Healer’s Art.
Holistic Nursing
Allison Ash

Because prayer is such a personal experience, in the past, it has been difficult to gauge how it impacts a patient's health. I have recently seen the power of prayer in my nursing experience as I began my rotation through the Intensive Care Unit.

Before I went onto the unit to begin my morning assessment of a new patient, I began my day with prayer, as I felt very inadequate in my knowledge and skills for the intensely sick patients. I was scared and so I began pleading with God to help me gain the skills necessary and apply the knowledge I had so I would be able to be my best for my patient. As I listened to report that morning, my nurse and I were told the patient had been anxious. As a student, this was my only patient and so once I heard report, I left to go into my patient's room and begin my assessment.

The noise of all the different machines intimidated me but once I saw my patient's face, with the tears running down her cheeks, I quickly forgot about my nervousness and remembered she was very similar to the many other patients I had encountered so far in the nursing program. She was sick and unable to care for herself, and I wanted to help her.

I introduced myself and asked what was wrong. As I did so, I grabbed some tissue and began wiping her tears away, holding her hand with my free one, while I waited for her response. When she identified her pain, I told her I was going to try to get her a pain medication and would be right back. Since my nurse was still receiving report on her other patients, and it would take a few minutes for the nurse to get the medication ready, I went back into my patient's room. We talked quietly as I continued to wipe away the tears because I did not know what else to do, I asked the patient if she would like to have a prayer together. She quickly agreed. I leaned close to her head and whispered a prayer, asking for peace and comfort for my new friend.

There is something that happens when two strangers participate in petitioning for divine power in one person's behalf. Suddenly, they are not strangers but two friends, asking God to help bring comfort where anxiety and pain once were. As I finished my prayer, she smiled and whispered that she was a “believer”, too. Although we were not of the same religious affiliation, we both knew we were of the same faith. The rest of the day, I felt I was taking care of my friend, not a patient whom I had just met. We continued to talk and laugh, as she shared part of her
life with me. Her family came and I got to know them. It was a wonderful experience and we both felt the peace and comfort we had pleaded for that morning.

Nursing is a profession that heals the patient as a whole and not just physically. It is precisely the holistic healing that drew me into this profession. Even the little things I do for patients do not go unappreciated and my small kindnesses to them are rewarded right back to me as I come to know I made a difference in their lives.

A reward came when I needed to know that all of the time I put into nursing really was helping others, since I was struggling to understand if I really made a difference as a nurse. The understanding came when the patient's family called after her release from the hospital to thank me for taking care of their loved one. It is precisely this knowledge that I helped to make someone's trial of health just a little bit better with a holistic approach to nursing care that fulfills me as a care giver. As a student nurse, and not feeling completely adequate in my knowledge yet, I take comfort in the fact that patients seem to remember the spiritual and emotional needs I meet before they remember what I do for them physically. The holistic approach is what defines the nursing profession.
Chapter 2

Who Am I to Judge Another?

Who am I to judge another
When I walk imperfectly?
In the quiet heart is hidden
Sorrow that the eye can’t see.
Who am I to judge another?
Lord, I would follow Thee.

The Church of Jesus Christ of Latter-day Saints, Hymn 220, verse 2
In report, I felt a little queasy as the night nurse reported a patient to me. The man she had cared for was homeless, had been found unconscious behind a local restaurant and was brought to the emergency room via ambulance. Later, his health care providers discovered he was suffering from alcohol withdrawal and had genital warts and lice. As I listened, my stomach continued to churn.

Upon entering the room, I nearly gagged again. The stench of body odor and urine fouled the air, and my client was writhing in bed. My first goal was to help him become comfortable. His lips were chapped, with formed yellow crusts, and his face was scraggily with whiskers. After doing an assessment and giving him medications, I brushed his teeth, suctioned him, and put lubricant on his lips. I then proceeded to shave his face. What a task! As I had only shaved male patients a few times, it was quite a challenge to apply shaving cream and shave the hairs close to his lips and on his chin. I nearly gave up, it was such a mess.

With goops of shaving cream on my gloves, I leaned over this heavily sedated man, and something changed. Maybe his whiskers were hiding something I did not see right away or maybe my eyes were adjusting to the light of the room. Yet, for the first time that day, I was able to see this man more clearly. Beyond his label as a homeless man, I was able to look at him as a child of God with a body and spirit. As this client was undergoing alcohol withdrawal, he was confused, agitated, and obviously uncomfortable. He needed my help. From this moment until the end of my shift, I realized I could minister to his needs in this vulnerable and difficult time.

From then on, I called him by name and talked to him as if he could hear and understand me. When we changed his gown and cleaned him up, I covered him to maintain privacy. I untied his restraints and did oral care every two hours to make him more comfortable. By the end of the day, he looked and smelled clean. Yet, the highlight of the day was when he looked over at me, and a big grin spread across his face.

Before this experience, I thought if I did a kind deed, I could accumulate service points—regardless of the judgments I thought but did not verbalize. Often I have thought, "If this person had stopped drinking or smoking" or "If only this person had taken care of his/her diabetes, he/she would not be here in this hospital. Why do I have to care for
someone who did not take care of him/herself?" Yet, as I interacted with this man undergoing alcohol withdrawal, my perspective changed. I learned that as Heavenly Father loves me in spite of my faults and shortcomings, so I should love others.

I have learned that it is not so much what I do that is important, but it is how I do it. I must evaluate if I am giving nursing care with a giving heart or a resentful heart. If I can look past the grungy dress or smell and see people as God sees them, then it will be simple to care for them. If my weaknesses were as visible as the smell on my breath and the look of my clothes, then others may not want to be around me.

I have chosen to be a nurse. This means I will come in contact with all types of people. I need to give love unrestrained, change my heart, and not allow myself to think judgments against others. My desire is to love them, to help them, and to bless their lives just as the Savior does me.
Nurses spend a lot of time trying to heal the physical body. We also need to learn The Healer’s Art, which is healing body and soul. Too often, we have preconceived notions of patients that limit our ability to care for the entire patient. Jesus Christ taught us to love. A part of this process is learning to "Judge not, that ye be not judged" (Matthew 7:1). This is a hard commandment to follow and I have struggled to improve my preconceived ideas. In exerting this effort, I have been able to make a difference in my patients' lives and have been able to care for their body and soul.

At each shift change, nurses give report about their patients' conditions to the oncoming nurses. I was receiving the usual report and the nurse from the previous shift was determined to inform me of my patient's long history. She described a hypochondriac seeking attention and always wanting pain medication. The nurse informed me the patient had had multiple visits to the Emergency Room the past two years, presenting various symptoms like abdominal, hip, leg, and shoulder pain, headaches, general malaise, nausea and vomiting, and decreased musculoskeletal functionality. As the nurse continued describing the patient, I thought this patient needed to have a listening ear. I would try to fulfill all her needs and listen to her questions and opinions to the best of my ability. I was going to suspend judgment for that day and serve my patient instead.

The patient awakened as I carefully poked my head into her room. She hadn't slept well, and she was in horrific and intense pain from the incision site following her exploratory abdominal surgery of the day before. I got some pain medication for her right away and then suggested ways to manage her pain for that day. We decided I would give her pain medication, as often as ordered, if she felt she needed it. If that was not enough, she would let me know, and I would call the physician. Pain control was our goal and I trusted her to know her own body better than I did. Immediately I could tell she was relieved and was able to relax.

The day progressed and I ran all over caring for my other patients. However, I took extra time to check on this woman and to enter her room to ensure that her pain was controlled. While in the room I handed her a toothbrush with toothpaste on it, helped her brush her hair, straightened her pillow and linens, handed her a cool wash cloth to wipe her face, and got her some crackers and juice. If she could feel good
about herself, then she could focus on the healing of her body. I continued to check on her frequently, and as I did, we laughed together and had deep discussions despite the fact that the actual time I was in the room was brief. Problems no one had mentioned in the report surfaced. We were able to talk about some of these problems and she was able to think of alternative ways of dealing with the issues she was facing.

The day was extremely busy, and I was tired. At times I wanted to just take a break and sit down and rest my weary feet. This particular day, I prioritized my patient’s needs. When asked, I hurried to obtain pain medication to relieve my patients' discomfort, as I had decided I would. Although I felt a little overwhelmed with all the things I had to do, I was able to fulfill each task and responsibility well. As I look back, I still do not know how I fit everything that needed to be done into my schedule, but I know I received strength and capacities I normally do not have.

As the day went on, we managed the woman's pain with repositioning, heat, and medications. When I looked at her chart and compared this day to the previous one, I noticed she had less pain medication on the day I cared for her. I not only cared for her medical problem, but cared for her body and her soul. I could tell she felt listened to and understood. Also, at the end of the day she expressed gratitude for my efforts to care for her. "You are the best nurse I have ever had," she said. Hearing this made the sore feet, the long day, and all extra efforts to be non-judgmental worth it. On the opinion questionnaire patients fill out as they leave the hospital, she wrote a note and thanked me for my efforts to meet her needs.
"We will have to operate." Because of the stress involved with surgery, we each hope to never hear these words. While often a new experience, surgery can have life-threatening complications. All surgical patients give up their autonomy to the power and expertise of those taking care of them, in hopes that the interventions will improve their physical well-being. A nurse’s role as an advocate and comforter has the power to transform a patient's surgical experience.

I have had the opportunity to provide this transforming care as a nursing student. It was a Friday morning in a large hospital in a metropolitan area where I was spending time learning about peri-operative nursing. I walked into Carl’s room to meet him before he went off to surgery for a total knee replacement. Cortisol levels in the room soared as Carl sat alone waiting to be taken to the OR suites. Sensing his tension, I found a chair near his bed and allowed him to express the anxiety he was feeling about surgery. Most importantly, our conversation revealed he was legally blind and deaf without the use of glasses and a hearing aid. A nurse had just been in the room to tell Carl he could not take any personal items, including his glasses and hearing aid, to surgery. Fear of the unknown became unbearable, as he thought about the absence of senses which could aid him through the process. I told him I would see what I could do.

I asked a nurse if they could make an exception for his case, but she said hospital policy was hospital policy and they did not want to risk him losing those expensive items. I returned towards his room, hoping my stride would spark an idea as to how to solve this problem. I picked up my pace as I saw his bed being wheeled down the hall towards the waiting area just outside the OR suites. As I approached his bed a nurse practitioner had just started pre-operative teaching to Carl, who was now "policy" directed blind and deaf. After watching the communication standstill for a moment, I interceded, telling the nurse the reason her teaching did not seem to be going very well. Then an idea came: "I know that they do not want patients to lose personal items by taking them with them to the OR, but what if I followed this patient through surgery to the recovery room making sure these items are accounted for?"
Recognizing that the lack of sight and sound compromised Carl’s ability to understand what she was telling him, the nurse practitioner said it was an excellent idea. I ran back to his room and grabbed his glasses and hearing aid, eager to help Carl know what was going on. As I placed the glasses and hearing aid on Carl, he grinned at me. That grin was the permission I needed from Carl to be able to follow him to surgery. Carl received the information about the imminent procedure from the nurse practitioner with ears open to her instruction and we waited for the operation to begin. Instead of lying in this unknown environment in confusion and fear, Carl spent his time holding my hand, telling me about his family and his hopes of having a functional knee again.

In recovery, he reached out his hand to hold mine while I sat in a chair at his side. Not only was he reassured by my touch, but also he could see my face smiling at him and hear my voice speak words of comfort. He expressed to me that he had never met a nicer nurse in his life.

At that moment, I got my first glimpse of why I wanted to become a nurse: to become as our Healer, Comforter, and Advocate, Jesus Christ. "And there were great and marvelous works wrought by the disciples of Jesus, insomuch that they did heal the sick... cause the lame to walk, and the blind to receive their sight, and the deaf to hear... And in nothing did they work miracles save it were in the name of Jesus." (Book of Mormon, 1991, Fourth Nephi 1:5)

I became a nurse to become a disciple of my Savior Jesus Christ. That day, the Savior gave knowledge to a surgeon to heal Carl’s knee to allow him to walk again. The Savior also allowed me to be an instrument to cure Carl’s eyes and ears, and comfort his fearful heart. That day I learned one of the most important lessons of my nursing career: the Lord is the source of my service as a nurse and his power enables me to perform miracles in nursing His children. As I envision His healing power and listen to the whispering of His voice. I will continue to perform miracles as a nursing disciple.
I was very anxious to attend clinical once I had started the labor and delivery rotation. I knew I had a passion for women’s health and was looking forward to this rotation for some time. Childbirth is such a miraculous, spiritual event that I wanted to be a part of it. However, I had no idea I could benefit a patient so much during the labor process as I did this one patient.

On my second day of clinical in the labor/delivery unit I chose to work with a 21-year-old woman who was in labor with her first child. I entered the patient’s room with the nurse and introduced myself as a BYU nursing student who was there to help her. She smiled in return and introduced herself as Mandy. Mandy was an attractive young woman with blond hair and bright blue eyes. As we were conversing with each other, she would cordially smile and answer my questions with brief responses. Everything seemed fine on the surface, but behind those blue eyes I could sense anxiety and fear. She had no support person with her. When we asked Mandy if anybody would be coming, she quietly shook her head and said that the father of the baby was out of town on business and that she had no family nearby. I assured her I would be there to help her in any way she needed. She looked up and thanked me as I walked out of the room.

As I left the room I thought about how difficult her situation was. She was an unmarried, soon-to-be single mom with no support person for the overwhelming laboring process. I deeply sympathized and had a strong desire to know more about her. Although she did not seem to open up to me too much earlier, I felt I needed to return to her room. Perhaps, I thought, by taking the time to talk with Mandy I could gain her confidence and trust so she would not be afraid to open up. I thought by having her express her feelings, she might be able to relieve some of her anxiety.

After heeding the feelings I had, I returned to the patient’s room to try to get to know her better. She told me about her family and where she grew up. I told her about my family and my experiences at BYU. Mandy was also a college student in Elementary Education. She professed her love for children, but never imagined she would be in the situation she was now: pregnant and single. Knowing that I was a Latter-day Saint and a BYU student, she held me in certain esteem, knowing I
held certain standards. I remember Mandy telling me what I must be thinking, since she was a young, unmarried soon-to-be mother. I told her I would never judge someone like that. She looked at my name tag with BYU written on it and said, “I bet you do not find too many girls like me at your school.” Mandy then told me she used to be a member of the Church of Jesus Christ of Latter-day Saints. Although she was active growing up, she later fell under temptation and slowly became inactive during her early college years.

Mandy then told me the story of how she fell in love with the father of the baby. She met him her sophomore year of college, describing it as love at first sight. They were inseparable from that point on. The couple began to have intimate relations and she later found out she was pregnant. Although she was very frightened at first, she was confident her boyfriend would support her. However, when she told him about the pregnancy, he wanted her to have an abortion. But in her mind, that was not an option, so she decided to raise the baby on her own. Her boyfriend broke up with her shortly after, and she was forced to endure the hardships of pregnancy by herself.

Mandy asked me if I thought she was doing the right thing, keeping the baby and deciding to raise it as a single parent, rather than putting it up for adoption. I pondered how to answer that question. I told her only she could answer that question. I told her she could answer that question. Tears welled up in her eyes as she wondered how she could have gotten herself into this situation and strayed so far from the strong religious beliefs she had growing up. Mandy doubted God could still love her after the things she had done.

I will never forget telling her, “Heavenly Father will always love you, regardless of the mistakes you have made. Nobody is perfect. It does not matter if you do not believe in Him or have lost faith or hope; He still loves you because He believes in you and will love you until the end.” Tears streamed down her face as I spoke those words of comfort. She seemed as if she had been waiting for such a long time for someone to tell her that. I felt the impression to ask her if she wanted me to say a prayer with her. She said, “Yes”, and I began to pray that she would be comforted, and despite the decisions she made, would know God always loved her. I also prayed she would find the strength to make it through the labor and be able to deliver a healthy baby. I felt the spirit strongly after that prayer and knew she had been comforted. I had such a feeling of peace, knowing she was able to confide in me and find someone to console her during this experience.
Mandy’s labor began to progress and it was soon time for delivery. Although the epidural helped with the pain, she spent a significant amount of time pushing the baby out. I tried to do everything I could to help ease her discomfort, such as placing a cool washcloth on her forehead and rubbing her back. As Mandy prepared for her last big push, she took a big breath in and pushed as hard as she could, delivering a healthy baby girl. Tears streamed down her face after the miracle of life had occurred. The beautiful baby was placed on her stomach and she was able to embrace the infant for the first time. She immediately fell in love with the baby girl as witnessed by the glow on her face.

During the recovery period, she took my hand and thanked me for everything I had done. She said she would never forget the way I helped her and that I was exactly what she needed. That night after clinical, I got on my knees and thanked God for the experience I had and the impact I was able to make on this woman. I asked the Lord to bless this new mother and the baby, so she would be able to raise the child well and know she was loved.

I knew from this experience the impact nurses can have with people during life-changing experiences, from the patient fighting for life to a new baby being born. Despite the occasional frustrations nurses encounter, experiences like this make nursing unique and wonderful. Often during life-altering experiences, patients and their loved ones need a shoulder to cry on or someone to comfort them. It is important for them to know support is there.
As I entered the hospital for my second ICU clinical, I was expecting a normal, uneventful day. My patient, who was in a coma took little care, so I helped my nurse with her other patient, a 25 year old male. He had been in a car accident and was now a quadriplegic.

I was not sure what to expect from this patient because I had never taken care of a quadriplegic before. The nurses had been talking about how quadriplegics were the worst patients, especially when they learned how to “click” their teeth to draw attention. When we went in for our morning assessment, I was amazed at how young this patient looked. I realized he was only a few years older than I and would be paralyzed for the rest of his life. He would have to have someone take care of him his whole life. He was single, and now would probably never marry. My heart was saddened with the thoughts of his future and I admired his will to live.

I helped with his care throughout the morning. After the nurse and I were almost caught up and finally sat down, he started to click. My nurse started to grumble and complain about how he did not need anything, and that he was so demanding. Since I was not doing anything, I volunteered to go check on him. Through some careful lip reading, I found out he was hot (he had a fever all day) and wanted some cold water on his head. My heart swelled with sympathy as I realized he couldn’t even scratch his nose or put a washcloth on his head by himself. His request was small, but I wanted to make him comfortable, so for about 20 minutes, I sponged his head with cool water, washed his face, and dampened his hair. His eyes rolled back as he enjoyed the cooling sensation of the water. I talked as I worked and it was amazing the information I learned about him, even though he had a tracheotomy.

The more I served him, the more I loved him and wanted to help him. When other people would do treatments for him, I made sure I was there and they were careful and gentle. There was a connection between us, I as the nurse, and he as the patient, because I spent the extra 20 minutes with him.

It turned out to be a wonderful, yet hard and challenging day. I learned a lot about myself and about true nursing. When I started the day, nursing was just a matter of giving a bed bath, administering medications, and assessing. But as I left, nursing was caring. Caring to spend an extra minute to straighten the sheets, so he would not have to
lie on a wrinkle; caring to make sure he was comfortable before I left the room; and caring to make a difference, however small in this man’s life.

As I look back on my nursing experiences, it is the time where I connected with patients and cared for their needs that I remember. I don’t remember when I placed my first catheter, or started my first IV, but I remember those with whom I spent time, nursing their physical and spiritual health. As nurses become busier, I hope I will still be able to feel that connection with patients and be what everyone imagines a nurse to be: caring.
Nursing education teaches us the ideal approach to nursing care, which is to look at the whole person rather than isolated body parts. However, in the real world of ever-present staffing shortages, we rarely have the opportunity to look beyond obvious needs. This frequently produces a conflict between the quality of care we desire to give and what we can practically provide.

I have repeatedly experienced this frustration for 36 years, until an incident two years ago gave me a glimpse of what the ideal nursing care model could feel like. I am an Occupational Health Nurse for a large Fortune 500 Company involved in manufacturing. In this capacity, I have the opportunity to get involved with several aspects of an employee’s life while administering programs such as medical leave, ADA, FMLA, and acute care. This seemed like an expanded scope of nursing until my experience with Erik.

During his vacation Erik became a victim of domestic violence which left his spouse dead and him seriously wounded with a gunshot wound to his neck and shoulder. His immediate injuries were treated in the ER, and he was admitted to a local hospital. His manager notified our office the next morning, obviously concerned about his employee and how to handle the situation.

Within 36 hours of the incident, our Employee Assistance Program representative, Emily, and I made a visit to the hospital, finding Erik in stable physical condition but severely depressed. His sister, who lived in South America, was with him and understandably anxious. While Emily assessed Erik’s mental/emotional status, I met with the patient care coordinator to evaluate his prognosis and treatment plan. Several gaps were found: 1) no antibiotics had been ordered; 2) no psychiatric consult had been ordered; 3) no plan for wound care at home existed, and 4) his surgeon saw no need for physical therapy upon discharge. The hospital was surprised but grateful for our intervention, and all four issues were quickly resolved.

Over the course of several weeks we continued to visit Erik at home, each time re-assessing his needs from every angle we could think of. Together we:

$ Assisted him in finding temporary living quarters away from the crime scene
Repeatedly reassured him he still had a job to return to
Assisted him in changing health insurance plans to provide best treatment
Acquired the services of a trauma specialist and added him to the treatment plan
Monitored wound care, range of motion, and quality of care
Reinforced home exercise program and self-care skills
Coordinated care with all medical providers
Assisted with required documents for life insurance, burial, etc.
Assisted his department manager in debriefing co-workers to dispel rumors and increase appropriate support groups at work
Met with his family to answer their concerns and provide support for their emotional needs
Designed a graduated Return to Work plan
Accompanied him on his first day back to work
Provided a quiet, private area for temporary rest periods while he integrated back into his department

Erik’s experience injured his entire being. It left him physically, mentally, emotionally, spiritually, culturally and socially damaged as well as completely vulnerable. Being an integral part of his recovery provided the unique blessing of perspective. I was privileged to observe his healing process, not just his shoulder and neck, but his mind, emotions, personality, and spirit.

Participating in any aspect of healing is a humbling, awe-inspiring experience. To be a part of Erik’s life for a short time was a once-in-a-lifetime event that will forever renew my delight in nursing. What greater joy can we receive in this life than to gently touch, and sometimes help heal, the body and soul of a kindred spirit?
In the field of nursing, we talk a lot about the holistic approach to providing care for our patients. We focus on the importance of accepting people for who they are, and to respect their differences whether they are cultural, religious, or behavioral in nature. All this talk finally became a reality for me through an experience I encountered during Capstone when I cared for a 20-year-old patient whom I will call Jared.

Jared had suffered major injuries from a motor vehicle accident. I received him to the ortho/neuro floor after he spent a week in the ICU following emergency abdominal surgery as a result of an internal bleed. Additionally, he sustained two dislocated knees, but nothing had been done to fix his orthopedic injuries, because his hematocrit was 17, placing him at high risk for surgical complications, or even death. Because my patient was of the Jehovah's Witness faith, he would not accept blood products, so he was assigned to my floor to "wait" for his hematocrit to climb to at least 25. At that time, he would undergo surgery again.

Day after day, Jared waited, hoping to see improvement in his hematocrit. But he gradually faced discouragement as little progress was made. By the end of the second week on our floor, the nursing and medical staff was starting to question if he would ever get the chance for surgery. They in fact, started to harass his decision to refuse blood products. Over time, they became less supportive and sympathetic. People just couldn't understand (nor did they want to try) why this young man wouldn't accept a treatment that would shorten his road to recovery.

The family was from the Salt Lake area and desired to transfer back home, or to a facility closer to their home, until he was stable for surgery. Emotions and opinions quickly intensified during the process of trying to find a surgeon in their area who would accept this condition and grant his desires. He was turned down again and again. No one wanted to be responsible for such a complicated case.

As all the members of the interdisciplinary team were wrapped up in solving the discharge dilemma and related details, I sensed the need to be with Jared and provide support while he processed the situation. When I took in his meal tray that afternoon, I mentioned to him that I
wanted to learn and understand more about his belief to refuse blood products.

After feeling somewhat lost in the runaround to solve his situation, he first expressed thanks to me for showing interest in him and his condition. He mentioned that not one person had tried to understand his background or even try to validate his belief system. He then proceeded to explain to me the history of his religion, giving scriptural accounts and spiritual examples. I actually don't really remember much about the details of his religion; however, I do know that what he expressed to me had deep value for him. I began to develop a great respect for his values, knowing for myself how important my belief system is to me. Our conversation continued for a while, and then I was pulled from his room to carry on with the routine on the floor.

When everything was finally arranged for his discharge, he expressed to me again the difference I had made by just listening and trying to understand him. As a nursing student, I wasn't in a position to call and arrange a care provider for him in Salt Lake, but I was able to soften the tension. This experience truly taught me the value of The Healer’s Art. Nursing is a field where human diversity is exposed in its truest form. To provide quality patient care, a nurse must create the opportunity to understand human diversity. Each individual has a need for custom-care. I hope I was able to meet Jared's need. This experience will forever remind me of the importance of respecting the differences among Heavenly Father's children.
An Act of Love
Laura Linton

In my last semester in nursing school, my rotation was in labor and delivery. I was assigned to a hospital that worked with an adoption agency for girls from another state. I went to clinical on Monday and during report, the night nurse told us about one of the girls in labor. At the age of seventeen, Michelle conceived through an assault from her father, who was divorced from her mother.

Michelle did not communicate much with the nurses or her family. The night nurse suggested we care for her one-on-one so she could receive better attention and care. During the day we found out a little bit more about the family. Michelle discovered she was pregnant when she started to feel the baby move (about four months). She tried to find out if she could have an abortion but it was too late. Michelle finally told her mother at eight months. They found out about the adoption agency that sends girls to Utah, because the adoptive parents live throughout Utah. Michelle and her mother decided that was the best thing to do, so they came to Utah for the delivery, even though the mother lost her job.

Throughout the day, the mother would talk with us, yet Michelle would only say a few words. One time I went in to check on her alone, without my nurse or the girl's mother. I started joking around and tried to see how she was really doing. After a couple of minutes Michelle started to smile and glanced at me for a second. Then a little while later she kind of laughed, made eye contact, and actually had a pleasant facial expression. Throughout the day she grew to be more comfortable with me and told me how she was feeling. She was very scared. She was in a lot of pain, not only physical, but emotional. She said that she did not want to hold the baby after the birth, but did want to see the baby. She did not want to remember this as her first child. She wanted to have a family right; not the way this baby had been conceived. She had a stack of letters from possible parents sitting on her bed table. We all looked through them to see if we could pick out the perfect parents for the baby. She decided on one family if it was a girl and another one if it was a boy.

That afternoon Michelle delivered a very healthy, beautiful baby boy. He was perfect in every way. It was hard to believe what his mother had gone through to have him. We showed her the baby, asked again if she wanted to hold him. "No," she said, so we took him to the nursery.
The next day I came back for clinical and was assigned to the post partum side. In report, we found out Michelle wanted to have the baby in her room during the night and then decided to keep him. She was sobbing all night and not verbally communicating with the nurses. Everyone was worried because the family did not have a place to live. (They had been staying in shelters for the last month.) Neither Michelle or her mother had a job or any money, and they had no place to go. They would have to reimburse the adoption agency for all the services the agency had already provided and try and find a place to go after leaving the hospital. Also, Michelle was not emotionally prepared for such a huge responsibility, especially knowing how she conceived the child. She asked to talk to a counselor to try and work things out.

Because of the time I spent with Michelle the day before and the rapport we had developed, the other nurses wanted me to care for her. I went in to find out how she was doing. Her mother was excited to see me, but Michelle wouldn't look at me and didn't really answer my questions. Her mother said she had never been the type to talk to anyone, and was quiet about her feelings and the issues she was dealing with.

I went back in a little bit later, sat on Michelle’s bed, put my hand on hers, and said, "I heard that you had a rough night. What happened?" The tears started pouring down her face. I held her hand more tightly, waiting a moment, until I said softly, "Do you want to keep your baby?" The tears came harder and she nodded and looked up at me and said, "Yes." "That must be so hard to carry a baby for nine months, see such a beautiful boy and then give him up," I replied. She nodded. "So what are you going to do?" I asked. She sat there for a moment, looked up at me again, and said, "I don't know."

"You must love him so much." "Yes," she said. I then talked with Michelle about what would happen if she kept the baby, where they would go, and what she would do. She knew the baby wouldn't have a good life, because she didn't even know where she was going. I shared an experience about a friend, Karen, who gave her baby up for adoption. Karen said it was the hardest thing that she had ever done. She held the baby for a couple hours, but in the end she gave the baby up. Karen said that she loved the baby so much that she did the best thing for the baby, which was the hardest for her. She gave the baby a wonderful family that promised to take care of her and love her for eternity.

Michelle looked up at me and said, "She did that?" "Yes, she did, and she did it out of love." I said, "If you give up this baby I know that you are doing it out of how much you love him. I do know it will be the
most painful thing you have had to do so far in your life." As she looked up at me, still with tears streaming down her face, I said, "And it is okay to cry; you need to grieve." She held my hand tightly and sighed. It was like she needed that permission to hurt.

We talked for a while longer, looked at the adoptive families again, and talked about what the baby needed. Throughout the next couple of hours, I spent as much time as I could with her. The hospital counselor and the adoption agency representative came and spoke to her.

That afternoon Michelle decided she would give the baby up for adoption. I was there as she signed the papers with tears dripping down her cheeks. I know it was difficult to come to that decision, and I know she will grieve. I know she will physically heal from giving birth to her baby, but I also know she will forever carry the memory of her first child. I hope the memory will not always be painful. Even though I didn't do much for her, she had someone to talk with. I gave her permission to hurt, which gave her a little bit of reassurance and strength. That day I had a taste of the art of healing by using the simple act of caring.
Chapter 3

My Brother’s Keeper

I would be my brother’s keeper;
I would learn the healer’s art.
To the wounded and the weary
I would show a gentle heart.
I would be my brother’s keeper;
   Lord, I would follow Thee

The Church of Jesus Christ of Latter-day Saints, Hymn 220, verse 3
Though I lack the physical healing powers of the Savior, I can follow His example in love and concern. His caring touch can become my caring touch, and His simple statement, "I will" the words of my own lips. Art, I believe, is the miraculous synthesis of passion and skill. Passion for the subject and skill born of years of tutelage has transformed roughly-hewn stone, paint, and ideas into the finest works of sculpture, painting, and literature. Likewise, the passionate love of mankind combined with the skills of the educated nurse produce the miracle of The Healer’s Art. Thus, following the Savior's example, nurses can move beyond the basics of treatment to true art, as they draw upon passion and skill to care for patients.

Entering the hospital room, I immediately sense a unique spirit. The husband smiles gingerly and pulls a chair across the floor for me. I sit comfortably, laughing with the couple, talking with the patient, and watching the various monitors. Though in active labor, the woman's cheerful demeanor is hardly indicative of the contractions building and releasing within her body, and I spend the next few hours enjoying conversation at her bedside.

As the next few hours pass, I begin to notice the increasing duration and intensity of her contractions. Though strong-willed and courageous, her face begins to stiffen, and I am able to sense an impending contraction before it appears on the monitor. Her breaths shorten and her speech diminishes as time passes. Though she does not complain or even grimace sharply, the slight changes in her demeanor reveal the mounting intensity of her contractions.

"Would you like to hold my hand?" I offer. Gratefully, she accepts, squeezing my fingers firmly as we breathe together throughout her contractions.

Finally, it is time to push, and the woman, her belly round and taut with pregnancy, winces with the pain of a mounting contraction. Her breath swirls through her nose and throat as she breathes rapidly through pursed lips. Though her whole body trembles during the minutes of waiting, with every contraction her frame becomes a solid, efficient wonder as she pushes the baby's head further down into her pelvis. Eyes clasped shut, cheeks flushed with determination, the woman's pain only
fuels her fortitude and sharpens her concentration. The pungent smell of amniotic fluid wafts through the thick air as I methodically count to ten. 1... 2... 3... 4... 5... 6... 7... 8... 9...10... A quick gasp for air and the woman bears down again as I count. Then again a third time. Finally the contraction subsides and the woman melts into the mattress, resting her exhausted limbs as she awaits the next contraction. The cool room air tickles the crown of the baby's head, and with the next contraction she will likely be born.

Again the pressure mounts, and the woman grasps my hand and begins to bear down with all her might. 1... 2... 3... 4... the infant's head is out... 5... 6... 7... 8... 9... happy birthday! Though coated in vernix and blood, the naked infant's body is beautiful. The floppy head with squinting eyes and a molded, conical skull is a masterpiece in human form. The shout of frightened, wet lungs rings through the air with a magical vibrancy only understood by those who have experienced birth.

As I warm and assess the infant, she starts to whimper softly. Not liking the hard plastic thermometer, she pouts her lower lip and cries mightily for her mother's warm, gentle arms. As I gently pat her back she calms for a moment, but resumes her cries as I place the stethoscope on the middle of her chest to listen to her rapid heartbeat. Patting her back again, I am able to soothe her just long enough to count her heart rate and respirations and to listen to the gurgles in her little tummy. I carefully inspect her ten tiny fingers and ten tiny toes, her glowing pale-pink skin, and her little flaring nostrils. Finishing the assessment, I wrap her tightly in warm blankets and hold her close to me. I brush the soft hair of her head with my fingers and speak to her calmly. As I look back at her inquisitive stare, I seem to find something beyond the natural appearance, beyond the tiny wrinkled nose and pink lips, beyond the body that fits easily in my arms. Maintaining my gaze on her wise eyes, I hand the little girl to her proud mother with a sincere congratulation.

Looking intently into my eyes, the woman says words of music to a student nurse's ears: "Thank you, Jacy. I'm so glad you were here." In a world where "student nurse" so often seems to conjure up reactions similar to "student driver," evoking expressions of deliberate hesitation and anxiety, a patient's gratitude for my simple presence is a gift beyond all others. Though my skills rudimentary and my offerings humble, I feel I have made a significant difference.

Though my experience is simple, I believe it is beautiful and
wonderful, precisely because of its simplicity. The humble, but sincere offerings nurses give to patients can have meaningful impacts. Though monitors, fluids, medications, and charts all press for the nurse's time and attention, easy interventions taking little time or effort, but requiring only a willing heart and genuine compassion, can make real differences for patients. By offering a hand to hold, whispering honest words of encouragement, and sitting by the bedside, I was able to show support for a patient in need. I believe the more nurses are willing to follow the Savior's example to say, "I will," the more we will make meaningful differences in patients' lives, with the simple reward of replies resounding, "I'm so glad you were here!" Thus, nurses will make important contributions in the lives of individuals and families as they combine sincere passion with patient care to create the masterpiece of The Healer's Art.
Being in the hospital can be a traumatic experience. The last thing patients want is to not be respected enough to be taken care of properly. Providing care was my goal in taking care of an elderly lady in the SICU. I had gotten plenty of sleep the night before and even said a prayer before entering the hospital doors to have help caring for this particular patient the very best I knew how. She had many tubes coming and going into her tiny, frail body. She was sedated and therefore could not speak or see, although she could hear me. As I began bathing and giving her oral care, I let her know what I was doing before I did it. I made sure I spoke to her in an adult manner and cleaned her skin carefully with warm, soapy water. I took care of her skin in places where breakdown was beginning, especially on her posterior side, and turned her every two hours.

The biggest aspect of caring I learned was that my own motivation and affect make all the difference, especially to those who are extremely sick. ICU patients need caring nurses badly. Having empathy and love for all are absolute qualities nurses need to possess when working in the ICU. Each little thing nurses do for patients, even down to dimming the lights or providing a blanket can touch the heart and soul of a patient.

As I did my best to give 100% care to my patient in the SICU, I knew she was grateful. Her heartbeat slowed down and as I talked with her and held her hand, she became calmer and less agitated. Nurses do have the ability to provide the utmost care; they need to have the desire to want to heal their patients and do all within their reach to care for them the best way they know how.

Learning The Healer’s Art is not something that comes in one day of experiences. It encompasses much hard work and determination over a period of time in acquiring the knowledge and feeling needed to care and teach patients about health care issues that are most vital. What a blessing it is to be able to work with so many different types of people from all different backgrounds! What a blessing nurses have in caring for the most sick, those patients who need a caring person to love them and give them the support they richly deserve! Throughout my nursing
experiences, especially working with those within the ICU, I have learned an incredible amount of material about nursing as well as about myself and about how to obtain my full potential as a successful nurse. It has been reinforced to me that everyone is a child of God; He loves each of us and blesses all people with different gifts to share with one another in order to better ourselves as individuals. Throughout my continued learning experiences, I know I will ultimately learn nursing is not just learning now, and then using only that information in practice. It’s more than that! Nursing is a continuous process of lifelong learning and service to others that I am truly excited to begin. Nursing is truly The Healer’s Art!
Putting the Caring into Nursing
Angela K. Leach

What is nursing? Is it just following the doctor’s orders? Sad to say, but that was the idea I had when I began nursing school. I thought nurses were there to give medications and hygiene care. I assumed that would be enough to help patients attain health, which I thought was the overall goal. How little I knew! Yes, helping people return to a state of health is our goal. However, being physically well makes up only a part of being healthy.

We cannot expect our patients to attain complete health if we focus only on their physical needs. As nurses, we need to care for our patients and not just treat their illnesses. In order to help patients attain health, we need to understand what is perceived as caring behaviors and the impact those caring behaviors have on patients.

I learned the importance of caring for the emotional and social health of patients during my first semester of nursing school. During the last week of my post-operative rotation, I had the opportunity of caring for a patient whose name described her perfectly—Joy. Joy was in the hospital because she had difficulty breathing. The doctors were trying to find out the cause, but at the time I was caring for Joy, they had not yet figured it out. As far as treatment goes, there was not much we could do for Joy. We were giving her various medications for heart problems, etcetera, but we could not yet work on the cause of her illness. The “treatment” I was able to give to her, though, was to lend her a listening ear.

A woman in her early 80s, Joy had a life’s worth of stories and advice to tell. However, Joy had no family or friends there to share her thoughts with. They were not able to visit her during the time I was there. That morning, I took every opportunity to go into her room and talk to her. We clicked with each other, and were able to share things about ourselves with each other. We had fun and we laughed. At one point during our conversation she said, “You are such a good nurse. You are so much more thorough than the others.” I would not say her other nurses were neglecting her. They were giving her very good care, as far as I could tell. As a new student nurse, I just wanted to make sure I was doing things correctly. Also, I had only two patients to care for, while
the registered nurses had four or five patients each. However, her statement made me feel good. As a nurse, I want my patients to feel they are getting the care they need and deserve.

I really did not realize the impact of the “care” I was giving to this patient just by talking to her until she said to me, “Thank you so much. You have made my stay here not only bearable, but enjoyable, too.” She then asked me if we could keep in touch, so we exchanged addresses. I may not have been fully able to treat Joy’s illness, but I was able to care for her as a person, thus helping her attain a higher degree of mental and social well-being.

Interacting with patients on a personal level seems like such a simple thing, and yet it can make a difference in the quality of care patients feel they receive. In order to make a patient’s hospital experience better, nurses need to understand what patients’ definition of caring is. Nursing care is more than just caring for the physical needs of patients. Social and emotional care also contribute to the overall health of patients. This can be accomplished by simply taking the time to talk to and get to know a patient.
Mr. P was a 70 year old Veteran of World War II. He came to our hospital in need of treatment for recently diagnosed cancer of the esophagus. After discussion with the family and physicians, the decision was made to take the patient to surgery to complete an esophagogastrectomy. Upon completion of his surgery, Mr. P returned to the Surgical Intensive Care Unit (SICU) for his post-operative care. Mr. P’s wife and children spent many hours at his bedside, holding hands, praying, and offering words of encouragement to their recovering husband and father. Joy and smiles were seen when they witnessed his seemingly uneventful wakening from anesthesia and recovery in those first few days following surgery. Mr. P was a delightful and pleasant individual who reciprocated his love for his family and shared his appreciation for their support on his behalf.

Mr. P’s condition held steady for little less than a week in the SICU, when the discovery was made that Mr. P was not tolerating his tube feedings well. He complained of nausea and vomiting, abdominal pain, and just not feeling well. The decision was made to discontinue his tube feedings and begin total parenteral nutrition through his intravenous (IV) catheter. After a week’s trial of this and other treatments, Mr. P’s condition worsened. The family shared a great deal of concern with the physician and staff, as they worried about his unusual behavior of not being so cheerful and happy.

During those couple of weeks caring for Mr. P and his family, I, as his primary nurse, became very emotionally attached to them. I found myself spending more and more time in the room at the patient’s bedside, trying to do everything possible. I found my efforts were not achieving the outcomes of getting Mr. P over his illness and on to recovery. The family and I began questioning the seriousness of Mr. P’s lack of improvement. The concerns were relayed to the surgical team, followed by a lengthy discussion with the family on the best treatment to pursue next. A decision was made to take Mr. P back to surgery to explore the possible causes of his pain and lack of improvement.

In surgery, the surgeons discovered that Mr. P had a new problem, coupled with his battle with cancer. The tissue around the
operative sight had eroded, causing the tissue to tear, with his tube feedings leaking into the surrounding area. With such fragile tissue, the possibility of being able to secure that tissue closed was questionable. In addition, his primary esophageal cancer had metastasized. Mr. P’s surgery was completed, unsuccessfully, and he was returned to his SICU room.

The surgical team presented the findings to the family, with the outlook of an estimated one week survival for Mr. P. The shock of the news saddened the family. The rest of that day was spent grieving and trying to accept the facts that had been presented. The family returned home that evening to consider their options with Mr. P’s care.

Upon the family’s return to the hospital the next day, they presented me with their proposal. They wanted to take Mr. P home, so that his wish of dying at home in his environment could be accomplished. My immediate reaction was one of, “We can’t do that, that’s never been done before. He needs us to take care of him.” I couldn’t see past his need for dressing changes, pain medication, oxygen, a hospital bed, etcetera.

Over the following hour or so, I thought intently about the family’s request. I started questioning my response to them. Why couldn’t they take him home? Why couldn’t we teach the family the necessary tasks to care for him at home? Just because it had never been done before, was this enough reason not even to try? If this were my spouse or father, would I want his wish granted? I became convinced this was not an impossible task. We were going to get Mr. P. home!

The wheels started spinning. I shared my desire with the family of wanting to honor their wish. I told them of our slim odds of being able to accomplish this, but we were at least willing to give it our best shot. The first hurdle was to get the surgical team to agree. After a phone call to them and their visit to the room within a short time, permission was granted to start the process as soon as possible. Orders were written to the effect, with the next couple hours spent arranging for necessary items to complete this mission. In coordination with home health, a hospital bed, wound dressing supplies, morphine, oxygen, as well as many other things, were scheduled to be delivered to the home the next morning. Since time was of the essence, transportation was arranged to take him home at the beginning of the next day. The final few hours of that day were spent teaching his wife and children the tasks...
of dressing changes, medication, oxygen administration, etc.

The next morning arrived and I was excited for the day. I arrived before the family, visited with Mr. P, and shared with him the excitement the day would bring for him and his family. With limited energy, he continued to smile throughout our conversation. His dream was to come true. I hastily made a sign to put around his neck as his family arrived which read, “PLEASE TAKE ME HOME!”

The memory of that moment when the family entered the room that morning, prepared to take their loved one home, will forever be imprinted on my mind. In spite of the tragic circumstances surrounding this situation, I will never forget the look on their faces of love, appreciation, and joy. The emotions shared were not of sadness, but happiness. This good and kind gentleman, was now free to go home and die with dignity and peace, with his loving family surrounding him.

Word came from the family that Mr. P died on the third day after returning home, with a smile on his face and his entire family surrounding his bed. The lessons I learned were invaluable. Things could be accomplished that hadn’t been done before. I learned the power of dedication and emotional and spiritual strength at times of adversity. I will never be the same, nor will I ever approach a patient in the same manner as I did before caring for Mr. P.
Nursing Support for the Patient in Labor & Childbirth
Olivia Miner

Imagine doing something strenuous, demanding, and emotionally draining all alone. Generally this is unimaginable. Labor and childbirth is one such activity. The demands of labor and childbirth are extremely intense on the body. Any support is helpful and nurses can be a support to the mothers. Nursing is caring and serving. Research indicates that the amount of labor support a woman receives directly affects outcomes and satisfactions of the child birthing experience. As I witnessed laboring women in Central America at the community public hospital, I felt the need for nurses to give more support so these unmedicated women would experience better outcomes and perceive less pain.

I studied for a month with a group from Brigham Young University in Guatemala City where I spent time observing in a labor and delivery unit in a public government hospital. Their organization and health system was quite different from the United States. No visitors, including husbands and close relatives, were allowed in either the labor or delivery rooms. All women labored alone. The only source of support patients could draw upon were the other five women who also were experiencing labor beside them.

You may ask, where were the nurses? Administrative responsibilities pull the professional nurse away from the bedside. The nurse’s aids or auxiliary nurses are required to administer medications and carry out basic cares and treatments. They are not trained to give labor support. Meanwhile, the residents who take care of all the deliveries and Cesarean births in the unit perform their duties without showing care or concern for any patient. Their work becomes automatic in nature. The few days I spent in the unit were rewarding since I was able to support laboring women through pain.

The first day in the unit, I gave labor support to a young primagravida who was experiencing extreme back pain (back labor). In addition to the back labor, she was laying on a thin mattress that did not fit the metal bed frame. Just by observing, one could see this young woman was very uncomfortable. She was experiencing labor, unmedicated. The only time pain relief (local anesthetic) was
administered was prior to an episiotomy, if time permitted. In addition to no administration of analgesics or anesthetic, patients were not allowed to ambulate or stand due to limited space in the unit. To help ease this patient’s pain during contractions, I assisted her in turning to her left side and applied pressure to her lower back with the heel of my hand. The young woman was very appreciative.

Throughout the late morning and early afternoon I gave this woman back rubs, wiped her forehead with a wetted cotton ball, and worked with her on taking deep breaths during contractions. Even with the lack of Spanish fluency, I was able to encourage and communicate that I cared. Unfortunately, I could not stay all day. I had to leave while she was yet laboring. I returned with my group the following day and saw this young mother in the postpartum unit. She had delivered through the night around 11 o’clock, requiring a Cesarean. She was extremely proud of her baby boy. When I saw her, she smiled. I felt rewarded for the act of service I performed. In the small amount of time I spent with this young woman, I felt like I extended a hand of service. I was helping someone in need.
A Mother's Love: The Healing Touch
H. J. Van Dam

My dad was diagnosed with cancer at the beginning of my senior year in high school. He died of gastric cancer two months before my high school graduation. It was because of this experience that I chose to become a nurse. I wanted to help people in need as the nurses did for our family during that hard time. Trul y unbeknownst to my family and me, this was not going to be our only time to face this dreaded situation.

At the beginning of June 2002, I found out that my only sibling, my sister, was diagnosed with gastric cancer. It was devastating to hear. Our whole family was and is often still in shock. My sister, Mun, went into the hospital on the 17th of June. On the 20th, my husband, daughter, and I flew out to Virginia to be with her. I went to help my mother take care of her as long as I could. I had no idea that the greatest lesson of the "Healer's Art" would come from my experience with my own family.

My mother and I took turns spending the days and nights with Mun in the hospital. It was often frustrating not being able to help ease Mun's pain, nausea, and suffering. Coming from a nursing background, I really wanted to be of more help. However, all I could do was be there for my sister and do what my mom had already been doing. I truly feel it was my mother's healing touch that helped when nothing else could. It was during these times that I learned the most about the "healer's art."

Tears came to my eyes the first time I saw my mother wash and massage Mun's feet. She took so much time and care as she wiggled each toe, flexed the feet, and cleaned them. It truly reminded me of the Savior when he washed his disciples' feet. My mother continued to help the healing process by wiping Mun's brows as the sweat from pain appeared. Mom made sure that Mun's sheets were always straightened and the pillows fluffed. She lovingly brushed what was left of Mun's once dark and thick hair and applied moisturizer to Mun's lips to help with the dryness, cracking, and bleeding. Day after day, Mom did all of these actions and more, not because she had to, but because she loved Mun, even to the sacrifice of her own comforts and need, she wanted to ease Mun's sufferings.

The love of a mother for her child was evident in the care my mother gave my sister. This love reminded me of the love our Savior and Heavenly Father have for each of us. Even though my mom had no
medical or nursing experience, she helped take care of my sister in ways that helped my sister heal.

Through my mother's example, I saw the impact I can have as a nurse. While I was with my sister I did what I had seen my mother do. This made a difference for Mun. I always want to make such a difference as a nurse. I know as a nurse I will always do what is medically necessary to help a patient in need, but the care my mom exemplified is what I want to do as a nurse, because I care. I want to show each patient the love our Father in Heaven has for each of his children by taking care of them the way our Savior would. Through this experience I saw the difference comfort measures can provide. Not every patient will have a loved one who is able and willing to help with such comfort measures. Thus, I can make a difference in each of my patient's lives, as I strive to do as my mom did with my sister; to offer the healing touch that medicine cannot provide.
As a new nurse, I started working in a long term care center, which can be very challenging. Often times I would start working the minute I got there and continue working the eight hour shift until the end, without any breaks. Patient numbers were always high. Most of the time I had twenty to fifty patients at a time. This left very little time for the individual patient care and attention many of these residents needed. There is one particular resident who has stood out as I have considered this. I will call her Ruth.

During the later part of Ruth's life, she had several battles with cancer. Until the last few months of her life, she had won those battles. Finally the cancer-fighting drugs seemed to work no longer. She lost an unbelievable amount of weight as the cancer started to spread. She also lost nearly all of her ability to function. Eventually all of her ADLs (activities of daily living) were done by nurses and CNAs.

Her physical condition made it very uncomfortable for her to remain in the same position for extended periods of time. She would ask for help with positioning each time someone entered the room. Many of the facility staff became very impatient with her, especially when she requested help only minutes after receiving it. Often CNAs complained about having to work with Ruth because of her constant requests for attention.

I felt a lot of compassion for Ruth, since I lost a close relative to cancer. As I watched the effects of cancer in Ruth, I remembered the discomfort my relative had gone through. I decided that whenever possible, I would take the time to help Ruth reposition and get more comfortable. Each time I would do so, she would take my hand and offer a sincere, heartfelt thank you. At the time I did not consider the significance of those expressions of gratitude.

Her husband died many years earlier, leaving her with two young sons to raise on her own. She worked hard to raise and provide for her children. She remained spiritually strong all of her life and taught her sons to follow her example. Now, this strong, independent woman was not able to do anything for herself. I tried to imagine what it would be like to have been active and independent all of my life and now unable to
do anything for myself. I tried to imagine the frustration she must have felt because of her helplessness.

In her final days, she was hardly able to swallow. We struggled to get her to eat or drink anything. Her doctor stopped her regular medications and ordered medication only for comfort measures.

The night before she died was very busy. I went to her room and tried to help her drink a small amount of supplement. I worked with her for a few minutes and then repositioned her. Just as I was about to leave she took my hand and kissed it, looked into my eyes and offered the most sincere thank you I have ever heard in my life. I bent down and told her what a great person she was and that she had led a great life. Somehow I knew that this would be the last time I would see Ruth alive, and I believe she knew it too.

There were never any heroics in my actions. In the end, it was a little bit of extra time that mattered. Though I often spent only moments with her, those moments not only increased her comfort but showed her that someone cared. Let us, as nurses, never forget that it is often effort outside what is "expected" that matters to our patients.
Working in the Operating Room at Fairfax Hospital in Northern Virginia was an opportunity for never having a dull moment. Fairfax Hospital is just blocks off the western end of the Washington D.C. Beltway on the Virginia side. Each day brought new challenges, and we had to be ready for anything.

I was working as the Assistant Head Nurse in charge of the Operating Room from 4:00 pm until midnight every day. One Sunday afternoon I got a call from the delivery room telling me that they had a very serious situation. A mother who had just delivered was hemorrhaging and they were unable to control it….did we have an operating room available? We had 4 rooms running, and that was the maximum we could run that afternoon. I told them I would call them right back. I talked with Anesthesia, and we decided that I could scrub the case, and we would pull a circulator from a case that would be finishing within the hour, to circulate for me IF Delivery would send an RN down to circulate in the ‘easy’ room. Arrangements were made with the Critical Care Supervisor to ‘Man the OR Desk’, and the go-ahead was given for the case to proceed.

I rushed to pull the case, scrub, and set up the room. While I was busy, the doctors brought the anesthetized patient into the room, prepped her for abdominal surgery, and I put all the drapes on a draping table and told them they were on their own, as I was still opening instruments and setting up the Mayo. By the time I brought my Mayo to the field, I had gowned and gloved a doctor and two residents, and the patient was fully draped and ready to go.

The case was truly a “serious situation”. This was in the days before the ‘Bovie’, and we clamped and tied each bleeder. Every time a bleeder was clamped, the clamp acted as though it was a hot knife going through butter. We changed to trying to use a needle and just tie off the bleeders. This didn’t work any better. We packed her abdomen and waited to see if the bleeders would clot off. This was not successful. The situation was getting desperate.

I was feeling heartsick at our seemingly helpless situation. I knew this particular doctor was not one that any of us would refer
anyone to, and I knew we needed help. I felt like the patient was “my sister”, and I could feel the tears beginning to sting my eyes. I was the charge nurse, and I was scrubbed in the case and unable to call for anyone to come to help us. While we were waiting to see if packing the abdomen was going to be successful, I turned to my back table, closed my eyes and pleaded with Heavenly Father to please send someone quickly, as this new mother needed more help than this physician was able to give her.

About 10 minutes later the door to the operating room opened slightly and the Chief of OB/Gyn peeked inside. He said he’d been out on a Sunday drive with his boys, and he felt like he needed to stop in at the hospital to see how everything was going. The doctor who was operating explained the situation, but said he thought he had everything under control. The Chief asked if he thought he could use another hand, to which the doctor said, “No!” I was shocked, and I looked at the Chief and said, “I have an extra gown here, what size gloves do you wear????” (He later told me the look in my eyes told him he’d better start scrubbing STAT!)

We worked for 3 more hours, with the Chief eventually taking over the case. The patient was saved, and my grateful heart said several prayers of thanksgiving while we were working.

As we were finishing the case, the doctor said that he was so happy that we had been able to save her. She was a Mormon woman and this was her 8th child. I said to him, “Will you tell her that I am also a Mormon, and I was her nurse during her surgery?” He said, “Well, she is a really good Mormon.” I said, “Well, so am I !!! I am the Relief Society President here in one of the largest Wards in Northern Virginia. She will know what that means!”

When the patient was taken to the Post Anesthesia Care Unit (Recovery Room), I realized that the doctors and circulator had forgotten to take her chart with them. I picked the chart up and started to take it to PACU when I read the nameplate of the patient. Imagine my shock when I realized that my impressions during the surgery of this being “my sister” were correct. She had been my Visiting Teaching Companion when we both lived in Seattle Washington several years before! Neither one of us knew that we were now both living in the Washington, D.C. area.
I called up to the Delivery Room and asked for her husband to come down to the Recovery Room. When he arrived, I asked him if he had his Consecrated Oil with him. He did, and he also had a friend with him. I made arrangements for him to give his wife a blessing.

I am grateful that not only was I privileged to learn The Healer’s Art at the Lord’s University, but I was also taught to listen to the whisperings of the Spirit and act accordingly. Being a BYU graduate has been an honor, and it has allowed me many missionary opportunities. Being a member of the Church of Jesus Christ of Latter Day Saints has been an enormous blessing to me personally, and to all those who have been entrusted to my care.
Chapter 4

Find in Thee My Strength, My Beacon

Savior, may I love my brother
   As I know thou loveth me,
Find in thee my strength, my beacon,
   For thy servant I would be
Savior, may I love my brother.
   Lord, I would follow Thee.

The Church of Jesus Christ of Latter-day Saints, Hymn 220, verse 4
He was 28, and his name was Mark – the same age and name as my oldest son. His marrow had failed him. He didn’t know it yet, but I did. He came to the oncology floor in the late afternoon, and I got him settled in, did an assessment and visited with him briefly. Labs previously drawn in the Emergency Room showed up on the computer, and it was pretty clear that Mark had Leukemia.

The doctor came in to do a bone marrow biopsy. They’re never pleasant. I had pushed some Demerol through his IV a few minutes before, but Demerol doesn’t really take care of the bone pain. I offered my hand “to hang on to, if you need it.” He didn’t. He was quiet, somewhat relaxed, solitary, and independent. The procedure didn’t take long. The doctor was quick, precise, and efficient. He palpated, marked the spot with an indentation of his fingernail, cleansed the skin, deadened the superficial tissues and then the deeper ones. The bone-coring biopsy needle slid through the tissues and then bored through the bone. A series of twists to the right was followed by a series of twists to the left to free the slender core of bone. Specimens of bone and of marrow were extracted and deftly deposited on slides. Mark pushed his face into the pillow and gripped the bed but kept his hand away from mine. A pressure dressing was applied, and Mark turned onto his back to increase the pressure on the dressing.

Now he just had to wait until tomorrow for the biopsy results to confirm what the lab report had already hinted. This one last day Mark was free from the knowledge of his diagnosis. It was Valentine’s Day, and his wife, Maria, was at work and would come later with their three-year old daughter. For now, he was alone with his thoughts.

Mark was quiet and seldom talked about his feelings. He was, however, always courteous, and he rarely complained. We talked that afternoon about peripheral things – what had made him decide to come to the hospital, how he liked to play basketball with his friends, what he did for a living. But cutting through the insignificant details of our conversation came the gloomy premonition, “I’m going to have to watch you die!”
What was that all about? I love working with oncology patients, and I’m the most optimistic oncology nurse I know. I believe every patient I work with is going to be in that percentage, however small, of patients who respond to treatment. I’m no Pollyanna, and I always tell the truth to patients; but I help them reach for the very best outcomes possible. I pushed the thought aside and went on about my work, but I couldn’t forget the feeling which had accompanied those words as they passed through my mind.

Mark had a brother whose marrow was a good match. Mark would have chemotherapy to get his leukemia in remission. After his blood counts returned to normal levels, he would come in for the bone marrow transplant (BMT).

The chemotherapy regimen went fairly well, and soon Mark was in remission. He went home to resume his life. Maria gave me a big hug, and Mark grinned and shook my hand as he left the hospital. He and Maria were expecting their second child – a boy – and Mark would return for his transplant about the time the baby was due.

In no time at all, Mark was back for the BMT. It was a weekday, and Mark arrived wearing a suit and a white shirt. He and his wife had just come from the temple. It seemed a good way to start this phase of treatment. There was a remodeling project under way on the oncology floor, and Mark smiled as he mentioned that the architectural firm he worked for had drawn up the plans. He spent a few minutes chatting with workmen before going into his room.

A week or so of chemotherapy, a day or two of rest, and then total body irradiation. It was a formidable assault on his body, but Mark was young and strong. The radiation treatments made him anxious, and he generally got Ativan just prior to going down to the radiation center. One day I made the mistake of holding the Ativan because he had received some earlier in the day, and it was only ordered to be given every six hours. I would give it as soon as he returned from radiation, and he would get some good rest.

About 20 minutes after he left the floor, I got a call from the radiation center. Mark had become so anxious during radiation that the treatment had to be stopped. When I got to the radiation center, Mark was sitting in a wheelchair facing the wall in the waiting room. He was distressed and embarrassed. I was devastated. It was my fault. I had not planned well, and he was paying for it.
I gave Mark the Ativan and sat with him until he felt relaxed. Then I assured him that I would stay until his treatment was finished, and I would watch him every minute on the monitor. I sat in the booth with the radiation techs and watched him as the techs talked to him over the intercom throughout the rest of the treatment. Then I took him back up to his room, and he relaxed and slept.

After the radiation was finished we moved Mark into the sterile laminar air flow (LAF) room in the BMT unit where he would receive his new marrow and wait for his blood counts to return. The transplant was hard on him, but he survived it. He was so anxious and nauseated while he was in the LAF that he threw up every time he moved at all. Each day I put on sterile attire and went into his protective room to bathe him and change his central line dressing. Gradually his blood counts returned as his brother’s marrow engrafted, and he emerged from his sterile cocoon. What a celebration we had! Now he just had to get off the TPN and take enough nutrients orally, and he could go home.

The day Mark went home his wife brought a little present to me—a 5 X 7 framed paper decorated with childish paint strokes on which she had printed the words “Thanks for making our daddy all better.” Mark and I hugged affectionately, and then he got into their car and was gone. I put the little framed note on my dresser, but I almost cringed as I read the words “all better” day after day.

Not many days passed, and Mark was brought back to the hospital emergency room. His bladder was bleeding (a late side effect of his chemotherapy), and he was very ill. Day after day we irrigated his bladder at a rate requiring a 2-liter bag to be changed every 30-40 minutes. If the irrigation slowed down, his catheter would clot and he would be in severe pain. Nearing the end of a 16-hour shift I was helping Mark to get settled back in bed. With all the energy he could muster, he looked up at me and groaned the words “I’m so sorry to be doing this to you.” I fought back the tears and assured him that it was I who was sorry to be doing this to him.

Miraculously the bleeding finally stopped, and Mark went home again, but he was not there long. He developed an infection and had to be readmitted. He had little in the way of physical energy to contribute to fighting the infection, and blood cultures showed that the infection was caused by a formidable organism. I went to endoscopy with him one afternoon for a bronchoscopy. I slowly injected Ativan at intervals with
one hand while Mark nearly squeezed the life out of my other hand. The culture results came back the next evening, and Mark sobbed as the doctor gave him the news. The infection was in his lungs, and there was almost no chance of survival.

A few days later Mark had become disoriented, and the doctor ordered a scan. I was home with a cold that day, and Mark’s nurse called to tell me they thought his infection had gone to his brain. She said she didn’t think that what I had could make him any sicker than he was and suggested I come in to see him. I met the family in radiology, and the radiologist confirmed the infection was now in his brain. Mark’s parents had come from out of town, and his mother was trying to reconcile with him after having estranged herself from him for years.

Mark was wheeled back to his room and his mother talked to him for nearly an hour. Then she came out of his room in horror and said she thought he was gone, and Maria hadn’t had a chance to say goodbye. I took Mark’s mother in another room and told her I believed Mark’s spirit was still there in the room, and Maria could say all the things she wanted to say to him. Maria said it was all right because she and Mark “were okay” and it was his mother who really needed to talk to him. I was amazed at the wisdom, the peace, and the grace of this young widow. After the family left, I stayed in the room with Mark for a little while, not wanting him to be alone. There he was just as I had feared he would be 6 months before. His tormented body was now still and at peace. I drove home and put away the little framed note. I couldn’t bear to look at it again.

Several of the nurses went to Mark’s funeral. It was uplifting and comforting. Maria called me a few days later. She said, “I think Mark would want you to know that you fulfilled in him everything that was lacking with his mother.” I never wanted to take the place of Mark’s own mother, but I did love him, and I believe he helped me learn to be a better nurse.

A nurse chooses whether or not to care personally about a patient. I chose to care deeply about Mark – to love him as a son. The pain of separation is the price for choosing to love. The pain will go away, but the love is everlasting.
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Learning the Truth Behind The Healer’s Art
Robyn Carlsen

When I began college, choosing a major was hard because I found it unfathomable to have to decide on that one thing I enjoyed enough to commit to for the rest of my life. When I finally chose nursing and began the prerequisites, it made so much sense. I had been sick much of my life with asthma, allergies, kidney stones, and infections; I felt there was no one better to empathize with those in pain. After all, what more could an eighteen year old girl go through? I had been in the hospital more times than all my known acquaintances combined. When I began the nursing program, I was confident in the hospital setting, with the medical terms, and with the seemingly complicated medical technology. I was going to be able to master this profession. I guess I could say I was "prepared" many years before! All of my confident empathy and nonchalance regarding patients vanished one term. It forever changed how I thought about myself and how I interacted with others.

During an oncology nursing elective, I arrived at the children's hospital outpatient oncology clinic prepared to learn as much as I could about childhood cancer. We saw the first patient around 8:00 am and prepared him to see the doctor and answer any questions. Matt and his mother were waiting inside one of the exam rooms. The nurse had prepared me to see the patient by telling me about the patient's disease, history, and reason for the visit while walking to the room. Matt was a seven year old who had been diagnosed with Leukemia over a year ago. It had gone into remission, only to be rediscovered a month ago. At the beginning of every patient's new treatment cycle, they were given a treatment calendar that displayed all the different injections, chemotherapy, and radiation appointments scattered over the next few weeks.

As I went over all of the appointments with Matt and his mother, something sprang alive inside me. Big eyes, scrapes on his knees, and dirty hands all contributed to the picture worthy of a Saturday Evening Post cover. Matt was old enough to know what was happening to his young body. He had not yet had a chance to attend school without this diagnoses hanging over his head. He was learning to read from the books
that were stacked next to the IV poles and learning to tell time from the clocks that hung over his chemotherapy. It was an uncertain future for a boy who had barely had time to dream, but still had large ones.

I began to think about all the things he needed and how little my nursing knowledge and hospital experience mattered to this boy with a potentially fatal disease. I knew my controlled asthma, antibiotics, and dreams for the future were not the things that were going to enable me to sympathize with and help these patients. There was nothing I had experienced that would compare to the courage this boy was already required to show the world because of the harsh regular treatments he had to endure and unsure future he looked forward to.

As a student, I had extra time to spend with patients, and I quickly learned pediatric patients loved to play games. I played checkers with him to pass the time. When waiting for a doctor or for a treatment to end, it always seemed like the minutes stretched on for days. I never was very good at checkers and when he beat me for the second time in a row, I smiled and threw up my hands in defeat, "Why do I try playing against a master? You are just too good. Tell me your secrets!" He giggled and looked at me innocently while setting up the checkers for another triumph. We played until his mother got back from lunch, the treatment was over, and he had to leave. I waved goodbye and was rewarded with a blue smile - the product of a large sucker he was given.

I knew the things I had previously relied on to give me the credentials needed to survive nursing heartache and triumph day after day did not include a special insight into hospitalization. I wanted all the patients who were facing the unknown to know that although I had not experienced the many things they were dealing with, I did have something more than understanding: I had love.
Do Unto Others
Marquelle Wilkinson

During my ICU rotation in nursing school I had a very humbling experience with one of my patients. I took care of a man who had back surgery. I was excited to take care of him because he was the first patient I’d had in the ICU who was awake and not in a coma or sedated. But he was intubated so he couldn't talk. However, he communicated by writing on a magna-doodle instead.

When I first walked into his room and started doing my assessment, I began to listen to his heart. Immediately, he pointed down to his leg. I looked at it but couldn't figure out what was wrong, so I handed him the magna-doodle. He wrote that his heart was in his leg—not in his chest, and he smiled at me as I read the message. I started to laugh because he had caught me so off guard. I was a scared nursing student who was very concerned about doing a thorough assessment, but he let me know right off that he was a real person, and had a sense of humor—it was okay to joke with him.

As the day went on I spent a lot of time caring for this man. He, along with the respiratory therapist and I, walked several laps around the unit. After our last walk, I asked this man if he wanted a bath. He said he did, so I had him sit down in a chair and bathed him there. As I knelt down and washed this man's feet, my mind flashed back to the scriptures to the account of Jesus washing his disciples' feet. It was at that moment that I caught a glimpse of what it must have been like for the Savior to perform such an act of love. I couldn't help but feel humbled that, as a nurse, I had an incredible opportunity to wash this man's feet and do what the Savior did, and would do, if He were there. This feeling was compounded by the fact that this man—who was three times my size and unable to do anything for himself—was humble enough to let me help him.

This overpowering feeling of complete humility stayed with me the remainder of the day, and I couldn't stop thinking about the event that had just taken place. Just a couple of hours before my shift was about to end, this man signaled to me to hand him the magna-doodle. He then wrote a message on it which said, "You've humbled me today. Thank you and God bless you." I was stunned and immediately told him that he
had truly humbled me. I honestly felt I was the one who had been humbled, not him.

Since this experience, I've had several feelings and thoughts about what nursing is, and what my role is as a nurse. Looking back though, I will never forget what I learned about nursing as a student during my ICU rotation. It was in that ICU room that the Lord taught me one of the greatest lessons of all about being a nurse--we aren't just performing menial tasks, but we are carrying on the Lord's work by taking care of His children and doing for them exactly what the Savior would do if He were here.
Working as a registered nurse in the medical/surgical PRN pool has given me many different experiences. I have dealt with a variety of issues which come with floating from one nursing unit to the next. While this variety is present on a daily basis, there is one thing which remains constant in my care: my love for the interaction with my patients. It is not always easy to find the time to sit down and listen to patients talk about their long and successful lives, the frustrations they have over their condition, or the concerns they have about their health care, but I find that every time I do it, I am able to build a stronger nurse-patient relationship and provide better holistic care for the patients.

One of my patients had been admitted to the hospital that day with an abdominal aortic aneurysm and was going to have it repaired in the morning. He was a big man in his late sixties with a large, supportive family. Different members of his family had been coming and going throughout the day, and my patient had been smiling and pleasant throughout the visits. Because of the many people visiting, I limited my own visits and went into the room only to do an assessment, give medications, and start the essential pre-operative preparations.

After the patient’s entire family had left, I went in to have him fill out his history and physical form. The patient looked tired and the smile on his face was waning, but he agreed to fill out the form. The problem was, however, that he couldn’t see without his contacts, which his wife had just taken home. So, I sat by his side and began to fill out the form with him.

We went through the form, question by question, until I got to one inquiring about his living status after discharge. Tears filled my patient’s eyes as he softly said he guessed that he would be going home. I stopped and put the form down. I put my hand on my patient’s arm and asked him what was troubling him. I spent the next hour talking with my patient about his concerns over the surgery, about death, and about his family. This patient had received two blessing from family members from which he received the impression he was going to die. He was already very anxious about the procedure, and he said he loved his family very much, but the visits had made him even more anxious. I
spent the majority of the time just listening to my patient, and it made all of the difference. By the end of the hour, we both had tears streaming down our faces as he related all of his concerns to me.

By listening to my patient, I was able to discover areas where he was deficient in information. He was very concerned about the surgery and some of the complications involved. Informed consent had already been obtained, but he still had many questions. I explained to him as much as I could, and then I called the doctor and informed him the patient needed to have more explanations about the procedure.

While I didn’t provide therapies such as guided imagery, hypnosis, or music therapy, I did focus on helping him relax by making him as comfortable as possible. I got him extra pillows, turned down the lights in his room, and tried to make the environment as quiet as possible. These non-pharmacological interventions help reduce anxiety by eliminating external irritating factors.

Generally speaking, support from family members and spiritual leaders decreases anxiety and grief. My patient was in grief over his expected loss of his life. Although my patient mentioned that the large number of family members and the blessings had caused him increased anxiety, he stated he was comforted by the fact that he knew his family was supporting him and loved him; when he died, he believed he would go to a wonderful place that is better than here. His anxiety came because he just wasn’t ready to go yet. Since the patient and I are both of the same religion, talking more about our common beliefs seemed to help ease his anxiety.

As my patient was talking about issues that were very difficult for him, I found touching him on his arm or shoulder really allowed me to reach out to him. It created a bond between us, and I was able to convey my sympathy for him without saying a word. My patient was alone in a place he did not want to be, believing he was going to die the next morning. Nothing I seemed to say could convince him otherwise, but just knowing I truly cared helped him overcome at least a small portion of the difficulties he was going through.

As I sat with my patient for an hour the night before he went into surgery, I was truly touched. I cared about my patient and his concerns, and by taking the time to listen to him and address some of his concerns, I was able to show I cared. By the time the end of the shift came around, my patient was not just my patient, he was also my friend. The anxiety
and grief he was experiencing were massive, and he needed support. I was the one who had to initiate the relationship, though. That night I learned creating strong nurse-patient relationships was the first step in establishing trust, unity in care, and providing holistic nursing; it is my responsibility to create it.
Holding a Hand and Learning The Healer’s Art  
Melanie L. Droubay

No, I haven't saved any lives and no, I haven't performed any miracles. My nursing career, as of yet, has not been flooded with astonishing accomplishments and shocking stories. Although those once-in-a-lifetime events are often the most interesting to hear or talk about, they are after all just that: Once in a lifetime. They don't tell the story of what most nurses do most of the time. And in nursing, the truth that I have found lies in the saying, "It's the small things that matter most". And this is a story about one small thing that, to me, made a very big difference.

It was my very first day in clinical as a student nurse. I had just started the nursing program at BYU a few months earlier. Although my teachers had been preparing me for this day since the program began, I was still a complete nervous wreck. I remember walking towards the hospital locker room to get changed into scrubs for the day and trying to remember the last time I was even inside of a hospital. How could my teacher expect me to help take care of patients? What would happen if I made a mistake? I kept asking what I had gotten myself into as I tried to remember exactly why I chose to go into nursing. But I was so nervous I couldn't seem to think of any reason that made sense to me at that moment.

I had been assigned to spend the day helping the nurses in the PACU. Patients wake up from surgery there and it's the nurse's job to make sure they are stable before returning to their individual rooms. I was designated by my teacher to follow and help one specific nurse in the unit, and then I was left alone.

The nurse I was assigned to pulled me over to her station and began to explain the routine. I was trying to take notes as quickly as I could but in the middle of her explanation, it suddenly became extremely busy. Multiple surgeries had finished at the same time and of course, the unit was short of nurses that day. My nurse had to stop explaining things to me to take care of more patients and she told me to just help out where I could. As all of the other nurses scrambled around trying to take care of all their patients, I tried my best to find ways to help. But it was my first
day and it took me as long to do one step as it took the nurses to do ten steps. I couldn't help but feel completely inadequate.

As I tried to get out of the way of all of the nurses, I ended up standing next to one particular patient who was a post-hip replacement surgery. The nurses had already taken her vital signs and deemed her stable, but she hadn't completely awakened yet. I looked on the chart and saw her name was Rose. She was an older woman, probably in her late 80's. She was one of those older ladies you look at and instantly think about your grandmother. Her hair was stark white and she looked as frail as could be, but her eyes had a glow to them that instantly made me like her. As I stepped closer to her bed, I could tell she was still quite confused. She seemed troubled and restless, tossing side to side in her bed.

"Rose," I said. She looked at me with a puzzled look as if she was trying to figure out exactly who I was. I told her the surgery was over and she was in the recovery room. She relaxed for a minute but then the perplexed look came over her again. She asked me, "Was I brave? Was I a good girl? I just wanted to be a brave girl. I tried to be brave," she continued. She repeated these questions to me. I couldn't help but think of a little innocent child as she said this to me. All she was concerned about was if she had been a good girl during the surgery. I didn't know how the surgery had gone and I knew it didn't matter at that moment. I sat down by Rose's bed, took her hand in mine, and told her she had been very brave and had indeed been a good girl. She continued to ask me the same questions for the next half an hour and I always told her the same thing, "Yes, Rose. You were a very good girl and you were very brave. You did such a good job. There is nothing to worry about anymore. It's over." And all the while I kept holding her hand in mine.

Eventually she started to calm down. I slowly stood up to let her get some rest when she asked me one more question. She asked me who I was. I explained to her that I was a student nurse from BYU here for the day to help out. But she shook her head at me, squeezed my hand, and said, "No. Today you are my angel".

I will never forget those words or the twinkle in Rose's eyes when she said it. It was a valuable lesson to me. When I returned to the nurse I had been assigned to, I apologized for not helping her much during the rush. Surprisingly though she said, "I saw what you did and it was the best thing you could have done. You helped that patient more
than anyone else. That is what nursing is all about". Earlier that day I had been nervous because I was afraid I would make a mistake. But I learned you couldn't make a mistake caring for someone else. Since that experience with Rose, I have had multiple opportunities to be someone's nurse and I've held a lot of hands. I know I will never forget the very first hand I held and the very first time I understood the true "Healer's Art".
Amazing Grace
Sara Udell Sullivan Henderson

I had a sweet experience with one of my nursing home residents last year. He was a 74-year old man, with advanced Alzheimer’s and Parkinson’s. We all liked Mel, because even though we couldn’t carry on a conversation with him, he was pleasant. He would smile at us and tell us, “Thank you” when we would feed him or give him a drink. All he could do was sit in a chair, eat, and sleep. I’m not sure if he even recognized his family when they visited.

I was standing at my medication cart, preparing to give someone an insulin injection when I heard “Amazing Grace” being whistled. It was Mel. He never spoke more than a word or two, let alone whistle. His whistle was strong and clear. He whistled a whole verse in perfect pitch and tempo. It gave me a goose bumps, because his vibrato sounded just like my Dad’s whistle. When he was done, I told him how beautiful it was. He gave me a wistful smile, and the moment was gone. Little did I know that it would be the last time I would see his smile.

The next week I came on shift only to discover that Mel was literally on his death bed. He had left instructions with his family that as his condition worsened, he wanted no medical intervention. His wife and two daughters were sitting by his bedside when I made rounds. I could tell by the way he was breathing that he would not live long. The family had requested that we keep him comfortable. I moistened his mouth before giving him a small sublingual dose of morphine. I learned in nursing school that the sense of hearing is the last sense to go. I like to speak to people, even when they are unconscious, because one never knows what they might hear. I stroked his hair and spoke a few kind words. I thought the family was very courageous and knew they wanted to be left alone. Within the hour, someone came to get me. They said one of the daughters had come out of the room to say that her father had just died. I had been dreading going into his room, but I really felt a strengthening, peaceful spirit came over me as I prayed for help. It seemed a sacred honor to be with the family at the passing of their beloved father. His body was warm, but lifeless. His wife had tears in her eyes, but somehow I found the voice to speak. “I’d like to tell you about a special experience I had with Mel just recently.” I told them the
circumstances surrounding the Amazing Grace incident and how special it was to me to hear him whistle so strong and clear. His wife told me that “Amazing Grace” was his favorite hymn. I think it was comforting for them to hear this story.

It was only ten days later that my father died in a hospital room. How I wish I could have been with him! Dad had inspired my desire to study nursing by the example he set as a hard-working, old-fashioned General Practitioner. I thought back to the Saturdays when I was about ten years old, accompanying him making rounds. He would leave me at the nurses station to speak to the Sisters while he went whistling down the hall to see his patients. On the way home, he would explain the different diseases to me, defining every medical term back to its Latin root, as if I were his intellectual peer (or so he made me feel). I didn’t know at the time that Mel’s music was a foreshadowing of my father’s death; his whistling an appropriate benediction on Dad’s life as well. Amazing Grace, to have been loved and taught by such a father.
After spending a whole year in nursing school dealing with sick patients, the idea of working with healthy, laboring women was more than exciting. We learned all about the labor process and how naturally the baby moves into position in the uterus and descends down the birthing canal until it is expelled by the uterus. Most babies followed the same sequence of events and millions of deliveries take place every year. We learned about complications that might result in a Cesarean-Section and maybe even death, but those events were rare. For the most part everything happened like clock work and there was nothing to fear.

My first patient was an ideal patient. She was a 23 year old, first time mother who had a wonderful, supportive husband. She came into the Labor and delivery room contracting every couple of minutes. Her pregnancy had been ideal. The baby was healthy; she was also healthy. She had every reason to believe her delivery would go just as smoothly. She progressed at a normal pace with her cervix dilating about a centimeter every hour. Finally she heard the magical words, "You're complete!" Her cervix was completely dilated and it was time to start pushing.

As a young student nurse, I was given the responsibility of holding one of the patient's legs and coaching her to push through each contraction. We had a great system going. As soon as the contraction monitor began to increase, her husband and I each grabbed a leg, pulled back, and the patient began to push while we all counted for 10 seconds. She'd push 3 times, faithfully, with each contraction. She was so motivated that sometimes she'd throw in an extra push during a contraction, or hold pushes for an extra second. Her mom and sister were in the room too, and everyone got excited about cheering the patient on. Everyone in the room would start counting when it was time to push, and would yell extra cheers and words of encouragement. The cheers would get especially loud as the tip of the baby's head would appear during a contraction. However, sighs of disappointment would also be expelled as the head would sink back when the patient relaxed. Nevertheless, after an hour and a half of pushing, we were all sure progress had been made and
the baby was close to coming. After all, the text books explained it was normal for a first time mother to push for about 2 hours.

It was about this time that the doctor came in to check on the patient. We all waited with anticipation as he performed a pelvic exam to determine the baby's station and the progress made. Upon completion of the exam the doctor looked up and said, "I'm afraid your baby hasn't moved a bit." An overwhelming sense of gloom and disappointment filled the room. After all that work, there was no change, and we had done everything right. We had held the legs just like we were supposed to. We used the best pushing methods, and the patient had used as much power as she could to push -- yet there was no change. The doctor continued by saying, "Your baby is experiencing what we call 'failure to progress', meaning something may be impeding his ability to descend. Keep pushing and I'll come back in 30 minutes. If the baby is still in the same position, than we'll have to go back to the Operating Room and I'll have to remove the baby by Cesarean-Section."

The disappointment on everyone's face was almost painful. From the moment this patient had walked into the room she had stated how badly she wanted to deliver vaginally and was scared to death of having a C-section. Given the normalcy of this pregnancy we assured her the chances of a C-section were very rare. And now, after 20 hours of labor and 1 hour of pushing, she would have to have a C-section. The doctor left, and the room was silent. Everyone appeared to be in a state of shock. However, as I looked more closely, I noticed that each head had bowed in prayer. I too bowed my head and offered a silent prayer to my Father in Heaven that this young girl's efforts would not be in vain. I prayed she would be able to deliver this baby on her own without any complications. I am sure that was the same prayer coming from the other four people in the room. After about 15 seconds, the silence was broken by the voice of the patient. "Come on you guys, let's get to work. We can do this!" A new type of energy filled the room as each person assumed their respective positions. Even though this sweet girl had already exhausted herself with 90 minutes of pushing, she began to push with a type of exuberance I had never seen, not even in the best athletes. She'd push four or five times per contraction and hold the pushes for at least 12 seconds. The family members were cheering louder and with more energy than before. Everyone was determined to get this baby out.
All too quickly, the 30 minutes were up. The doctor returned and we all awaited the verdict, praying more fervently than before. "The head’s right here," the doctor said. "Your baby's coming!" The joy filling the room was so overwhelming we couldn't even speak. Instead, we were all moved to tears with gratitude for the miraculous outcome. Within ten minutes a beautiful, healthy, baby boy was delivered. As the doctor placed the baby on the mother's chest, my heart was filled with the wonderful Spirit of the Lord, as I finally came to understand the power of that invisible hand. One more prayer was given by each of us that day. It was a prayer of gratitude as we thanked our Heavenly Father for extending His healing hand.

In all my studying, and as much as I try to become the best nurse, it is impossible to surpass the healing nature of God. He created our bodies, and He makes the rules. At that time in my nursing career, I knew very little. I was ready to learn more and to grow in my knowledge and understanding. It was amazing how in just a few moments I learned more about The Healer's Art than I could have learned from years of nursing school. The answer to this dear mother's problem could not be found in medical books or learned through time, but the answer was found through faith in God, the true healer. For He has stated, "I am the Lord that healeth thee". (Exodus 15:26). No matter how smart a doctor or nurse may be, or how well they perform their job, no hand is as powerful as the Master's hand.
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The Stranger with the LVAD: Implementing The Healer’s Art in Nursing
Kari Kiholm

The purpose, mechanics, and results of the LVAD (Left Ventricular Assistive Device) happened to be the focus of our clinical post-conference discussion in the ICU unit. We talked of the benefits and miracle of the LVAD, and how it actually works as a left ventricle for those too sick or weak to get enough blood throughout their body from their own frail heart.

After the discussion, the RN who organized the conference walked us around the hospital to meet patients who had been able to receive an LVAD. These patients had previously been perilously ill and would have died within days, were it not for the miracle of the LVAD surgically placed inside their abdomen.

As our little group of BYU nursing students, all dressed in scrubs and carrying clipboards, walked to a couple of patients’ rooms, I immediately sensed a strong feeling of gratitude and joy among the patients and their families. These were not just patients who had “benefited from the LVAD”. These were not patients at all, but real, everyday people with trials and sorrow, successes and joys; compassionate mothers and grandmothers, brothers and hard working fathers who had been on the verge of death, when they were blessed with the miracle of another chance at life. How grateful and appreciative of life they were! How happy and motivated these people were to make the most out of a new breath of life.

We walked into our last patient’s room and we all watched as the RN pointed out mechanics of the machine. I listened, but kept noticing the older man lying in the bed, hooked up to the LVAD. At the end of our instruction, the RN asked the man to explain how he felt about the “new heart”. Bill spoke with a small smile around the corners of his mouth and a twinkle in his eye, about how this little metal pump had literally saved his life. He whispered how incredibly happy he was, and attempted to enlighten us with his personal perspective of his experience (he was in a coma before he received the LVAD). The RN thanked him and proceeded to leave the room with the trail of student nurses following behind. Before I followed, I looked one last time at that man
lying in his hospital bed and smiled at him. He smiled back. I couldn’t help but sense a genuine spirit and deep soul just yearning to come out and talk with someone about this amazing experience he had been through.

As we walked out into the hallway and began to return to our specific units where we had previously been working, I felt a strong feeling to go back into Bill’s room, talk to him, and let him share the spirit he emanated. I asked my professor, got her approval, excitedly hurried back to his room and knelt by his bedside. Bill’s eyes lit up as he saw that someone was next to him again. I told Bill I was one of the student nurses who had just been in his room, and asked him to tell me more about his experience, and what happened with his mind when he was in a coma. He smiled really big and began his story of how he was on the verge of death.

Bill’s heart had been so bad and ineffective that he was getting hardly any blood to his brain. He remembered calling 911 and then going unconscious. He was transported to the hospital where he had a heart attack, his kidneys were failing and Bill began to deteriorate rapidly. Thirty days previous to our meeting, Bill underwent surgery to receive an LVAD and had been in his bed since that day. Bill had been in a coma for 28 days, but he stated he remembered everything. He told me of his dreams, and how he made movies in them. He went on helicopter and train rides to Japan and Wyoming. He dreamed of driving a truck and getting in an accident where the stick shift went through his abdomen, but he felt no pain. That dream occurred when the LVAD was placed, but the remarkable thing was that he felt completely protected and experienced no pain, either before or after his surgery. He spoke of how the spirit had taken care of his mind while his body was out of commission. He was so astounded at the power of the mind and spirit and how he had been in another world for four weeks, but had been blessed with the opportunity to emerge from it and have life again.

When he finished telling me his story, Bill looked deeply at me and said, “Why did you come back?” I told him I sensed a spirit about him when he spoke to us and I felt impressed to talk to him. Tears filled his eyes and I took his hand. He whispered his appreciation, and I could see through his face what he did not need words to describe. He told me he knew he was preserved for a great purpose in life and wanted to find out what that was and complete it. I squeezed his hand and told him how
strong the spirit was he carried about him. No words were spoken as we cried together and experienced the sweet, calm spirit that was abundant in that little hospital room. We talked together of a Priesthood Blessing he had received a few days earlier. Bill spoke of how beautiful it was to connect with someone with his same beliefs, someone that could understand and appreciate him. There was an instant bond between us at that moment and a spirit of caring and appreciation filled the room. He again expressed how grateful he was that I would take the time to come back, kneel down and listen to him talk about the life-changing experience he had just been through.

Before I left, he asked me to please come back and visit with him again. I made my promises, said goodbye and made my way back to my unit with a greater appreciation of inter-personal relationships, and a special love for a new found friend who, minutes before, had been a complete stranger to me. There is a unique feeling that accompanies the sharing of two hearts.
We know from the scriptures that the Savior has a special love for little children. It is my privilege to have worked with some of these children at a children's medical center for over twenty years and to have witnessed the ministering of angels.

About ten years ago there was a young girl who was admitted with multiple traumas. She was on life support and was also in a coma. After about two weeks she came out of her coma and was subsequently transferred to the rehab floor. One evening her mother was questioning her about her experience in PICU and she said that the entire time she was in the unit, an angel was at her bedside. She said every child had an angel at his bedside!

My first reaction was an overwhelming realization of how much the Savior does indeed love and care for His children. And it couldn't be just for the children in the west wing of the second floor of one hospital - surely there must be angels watching over children all over the world!

My second reaction was personally more sobering. I had worked in that very unit on many occasions and realized that I, too, had no doubt unknowingly been observed by angels as I administered to children. It almost felt like an invasion of privacy, and then I was reminded that we will all someday be judged by God, angels, and witnesses.

A few years later I had a personal experience with an angel in behalf of another little girl. It was night shift and I was working in the bone marrow transplant unit. There are four single isolation rooms in the unit and I was caring for only one patient -- a beautiful little two year old girl with blond ringlets. She received a transplant for a neuroblastoma and was post transplant about two weeks. It was 2:00 a.m. and I had just finished giving her a transfusion of platelets (which is almost a daily occurrence). Just as the transfusion was complete, she started to seize. I signaled for help from the other nurse in the unit and, thankfully, she called a code blue, even though the patient hadn't yet shown any compromise in her cardiac or respiratory status. Soon there were three other medical personnel there: the head resident, a respiratory technician, and another nurse from PICU responded to the code. There were two of us on each side of the bed and no one else in the room (the mother had
left for the evening). This scenario is drastically different from responding to a code during the day shift when the child is literally surrounded by a myriad of people. There was almost a feeling of peace and quiet that early morning rather than the usual stress and activity.

We immediately began administering CPR in an almost clock-like precision that we had rehearsed so many times before. I was the nurse administering the emergency medications. Because children in the transplant unit have triple lumen central line IV catheters, medications can be given quickly and dosages are pre-calculated according to the child's weight. We started the cycle of airway management, drugs, and compressions and continued for two cycles. She was glassy eyed; her pupils were dilated and she was staring at the ceiling. We used paddles on her chest to no avail. The typical EKG pattern was lengthening and becoming a flat line. It was obvious she wasn't responding as we had hoped. The doctor gave the order to start the cycle over for a third attempt. Just as I put my arm up to give the epinephrine into her central line, I felt a hand on my forearm holding my arm back so I couldn't move it. I thought it was Mary, the nurse standing by my side, because it felt like a woman's hand, but she had crossed the room to the other side. There was no one there; I saw nothing. I attempted to try again, but it was futile. I tried again for a third time with the same results. Everything was quiet. No one said anything but it was obvious to everyone what had happened. She died quietly and the doctor called the time of death. Tears were running down our faces. There was no doubt that angels were among us that night and that the Savior's will was done. I shall always remember that night and be thankful for the part I had to play in His plan.
Chapter 5

Stir My Heart With Love’s Compassion

Stir my heart with Love’s compassion,
When in weakness I withhold,
I would heal, as thou hast healed me,
Comfort, strengthen, and enfold.
Stir my heart with Love’s compassion.
Lord, I would follow thee.

Susan Evans McCloud, Hymn 220, verse 5
Everyone knew the little fellow wouldn’t live long following his arrival to inhabit his tiny, misshapen, inadequate body. I don’t remember all that was wrong with him, but I clearly remember the dimples where eyes should have been. And I can still hear the kind of wail that would come from his room when he was crying. I felt caring for this baby would be a tender, significant experience for one of the nursing students, and I assigned him to her. As I share this experience, I want to give both the baby and the student names to make it more personal, so I’m going to call them Matthew and Gwen.

Gwen arrived a little before 7:00 a.m. and I handed her the assignment. It had Matthew’s room number and a little bit about his condition. I was busy getting all the students started with their morning routine when I noticed Gwen waiting to talk to me. She was a rather quiet and timid student, and I immediately felt concerned. She looked upset and was fighting tears. “I can’t do it; I just can’t do it. Please, can you change my assignment?”

I asked her to tell me what had happened. She said she had gone to the room and had been shocked to see Matthew with all his physical problems. She said she felt overwhelmed and completely inadequate, even frightened. Not wanted to add to her trauma, I did change her assignment. But later in the morning I asked if she’d come with me to visit Matthew. She agreed.

We went into Matthew’s room, and it was just the three of us. I had a feeling that it might help her if I spoke for Matthew, got acquainted with her and let her get acquainted with him through me. I asked her some questions about herself: where she was from, why she decided to be a nurse, what she liked most about it, and what she found the most challenging. Then, as Matthew, I told her I knew she’d been shocked and upset when she first came in the room. “I know it’s hard to look at me. I don’t know what I look like, but I know I’m not like any baby you’ve ever seen. Can you imagine MY shock at being assigned to this body? It seems like almost NOTHING looks or works the way it’s meant to!”

I went on, speaking for Matthew, praying I wasn’t doing anything too far over some line of appropriateness. My desire was to
help Gwen see Matthew in an entirely different way, and I later wished I had done that before giving her the assignment. Through me, Matthew asked her if she had any questions. I think she asked if there was much pain. I said not really, that most of my crying was because I felt lonely and frightened. I told her, “I get hungry like any baby does, and I like to be clean and dry. I also like to be touched and talked to.”

This went on for maybe half an hour, and then Gwen asked if she could help feed Matthew. Absolutely! By the end of the shift, Gwen felt a tenderness towards Matthew that was wonderful to see. She asked if she could be assigned to him the next day, and I happily agreed. I felt it would be good for both of them.

On the third day Gwen was assigned to care for Matthew, I arrived about 6:30 a.m. and found his room empty. When I asked where he was, the nurses told me he had expired. They put his little body in another empty room to wait for someone to pick him up.

When Gwen arrived, I walked her to Matthew’s room to show her it was empty. She looked at me with questioning eyes. I said, “Matthew’s gone Home.”

“What? He’s gone home?”

“She’s gone Home.” Then I asked her to come with me. We walked into the darkened, quiet room where Matthew’s little body lay, peaceful at last.

At first she didn’t understand. “You mean he’s ready to go home, and they’re going to come and get him?” She said she’d never seen him so deeply asleep and looking so peaceful and still.

I said again, with emotion, “No . . . he’s gone HOME.” And then she understood. He was free from his little prison. He had indeed gone Home—back to that Father who had given him life and would certainly welcome him tenderly.

Gwen and I shed some tears together. Matthew had been an incredible teacher.
I have never really had the desire to take care of people in nursing homes and I was not looking forward to that rotation in the nursing program. After my two weeks at the home, however, I learned a lot about how a nursing home works and the type of care each patient receives, including the interaction with nurses, doctors, and aides. I was able to see how I affected the life of one individual who was about to die due to serious complications of congestive heart failure and other disease processes.

When I was assigned to Joe, the nurse warned me that he was uncooperative and had a temper at times. I spent time giving him his medications, doing a full head-to-toe assessment, eating with him, helping him shower and get changed, and talking with him. Each day I discovered more about his personality and how he liked going about his daily activities. Since he liked to get his meds early, I would go find the nurse to unlock the cart so he could have his meds when he wanted them. I think this made him feel more in control of his life.

While doing his assessment I was able to take time to ask him about the pain he was having. I asked him about the location and the onset of the pain. I knew one of the main nursing priorities for Joe was pain management. I think it relieved a lot of anxiety just to talk about it. When Joe ate his breakfast I would encourage him to eat all of his food so he would have adequate nutrition. I had looked at the percentage of food he had been eating and noticed it wasn’t very much.

My favorite thing was hearing him talk about his family and his feelings. He would call his daughter occasionally and loved to talk about his grandson. He never wanted to go play bingo, so we would just sit and talk some more. I know our relationship was strengthened through this time because he started calling me “Sweetheart” and always wanted to know when I was going to be there and for how long.

Valentine’s Day was one of the days we were scheduled to go to the nursing home to take care of our patients. I made Joe a valentine and he insisted I put it up on his TV so it blocked his view of the screen. It made me laugh, but I also felt special because that told me he liked it and
it meant something to him. Valentine’s Day was also our last day together, so I told Joe I would no longer be coming to see him. I could tell he was sad about it. Joe and I had a friendship built upon trust. It took a listening ear and a little extra time in his room to develop this.

Joe’s hospice nurse was also very nice and fun to interact with. She made jokes with Joe and asked me how he was doing. She stayed in the room and chatted with us, and Joe continued to smile throughout the whole visit.

Joe’s hospice nurse was a friend to Joe. I was a friend to Joe. I believe these two meaningful relationships improved Joe’s satisfaction concerning quality care. He ate more, which should have helped his nutritional status and homeostasis. I think he enjoyed being happy with good company more than he worried about his medications. I think talking with him about his family and his accomplishments in life helped him find closure and a sense of completion in his life.
The Stillborn
Tyrone Brown

We often think of the nurse who has The Healer’s Art, but on this particular day it was two patients that touched my heart. Three years ago my life plan took a dramatic change. I was a football player for Brigham Young University, a nationally ranked division I team. Like many players, I had the dream of playing in the National Football League. During my sophomore year I suffered an injury that caused two herniated discs in my lower back and ended my career as a football player. Not only was my dream cut short, it was completely obliterated. Despite this unfortunate event, I was a firm believer that other doors will open when one closes.

I had a close friend who encouraged me to go into nursing. I courageously, and with an extreme alteration to my ego, acted upon his advice! I applied to and was accepted into the nursing program at BYU.

After about half a year in the program I was going into the clinical rotation that I dreaded most: Labor and delivery. This is where my story begins. You see, I’m six-foot-three, male, muscular, African American, and bald (by choice). Sometimes I see myself in the mirror and I get scared! I was terrified that the patients and other nurses would be so afraid of me, they would ask me to leave the room or wait outside the door during my time there. Most of all I thought, “How am I, a man, going to offer encouragement and support to a woman when I have no clue what it is like to be pregnant and in labor?” I thought my whole time there was going to be miserable and a waste of time.

Ironically, this turned out not to be the case at all; it turned out to be one of my most memorable rotations as a nursing student. It was during this rotation that I had an experience that would expand my perspective and outlook on life, for it was this experience that taught me what The Healer’s Art is all about.

On this particular day I was assigned to work with a nurse who would be helping a mother and her family recover physically and spiritually after giving birth to a stillborn that morning. When we walked in the room to introduce ourselves, a Catholic Priest was there giving the baby a blessing. The baby was in the arms of a young boy who was lying down asleep on a bed. I later learned that this young boy had cried
himself to sleep with his baby brother in his arms. The room was dark and smelled of blood and body fluids. The father was in the bathroom.

We learned from the night shift nurse that the father had passed out when the baby was born. The mother was lying in bed with the underlying sheets covered in blood. She was sad, disappointed, and confused. This would have been her eighth child. She was diagnosed with chronic hypertension and had had poor prenatal care. The baby had apparently been dead for a month because upon her admission to the hospital she reported no fetal movement for about this length of time.

Finally, the Priest left the room and then the nurse also left to get a consent form to have an autopsy performed, so it was me alone with this family. I sat beside the father as he held his baby boy in his arms. I didn't know what to say, so I didn't say anything at all; I just put my hands on his shoulder. The nurse returned to the room with the consent form. The father then asked me if I could hold the baby while he signed the papers. It was a moment in time that I will never forget. There was not the usual movement, crying, or opening of the mouth and eyes. There was blood around the baby's mouth, eyes, and on his head. Vernix was still around his arms and legs. A million thoughts rushed in my mind. I thought about what this little boy's spirit would have been like. I thought about all the fun things he would miss out on in life, like learning how to throw a baseball or ride a bike or his first kiss.

The nurse and I finished helping this family. We switched the mother to another bed. We took the baby to the morgue. I learned all about the process and the extended amount of paper work that must be done in these terrible situations.

Later that day as I was sitting at the nurses station watching the fetal monitor of a new patient, one of the nurses walked by with a newborn and asked me if I would hold the baby while she finished getting a few things together. As I held this live and active newborn in my arms, I thought about my earlier experience. I could feel the heartbeat of this new baby boy I was now holding. He opened his mouth wide and moved his arms and body. I couldn't help but smile and feel love for this precious gift of life. My troubled heart was becoming mended.

The first time I held a baby in Labor and delivery was when I held the stillborn. The second time was later that day when I held the live newborn. In just one day I saw and felt the whole spectrum of the good and bad in Labor and delivery.
You see, most of the time we think of the nurse as the one who has The Healer’s Art, but on this day it was these two tiny little babies that opened my heart and touched it forever. Who knows, maybe it was part of this little stillborn’s mission to come to earth and touch my life. I will never forget him. He will always remain close to my heart. Wow, the children—no wonder Jesus loved them so much. Theirs is truly the kingdom of Heaven.
Patient as Healer
Julie Price

One experience that meant so much to me personally during nursing school involved a patient "healing" me. I had gone through the entire secondary education program, hoping to become a high school biology teacher. During my final semester of student teaching, however, I decided I did not want to become a high school teacher. I had all of the prerequisites for nursing so I applied for the program and was accepted.

As I started the program, I was feeling a bit discouraged: I was older than most of the students and couldn't decide what I really wanted out of life. Most of my friends were married. Was I supposed to go on a mission? Was I a loser?

Those were my feelings when I met one of my first patients at the hospital. He was an older dignified gentleman. After chatting with him a bit and going in and out of the room a few times, he stopped me and told me to come closer to him.

I will never forget his words to me. He looked me right in the eye and said, "You are a really good girl, aren't you?"

I didn't know where he was going with that kind of question. I answered, "Well, I'm trying to be."

He patted my hand and said, "I am a Stake Patriarch and I can tell those kinds of things. You are well loved."

My eyes filled with tears as he confirmed what I already knew, but was beginning to doubt. I left the hospital that day feeling so much better about myself. God loved me and in the eternal scheme of things, whatever happened, it would be all right.

I have thought of that conversation often over the years and it always fills me with joy and hope. That patient taught me the art of healing.
I have been a nurse for many years and have enjoyed every moment of it. I have found respect for your patients and the difficult battles they fight in dealing with their illnesses are a vital part of "The Healer's Art". It is easy to admire those dealing with strokes, amputations, etc., but it is a little harder to realize how much strength it takes to battle with a mental illness for many years.

This last year I have begun to use poetry to express and solidify my feelings about the things that mean the most to me. I have written about one of the patients I have treated over the years, and how much I admire her strength and courage.

A SOLDIER TO HONOR AND PRAISE
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Sometimes it hurts when we love those we help most,
For we face their deaths and heartaches.
Our hearts would grow weary without some great souls,
Who give us more help than they take.

One patient warrior we have helped through the years,
Shares courage and strength when she comes.
She shows us how humor and laughter defend,
Far better than weapons or guns.
She doesn't realize that so many admire
Her courageous and stubborn ways,
That earn her a place with the veterans of war,
   A soldier to honor and praise.

Her eyes look much older than her face,
   She's aged far beyond her years.
Lines of exhaustion and tiredness,
   Compete with lines of good cheer.

This horrible battle is not overseas,
   Nor deep in the inner-cities,
This endless battle rages all through her mind,
   As she struggles for sanity.

There is no real safety, there is no sweet peace,
   Watchful enemies have her pinned.
But always she'll have her very best weapon,
   She'll fight and she'll laugh 'til the end.
My first encounter with someone who had a great need for pain control transformed our pain control class into reality. The first day of my postoperative rotation the students were advised to shadow an RN to get a better idea of what we would later be expected to do. This was our first real experience in the hospital, and I was more than happy to simply follow the nurse. All our patients had some degree of pain that needed addressing. However, one particular patient comes to mind when I think about pain control.

I do not remember her name, but I will never forget how I felt as I helped care for her. This patient was probably in her mid-thirties and had been diagnosed with stomach cancer. She had three children and had previously undergone chemotherapy. She had just undergone an exploratory surgery to see if the cancer had metastasized and if there was anything that could be done to improve her prognosis. The cancer had spread so much there was nothing the surgeon could do.

I was unfamiliar with many of the tubes connected to our patient. She had a feeding tube to provide nutrition because she was unable to eat. She had an epidural with Patient Controlled Analgesia (PCA) to help control pain. She was also in kidney failure and receiving dialysis. Her pain medication made her nauseated, and she was dry heaving. She had tears in her eyes because she was in such pain.

She kept telling us she was “sorry for complaining, but it hurts so badly.” She consistently rated her pain at a 9/10. Her husband stood valiantly by her side and tried to make her as comfortable as possible. The sight of someone so sick completely overwhelmed me. I left the room and cried for her and tried to regain my composure before returning.

After charting her initial assessment, my nurse and I went back into the room. With her husband, we developed a plan of relief. We first gave her Zofran to reduce the nausea and went through all the pain medications that were PRN and wrote them on the white board in her room, with the times she could take them. As she took a medication, her husband marked off that time slot on the white board and then we evaluated how effective the medication had been.
After checking the PCA pump’s history, we realized our patient was not getting the maximum dosage she could have to control her pain. We told her to hit the PCA button whenever she felt pain. The machine, of course, only allowed a dose every 15 minutes. In this way, we were able to evaluate if her dosage needed to be increased or if receiving the maximum amount of pain medication available would be sufficient to manage her pain properly. Ultimately, the Pain Service nurse increased the dosage available.

Through working with the patient’s husband, communicating with the patient, and working with the nurse and the physicians, the patient’s pain was brought under control. This situation resulted in at least temporary success in managing pain.

In contrast to this experience, many patients do not experience effective pain management. This stems from a variety of issues ranging from patient fears of addiction to healthcare providers lacking competency in assessing pain. While the benefits of analgesics can sometimes be eclipsed by patient and healthcare concerns, solutions to pain management may be found through education, communication, and alternative therapies. Effective pain control involves collaboration between health care providers and patients. Such collaboration helps us practice the art of nursing, as well as the science of nursing.
I sat there alone in Room 10 of the Surgical Intensive Care Unit, reading the chart of a man named Andy. For a week I had been watching the chart grow, as the information representing Andy’s every physical change was recorded, and every medication precisely documented.

Andy was thirty-six years old, married, with two children: a daughter named Becky and a son named Ronald. His wife could frequently be found at his bedside, gently holding his limp hand, and sweetly talking to him about her day. Andy had loved bike riding, and had placed first in many of the local marathon races. To him, it was more than just a hobby—it was a passion. In fact, of the many pictures that Andy’s family had hung on the wall of his room, most were of Andy riding his bicycle.

However, this love of bike riding, this passion Andy had, was the reason he was in ICU. One evening, a week earlier, Andy had been riding his bicycle when he was struck by a car. He was admitted to the hospital with several injuries, the most serious of which was a head wound. He was rushed to surgery, where the surgeons evaluated his injuries and repaired what they could, then transferred him to the surgical intensive care unit. The injury to his head had significantly increased his intracranial pressure, so Andy was induced into a coma to try to decrease it.

A week passed. Andy’s intracranial pressure had not reduced sufficiently, so the doctors continued to keep him in the coma. I sat in the silence of his room and stared at the pictures of him mounted on the wall. It was hard to believe the man in the pictures and the man in the intensive care unit were actually the same person. The man in the pictures was vibrant, healthy, strong, and full of a passion for life. The man in the bed was bruised and beaten. There were tubes going into and coming out of his motionless body. The only sound in the room was the ventilator, helping him breathe. Andy seemed more like a machine now than a person.

While I was sitting there, one of the nurses walked in and asked me to help her turn Andy. I followed her example, and we prepared to turn him. “Andy, we are going to turn you onto your left side now,” she said as we moved him. At first, I found it to be quite peculiar that this
nurse was talking to Andy. After all, he was in a coma, and couldn’t possibly hear her, or even care about the fact he was being turned. I asked her why she was talking to him, since he was unconscious. She explained to me a person’s hearing is the last thing to go when they are in a coma. Patients may not be showing any signs of consciousness at all but often still hear what is being said.

I found this to be quite amazing. To think somebody who was deep in a coma might actually be able to hear what I was saying to them was astounding and, in a way, special. It made me aware I must be careful of what I said around Andy. If he could hear me, I did not want to say anything negative or potentially insulting. So, during the week that followed, his nurse had me practice this aspect of nursing whenever I was caring for Andy. I would talk to him whenever I was in his room and whenever I was doing anything for him, such as moving or suctioning. I didn’t know for sure whether or not he could actually hear me, but just the thought that he might be able to made me want to make him comfortable with me. I wanted him to trust me as his nurse, and as a friend.

After two and a half weeks in a coma, Andy did finally wake up, but he was not the same person he was before his accident. The increased intracranial pressure had caused some brain damage, and it was now very difficult for him to speak coherently or move his muscles in a fluid manner. One day, when I was helping a nurse change Andy’s sheets, I looked into his eyes. He was staring straight at me. It was as if he recognized me. I had been talking to him as I was changing his sheets, just as I had done while he was in his coma. The way he was staring at me—the way his eyes followed me wherever I went—led me to believe he recognized my voice. I kept staring back at him, and in his crystal blue eyes I could see so many things. I could see the frustration he felt at not being able to communicate, or even move properly. I could see the embarrassment he felt about having to have other people bathe and feed him. Most of all, I could see the fear in his eyes: fear of not knowing what the future now held for him, fear of a forever crippled life, fear of never being able to ride his bicycle again. It was if I could see into his entire soul in that one stare. Andy awkwardly reached his hand up to the bed railing, still looking into my eyes, almost as if he was begging me for some form of reassurance or comfort in his now chaotic life. He was crying out for help, and he was looking to a familiar voice, a
friend, to provide it. Gently, I reached down, put my hand into his, and softly stroked his quivering arm. Somehow, I felt some of his fear fade away.

It was at this moment I realized why I wanted to become a nurse: I wanted to make a difference in people’s lives. I wanted them to trust me, not only as their caregiver, but as their friend. I realize nursing is a difficult profession, often suffocating and unappreciated. Nurses are often overworked and underpaid, and often treated with disrespect by patients, families, and doctors. The reality is that nursing is not full of praise and accolades, and nurses often don’t get the recognition they so greatly deserve. However, even in knowing this, I am still passionate in my desire to become a nurse. I believe nursing carries a certain nobility with it, a nobility that comes from knowing I have been able to make a difference, that I have been able to touch someone’s life and make it better. I have the opportunity, as a nurse, to build a trust and a friendship with the patients I take care of. Patients will look to me for help and reassurance, and because of the relationship I can build with them, they will trust I will provide it.

All that I could offer Andy was a gentle hand and loving touch, but I am sure this simple gesture made a huge difference in his life, just as it did in mine. It is my hope that in my career as a nurse, I will be able to reflect this great nobility every day of my life. It is my hope I will be able to dedicate myself fully to my profession, and know with assurance I have truly been able to make a difference.
Humanitarian work has to be one of the most meaningful ways to give of self and follow the example of the Savior. I have made six trips so far—three to Mexico and three to Guatemala—as part of a plastic surgery team, Hirsche Smiles Foundation. The team consists of a surgeon, an assistant, two anesthesiologists, perioperative and recovery room nurses, and students. The goal of the team is to help children and adults who can not afford or lack access to the surgical care they need for birth deformities such as cleft lips and palates, microtia, and polydactylyism; and for injuries such as burns.

As we arrive at the hospital, the waiting room is filled with parents and over 100 children, some of whom have walked or traveled by bus for hours for the opportunity to be seen. They wait their turn to be evaluated and are either chosen for surgery or sent home disappointed. Those whose deformities are too complex to be done in their country are referred to an agency for possible transport to Utah. Some children appear for a second surgery wearing their dirty and tattered Hirsche Smiles T-shirts from the year before. The children with cleft lips and palates are always first priority. We schedule ten to twelve surgeries per day and announce to the waiting parents which child is scheduled on which day. Each time I see that line of children and look into their beautiful faces, I feel as if I am standing next to the Savior as he calls the children to come for a blessing.

Busy days follow as we bathe the children, set up the operating rooms, clean and sterilize instruments, perform the surgeries, give immediate postoperative care, and educate the parents regarding oral antibiotics, pain medications, etc. The nurse liaison works with the native nurses to make sure the children are well cared for during the night. Somehow, miraculously, we are able to communicate in Spanish, at least enough to have open dialogue with the native nurses, visiting surgeons, medical students, parents, and the children.

As the week progresses and we count the remaining surgeries and make sure the number of needed supplies will be adequate, we always seem to have OR packs and IV solutions left over. We remember
and understand the parable of the loaves and the fishes in a broader context.

We work non-stop from early morning to late at night, sleep very little, and rise again the next morning to do the same thing again. And miraculously, rather than turn some children away whom we could help given enough energy, supplies, and time, we are able stretch our own energy to its maximum and go beyond what seems humanly possible to help the children. We are given the blessing of “strength beyond our own.”

We also have the opportunity to touch the lives of the native medical team who observe the surgeries. They are invited to join in our prayer, given in either Spanish or English, as we ask for a special blessing for each child before the surgery begins.

An additional blessing on our missions is having former BYU students who went on earlier trips return to contribute to the team as RNs. It has been rewarding to see their professional growth, to work with them as colleagues, and to see their dedication to performing the “Healer’s Art” in this meaningful way.

Most of all, our hearts fill with joy and peace each time we take a child back to the parents. Their tears flow as they see their child for the first time whole, beautiful, and safe. Our tears flow, too, as mothers cover their children with kisses and turn to say, “God bless you for coming. You are an answer to our prayers.”
Precious, fleeting is my time here,
Whisper wisdom to my mind,
Courage when my heart is aching,
Faith when fear is all I find;
Precious, fleeting is my time here;
Lord, I would follow thee.

Susan Evans McCloud, Hymn 220, verse 6
Handel's "Messiah" was surely not composed in a single day. Nor does a new nurse master the art of nursing after his or her first shift. Just like the hard work and creativity that goes into composing a beautiful piece of music, my first nursing job enabled me to discover the wonderful products resulting from one's dedication to developing skills and talents.

My first shift as a pediatric licensed practical nurse truly felt as if I had been asked to sight-read an entire piece of music when I did not even know how to read a single note. The home health agency I worked for had provided me with only minimal orientation, which included packets to read and a video to watch. I arrived at the patient's home for my shift after the supervisor told me he was an "easy patient" I could handle on my own. At ten o'clock in the evening, the nine month old's parents showed me to his room, closed the door, and said they would see me in the morning.

As the door closed, I sat straight up in a fluffy recliner next to the baby's crib and began to flip through the charting packet, which I had never used before. I immediately noticed the patient needed to have his tracheostomy suctioned, which was something I had never done before. I tried to remember how they had done it in the video I watched the day before and gave it my best shot. When it was time for his scheduled feeding, I was pretty sure he vomited every ounce. When I returned him to his bed and reset his oximeter, it took me the whole night to figure out how to reset the alarms to pediatric rather than adult settings. The entire night seemed to be a night of firsts, filled with anxiety and nervousness. However, by the end of the night I truly felt as though I was beginning to figure out a few of the notes to the score I had been given.

As days turned to weeks, and I began to spend more and more time at my patient's home, I gradually began feeling more and more comfortable with my nursing abilities. The butterflies in my stomach began to go away when the parents would leave me alone for the night and I began to feel more relaxed. I could now suction and adjust the oxygen while maintaining his oxygen saturations. As if he could sense my lessening anxiety, he also began to have less emesis after feedings. I had finally learned how to properly use all of the equipment and did not
look at the clock until his parents came back to the room. It began to feel as though the few notes I had begun to pluck were becoming lines of a wonderful piece of music I was composing on my own.

Eventually, the weeks turned to months, and my fears and insecurities about going to work no longer existed. Rather than having trembling hands, I could have probably suctioned and performed his tracheostomy care with my eyes closed. My tiny little patient was beginning to gain weight, attributable to the fact that he no longer had any emesis after his feedings. I now spent my shifts relaxed in the fluffy recliner next to the crib, usually curled up with a good novel. The lines of notes were slowly becoming pages; and it was as though I was beginning to hear the music or feel the rewards that come from nursing.

Fortunately, my patient was beginning to be weaned from home nursing care just as I was ready to move and switch jobs. He had come home from neonatal intensive care as a tiny and sick preemie, but was now beginning to become a chubby, healthy toddler. I too had grown during this time from a new nurse with no experience to a nurse beginning to acquire wonderful experiences. My hard work through school and the stress of beginning a new nursing job were well worth the efforts. My greatest reward from this experience came when I received a phone call from my patient's mother after my last visit. She expressed deep appreciation for my nursing care and told me she slept well at night knowing I was caring for her son down the hall. I had always wondered if she were able to sleep at all during the night when I was caring for her child, so I was genuinely complimented when she told me she had indeed slept well. In fact, it was music to my ears.
Patient Advocacy in End-of-Life Decisions
Laurie Beth Egan

My elderly widowed patient came into the hospital with the tentative diagnosis of emphysema, but when she underwent surgery, the doctors discovered she had advanced metastatic lung cancer. She was transferred to the intensive care unit; the treatment prolonged her life. We started her on medications to treat underlying problems and gave her oxygen via a facial mask to keep her saturations within a reasonable range.

One by one, the patient’s five children, their spouses, and other family members arrived, each distraught and unsure of what they should or could do. My patient clearly expressed to them she wanted treatment stopped. She stated, “Please, just let me go. I don’t want any more treatment, please let me go.” She had expressed these desires earlier to another staff nurse, her surgeon, and me. At this point in time the family didn’t want to consider stopping treatment as an option, although that is what their mother wanted.

As the day continued we wanted to support and comfort both our patient and her mourning children. We had discontinued most of her medications, leaving only an IV and the oxygen in place. Occasionally her oxygen cannula fell off and the saturations quickly dropped to around 60%. The eldest daughter saw the pain her mom was experiencing and started to understand that although she wanted to keep her mother here, it may not be the best thing to do. As this realization set in, the family began to communicate with the staff about what needed to be done.

Throughout this time, the staff nurse and I kept repeating to ourselves that we needed to be the patient’s advocate. I wanted so desperately to see this patient comfortable, yet I mourned while thinking of the family who would lose their mother, grandmother, sister, and friend. We called her surgeon and he said he would visit when he was through at the office, around 7:00 or 8:00 that evening. This frustrated us, as we realized the patient would continue to suffer throughout the day, continuing the treatment that would only prolong her life for a short period of time. Her surgeon did not want to be responsible for her death and said it would take some time before we could stop treatment, because we needed to have a neurology consult to see if she was in her “right” mind.
We spent the next few hours looking for all the resources we could; we called social work, and attempted repeatedly to find a psychologist or neurologist. We all knew what she wanted; she had made her requests very clear. This was the time when we needed to step up our patient advocacy a notch and make her requests known.

Upon finding another doctor who was involved in her care, we explained the situation, worked with him in looking at the legal aspects of discontinuing treatment, and spoke with the family. The options were that we could aggressively treat the cancer with chemotherapy and possibly prolong her life for a few hard months, or we could let the cancer take its natural course and try to keep her as comfortable as possible. She was already weak and tired and using accessory muscles to breathe. The next step was most likely intubation, as her oxygen saturations were slowly decreasing even with the supplemental oxygen and her struggle to breathe.

We decided we needed to talk to the family once again, and this doctor agreed to explain the options to the family. This was an emotional experience as the family realized death was a reality and they had to help decide the treatment plan for their mother. As I looked at the social worker and the other nurse, I realized we were all fighting back tears, but not being very successful. I felt I had to be strong, and yet wanted so badly to break down and tell the family how sorry I was. Upon hearing the options, all the children but one agreed their mother would not want to be intubated, and wanted to let nature take its course. One son wanted to fight for her life, not realizing this would hurt her more than discontinuing treatment. His mother had made her decision and now the family had to face the difficulty of accepting this end-of-life decision.

Thankfully, the other children worked with their brother to help him realize what continuing treatment would do. The children were able to mourn together as they decided the plan to make their mother comfortable by giving her pain medications. I was relieved my patient’s wishes were granted, and grateful we didn’t wait for her surgeon to bring up all the reasons why treatment should continue. We informed the surgeon of the family’s’ and patient’s decision and he finally agreed with the plan of care. My patient was in her “right mind” and knew what she wanted; I’m grateful we were able to persist in being her advocate, and help her with her wishes.
Looking back on the situation, I wonder how things would have been different, had the patient had an Advance Directive or a Durable Power of Attorney. She was able to use autonomy in making her decision, but had she not been in her “right” mind we may have disregarded her wishes and caused more harm than good. In nursing it is important to encourage patients to obtain Advance Directives, and speak with their loved ones about their healthcare wishes. It is also important to remember being a patient advocate is the foundation of our practice. Whether dealing with life or death, pain, or general well-being issues, we have the responsibility to be an advocate for our patients.
Meeting the Emotional Needs of Our Patients
Robin Parker

As I am finishing my first year of nursing school, the scope of my experience is varied. I have had clinical experience at five different hospitals and worked with nurses of every imaginable personality. However, the experience that has done the most for me was not in any of these settings. I have learned the most at my job, where I care for Carla, who has Multiple Sclerosis.

I originally took the job during my first semester of nursing because I knew it would help with my basic care of patients such as feeding and giving bed baths. The valuable things I have learned far outweigh my original objective. I have learned how to be a patient advocate, both in and out of the hospital; I have learned how talk with my patients and really find out how they are feeling; and I have learned how to sincerely care about my patients and to fill their needs according to what would make them happiest.

I learned to be a patient advocate when Carla was taken to the hospital due to a UTI. As a result of her MS, which she has had for 27 years, she had lost all ability to move or feel her lower extremities. Carla had some feeling in her upper extremities but almost no ability to move her arms. The Foley catheter has been in for almost 15 years, and UTIs over the past year have become quite a problem. Since she is not aware of the UTI, one of the first indications of an infection is that Carla becomes comatose. Immediately, she is rushed to the hospital to be placed on IV antibiotics. Her last visit to the hospital was when I got a new perspective on patients’ experiences in the hospital.

While I was there, I noticed Carla’s catheter bag was getting extremely full. Considering she was being treated for a UTI, I thought it was an important detail. Almost an hour later, the nurse finally came to empty the bag when it was so full it was nearly backing up into the tube. This was a relatively small thing, but I learned how important it is to care for patients as if they were my own friend/relative.

As I visited with Carla, she mentioned she wanted to talk to her doctor but hadn’t had the chance. Carla was feeling helpless at this point, because both her husband and only daughter were out of town. They usually talked with the doctor and made sure she was getting appropriate
treatments. I wondered if the doctor had been on his rounds, so we called the nurses station. The receptionist told Carla the doctor had come and gone a couple of hours previously. Then the receptionist added that she had watched the doctor go in and out of Carla’s room, so she should have talked to him then. Carla cannot move in bed, and if she had been on her side, would not even know if someone walked into the room. I was aggravated at the uncaring attitude of both the nurse and receptionist. Although the doctor was really the one who was responsible, the nurse should have cared more about the needs of her patient.

One of the most beneficial things I have learned from working with Carla is how to talk to my patients. Granted, my employment situation is a little different than what I will ever experience in a hospital, because I have been caring for Carla for almost a year, and we are good friends. But I am referring to the skill of talking and nursing at the same time. It is a valuable ability I have learned to use at every clinical experience. Working with Carla has taught me how to learn about my patients, find things in common with them, and engage in real conversation. Most people, especially the elderly, love to tell stories about their lives. They have usually led long, eventful lives, and if they have someone to listen, would love to talk about them. This may seem like something a nurse does not have time to do, but I am confident it helps a patient. In my scope of experience I have found nurses who talk to their patients have happier patients. When patients are happy, they fight harder to get better.

While working with Carla, much of my job has been spent meeting needs related to activities of daily living. I make her lunch, do range of motion exercises, get her dressed, and fix her hair and makeup. These have been my favorite times at the job. I have been able to be a nurse and participate in activities nurses in a hospital rarely have time to do. Carla loves getting her makeup done, and I will be immodest for just a second to admit that I do it pretty well. I know feeling pretty is significant to her morale, and she is so appreciative of my efforts. Even when no one will see her during the day except her husband and maybe me, Carla wants to get ready.

She was born in the South, raised as a southern belle, and taught to always look like a lady. I know Carla would be a different person if she did not get dressed every day, have her hair and makeup done, and wear jewelry. She would not be as happy, her attitude would be grim,
and she would be unmotivated to have any visitors. Although none of these tasks physiologically prolong Carla’s life, I know her life will be longer, and her quality of life will be much better because of these things. They are what have been important to her for her entire life. To set them aside as trivial now would flip her world around ever more.

The education I have gained through working with Carla has been priceless. I have grown to know what makes her tick. Most importantly, I have learned what she values in her nursing care. She wants a nurse whom she trusts and who is watching out for her well-being. If Carla is confident about that one fact, she will be the best patient. She wants to talk to her nurse. Patients who are bedridden appreciate any companionship. It does not take much, but if her nurse will share casual conversation, Carla’s spirits will be lifted much higher. She wants her nurses to care about her. When Carla feels she has no one around who cares, the nurse has the power to fill that void, if he/she only takes a little bit of time. With conditions like MS, where patients will not necessarily get any better, it is crucial for the nurse to take time for their emotional health. With some patients, it is just as important as following through with doctor’s orders.
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Education and Decision-Making in Childbirth
Rachael E. Bradford

Childbirth is an experience that connects women through the ages. The ways women experience birth have evolved and changed with greater scientific and psychological knowledge to improve both the physical and emotional aspects of birth. This age of technology brought with it much advancement, but in the process, has taken the normal childbirth experience and transformed it into a medical event.

The beauty of birth and its miraculous course has long intrigued me. I was, therefore, very excited to begin my labor and delivery rotation at the hospital. The first day of clinical arrived (as it always does so quickly) and the usual nervousness, topped with anticipation, churned within me. It had become so familiar to feel this way---to anticipate the beginning of a strange, new aspect of the world of nursing. I knew this day would be long, but satisfying to me, both emotionally and intellectually. I had discovered the art of nursing included the joining of both emotional passion, and critical knowledge exercised with that passion. Being a nurse could never be very easy, because it required a constant draining of energy from the soul. But no other profession could provide more excitement and zest for life. Nurses hold life in their hands. What could be more essential or beautiful?

“Rachael, you take this room right here. The mother has agreed to have a student present.” My thoughts were interrupted by my instructor, although they still kept their presence in my mind the rest of the day. I quietly entered the room to find an almost-new mother on a bed, and her husband and another woman standing protectively next to her.

“Good morning. My name is Rachael, and I am a student nurse. I am very excited to be with you today.” I walked a little bit closer. “I understand this your first.”

“Yes”, the mother said, with a smile that spoke pages. She was thrilled to be starting a family. Next, her sister piped in and introduced herself as a nurse. She said she knew the stresses of being a student and wanted me to feel comfortable. I was touched at their instant friendship. We then began to discuss different subjects from what the new baby’s name would be, to the mother’s life in Laos. All members of the family
wanted to talk and we enjoyed getting to know each other. I also explained a little bit about the fetal heart rate monitor. The family was excited to learn what the computer could tell them.

Labor progressed slowly. The time seemed to quickly pass us, though, and we continued to learn more about each other. That is my favorite part about being a student nurse. I usually have a small patient load, and therefore am able to talk with patients on a deeper level. I can meet their needs very well, because I focus on them. I took full advantage that day of my one-patient load, and talked for hours with the patient and her family. I also made sure I gave the family time alone, because I did understand I was a visitor at a very special event and did not want them to feel I was intruding. The kindness they showed me in buying my lunch and continuing to converse with me showed I need not fear being looked on as an intruder.

By 5:00 p.m., I could tell the mother was exhausted. Her epidural relieved a lot of pain, but she was worn out with labor. Before she received the epidural, she felt a lot of pain and in addition, had been in bed most of the day. The nurse came in and told us she was progressing enough to call the doctor. She was dilated to a “9” and we all were filled with anticipation for the event we had waited for all day. The instruments for delivery had been laying on a table all afternoon, reminding and teasing us that it was so close to delivery, but yet still hours away. Those hours were now gone and the moment had arrived.

After a wait of about half an hour, the doctor hurried into the room. He had the nurse retrieve some forceps since the baby was still too deep, and would need some assistance. After coaching the mother to push while he pulled, the baby’s head began to emerge. The event seemed more traumatic than I had imagined, but I still felt this birth was the most beautiful event I had ever been privileged to see. As the baby’s purple head emerged the doctor cut an episiotomy, and the mother ripped. “Fourth degree laceration,” the nurse whispered to me as she grimaced.

I did not comprehend the meaning of those words at first. I saw blood dripping, and the doctor, after handing the baby to a nurse, began to sew. “But wait,” I said in my mind. The mother had just told the nurses and the doctor that she wanted the baby on her belly. “Why are they whisking him away to give him shots and ointment?” I felt dismayed. Finally, they handed the baby to the father who proudly held
him. Next, the aunt held him and then handed him to me and snapped a photograph. I could not bear to hold the sweet baby any longer, knowing the mother had still not held him. I brought him over to his mother’s arms, which were too weak from analgesia to hold him. She was nervous, and hesitated. I put him on the bed securely, and watched as she smiled and clutched him. Her few moments of joy were shortened as the nurse decided she needed to do some more assessments, and snatched him away.

Tears had come to my eyes earlier, at the beauty of this new life; now I felt tears because the mother could not hold her new baby boy. I wondered at how these professionals had lost sight of the fact that the mother was the “star” of this event. I did not understand how health care could have added to the trauma of this birth. I came away with a deep awe for birth, but a confusion, and strange feeling that something was deeply wrong. There was something about this birth that felt “not right” in my mind. After the privilege of watching subsequent births, I realized I had come upon a common problem---women were not decision-makers in their own childbirth. Since then, I have wanted to research and understand the role of education and decision-making in childbirth. I feel energy to crusade for the rights of mothers to create the birth experience as they see fit.
I love nursing! I guess what I love most is that it is versatile. One must be multi-task oriented in order to be able to keep track of many things at once. Some of the qualities a nurse needs to acquire are being confident, organized, responsible, knowledgeable, anticipate problems that appear, have good communication skills, be autonomous, independent, loving, caring, detailed, strong-willed, determined, not afraid to ask questions, and able to empathize. Through these qualities, one is able to see that nursing is not a typical 9:00 – 5:00 p.m. job. Therefore, I believe nursing is more than a career because there are so many aspects that go into nursing. The type of care a nurse gives affects not only the patient, but also the entire health care team, the patient’s family, and oneself. I learned this through one experience particularly.

Imagine seeing a bed-ridden patient not able to communicate through words. One of my patients was 82 years old, had a history of pulmonary edema, deep vein thrombosis, edema, and was diagnosed with urosepsis. He had an allergy to one of the medications he was taking, resulting in a pustulant rash all over his body. He was at risk for pressure ulcers and needed to be turned every two hours. He also had a pseudomonas infection, which is resistant to almost all antibiotics.

The doctors were trying to decide his correct treatment plan, debating on what was best for him because of his age and severity of illness. They did not want to give him too many antibiotics, with the accompanying necessary fluid, since he already had edema and they did not want him to be fluid overloaded. He was not a surgery candidate and he had DNR and DNI orders.

The patient was not able to communicate verbally, but his body language spoke volumes. The nurses could tell he was not happy. He grumbled and grimaced through all the care. He had so much edema that it hurt even to turn. His skin was weeping from fluid overload and skin breakdown.

The nurse became extremely upset upon discovering numerous tests were ordered. She tried to explain to the doctors that the tests would not find anything new and it would not change his care. She said she wanted her patient to rest and be as comfortable as possible since he
was not going to live much longer. However, the doctors did not listen and had ordered a CT scan four times earlier in the week!

The nurse was able to speak to his wife and explained the tests would probably not find anything she did not already know. The wife said she just wanted her husband to be as comfortable as possible.

Since the patient was not able to communicate, a really good nurse could sense and know what the patient might be thinking. One must be able to read body language and defend patients’ wishes. The nurse assigned to the patient was not afraid to question the doctors about the tests and procedures by asking if they were really necessary.

I am grateful for the experience I had. It was a hard one to witness, but I learned a lot. It gave me a first-hand view of what nursing is all about. Before, I was worried about being able to handle all of the nursing techniques to the best of my ability. However, this is only a fraction of what nursing really encompasses. Nursing is definitely more than a typical career. Everything nurses perform is important for the nurse’s well being, for other health care personnel, and ultimately, the patient.
It was my first clinical experience, and we were working on the medical-surgical floor. My patient was a man with lung cancer who coughed and choked almost constantly. It was very unpleasant but I did my best to provide the best care possible. The second day, he rejected most of my offers for help. Early in the day he would say things like, "I'm not going to be here by lunch" and "Don't bother changing the bed, I won't need a clean bed anyway." As the day progressed, his statements changed to a more immediate time frame: "I'm only going to be here a little bit longer." I wasn't sure how to respond but I let him know I still wanted to give him care.

Since he was so sick, my professor spent a lot of time helping me. Just before noon, as she and I were in the room, he coughed a bit, closed his eyes and died. This was my very first patient and he died! I just stood there and my professor realized I probably needed to leave the room. She suggested I take his wife down to the waiting room.

I'm not sure talking with the wife was less difficult than dealing with the dead body but that is what I did. I didn't know what to say to her so I just listened as she told me what a wonderful man her husband had been. She said he had never smoked and only became ill three months ago. He had a form of lung cancer that was not related to smoking and was very aggressive. I listened and tried to be supportive. I thought it was nice she thought so highly of her husband.

The next day, I opened the newspaper and on the front page in the lower right hand corner was a picture of my patient with a rather lengthy article. It repeated many of the things his wife had told me: he had been a wonderful man, active in the church and a professor at BYU who had conducted many important research projects. I sat looking at his picture and wondered if I had treated him with the respect he deserved. I thought I had.

It was my next thought, however, that would define the way I would practice nursing throughout my career. I wondered if he were more worthy of respect and excellent care than other patients who had not accomplished as much. Of course, my answer to myself was that all my patients should be treated with respect and care regardless of who they are. So, I have always strived to give each of my patients the
greatest respect and care. I have taken care of people from all walks of life, of all races and all socioeconomic levels but I have never had to decide how to treat them because they have all received the best I was able to give.
There are many arguments suggesting nurses make the best patient advocates: we spend the most time with patients and have endless opportunities to represent what patients want. We are taught it is our responsibility to act as patient advocates. I have had many opportunities to do this very thing. One example of this was when I worked with a laboring mother and the RN was able to advocate what would be best for her delivery and baby.

The mother came in at 6 cm dilated with her membranes still intact. She was not having regular contractions or showing signs of true labor. The mother was also group B strep positive, which meant we needed to get two antibiotics into the mother before the baby was delivered. If we did not get both antibiotics in, the baby would need a CBC and blood cultures drawn after birth. These would have been unnecessary needle sticks because no risk factors existed that would require the baby to be delivered quickly. There was plenty of time to let the mother’s labor progress slowly and get both antibiotics administered.

The doctor was called and told the scenario. Regardless of the protocol for CBC and blood cultures, he wanted the mother’s membranes ruptured and Pitocin started. Both the registered nurse and obstetric fellow working with the mother disagreed. They felt these measures would hasten the labor and they would not have time to get both antibiotics administered. The RN and the fellow expressed their concerns to the doctor but he still did not change his plan of care. He insisted we break the membranes and start Pitocin. We followed the doctors’ orders, but did not feel good about it.

It was presumed the doctor wanted the labor to start so he would not have to return during the night to deliver the baby. This may not be true, but the fact that health care professionals’ opinions sometimes conflict, is true. The labor ended up going long enough that we were able to get both antibiotics in, but there were safer ways of inducing labor.

Advocacy means to inform the patient of his/her rights and then support those rights as well as the patients’ interests. This is what advocacy is all about—standing up for the patients’ best interests and
hopefully continuing to make a difference for other patients faced with the same situation in the future.
The Effectiveness of Health Promotion
Christy M. Spaulding

During my Sophomore year at Ricks College I had the opportunity to spend seven weeks in Merida, Mexico with the nursing program. Fifteen students were chosen to go with one of our Ricks College professors. As part of our experience, we worked in a village called Tekit. For clinical we all dressed in white scrubs. When we arrived at the village passers-by watched us closely. To have healthcare workers in their village was a big event. We were welcomed to the village by the mayor and even got to sign our names in the village records book.

In the center of the village was a park surrounded by a Catholic church, the city offices, and other shops made of concrete. Further up the street was an open market where vegetables, meat, clothing, and miscellaneous items were sold. Further away from the village square, on the side streets, we saw older women scrubbing on washboards behind small thatched huts or concrete compounds. Each hut had several hammocks. Children, dressed in rags, played on the dirt roads.

I often felt like I was stepping inside National Geographic as I walked past those homes. It was a simple life, yet they were missing the knowledge that would allow them to be more capable, fulfilled human beings. Knowledge could enable them to lengthen their life span and prevent devastating injury or illness. In an effort to help these people with health promotion and prevention we administered surveys, taught health promotion in the schools, and helped screen people at the small clinic located in the village.

I felt one of the most effective ways we were able to teach health promotion was by educating grade school children about hand washing and dental hygiene. We went to several different schools and brought soap, toothbrush, and toothpaste samples to pass out to the children. I was in the group that taught dental hygiene. Using homemade models of teeth and a toothbrush, we taught the children how and when to brush their teeth. It was so fun to see the excitement on their faces as we handed them their own personal toothbrush. It was our hope they would take it home and teach their family, or at least establish a personal habit of brushing their own teeth. Even though it seems like such a simple
principle, we knew with persistence and forming that daily habit, these children could be healthier.

I often wondered how effective our few days in Tekit were in promoting health and preventing illness. Our desire to teach the people of Tekit was great. But, without consistent reinforcement, knowledge of the need for change, a desire to change, and resources, the effect of our project on health promotion was most likely minimal. This experience caused me to wonder how we could make health promotion more effective. In order to increase effectiveness we must collaborate with other disciplines, become better health educators, and base our health promotion measures on sound evidence.

Health promotion must be a collaborative effort between school teachers, nurses, governments, companies, and families. By involving people from a variety of disciplines, health promotion is reinforced in many areas and change is more likely.
On a return flight home from the Middle East, our plane was somewhere over the Atlantic. My fellow passengers were a varied ethnic group, mostly Arabic, many East Indian, some Europeans, and a few Americans. Most of us had been on board for over nine hours, from our Amman, Jordan embarkation site and were tired and somewhat crotchety. Other passengers joined us during a refueling stop in Shannon, Ireland. We were about two hours out of Shannon when an overhead announcement asked if there was a doctor or a nurse aboard. I could tell by the tone of voice this was no ordinary request.

With my Critical Care senses kicking in, I pushed my call light, stood up, and started toward the front of the plane. A flight attendant hurriedly escorted me to the bulkhead, where a row of portable cribs hung, filled with babies, in front of their mothers’ seats. Another flight attendant handed me a large seven month old baby, Mohammed, who was in obvious distress. My senses were reeling, as I performed my initial assessment. Even as I noted he was seizing and not breathing, the smell of diarrhea and vomit assailed me, and the feel of hot, soiled clothing met my touch. Luckily, I could see his heart was still beating, as his pulse pounded in his throat.

As I stood in the aisle, surrounded by the baby’s young mother, Amal, and other concerned passengers, I tried to block out the confusion so I could function. “Baby, baby, are you all right?” I mechanically asked, extending his neck to assure an adequate airway. When he began to gasp for air, I quickly took stock of the surroundings and determined how to eliminate some of the confusion and get enough space in which to work. Since the plane was not full, I asked the flight attendants to move the other mothers and their babies to new seats. Amal hovered over me, worrying about her son, frantically asking questions in Arabic which I could not answer. Another nurse (Mary Peterson) arrived, saw someone was in charge, and began to return to her seat. Since my background is with adults, and though she was not a pediatric nurse either, I asked her to stay, knowing two heads were better than one, since we needed at least two pairs of hands and someone to communicate.
Mohammed drifted in and out of consciousness, sometimes able to focus on my face, alternating between no respirations and rapid respirations around 50 breaths per minute, with a heart rate of 160 to 180 beats per minute, sometimes seizing and sometimes lying limp. We unbundled him from his blankets and outer clothing. Now at least, we could see more easily whether he was breathing. He was clammy to the touch, leaving me wondering about his underlying problem. I knew he must be dehydrated due to the vomiting and diarrhea. Was he also hyperthermic? Did he have an infection? It was difficult to tell. My limited Arabic, “Marhaba, Kaef Halak? (hello: how are you?) was inadequate for the occasion.

One flight attendant served as a translator and brought the aircraft’s small first aid kit to us. Oh, for my emergency supplies and sterile gloves locked carefully away in the hold below! The first aid kit had a fever scan thermometer inside and we quickly checked Mohammed’s temperature. It was somewhere around 39 degrees, but we did not know whether it was accurate. A nearby grandmother handed us a rectal thermometer, which gave us a more precise reading of 41.2 degrees. We quickly asked for and received a container of ice, which we placed in strategic locations around Mohammed’s body, as we were getting his history from his mother.

She had taken him to see a doctor the day before the flight, when he would not nurse as usual, following several bouts of vomiting and diarrhea. The doctor had given her some acetaminophen suppositories to control his fever and Pedialyte to provide fluid, calories and electrolytes. Mohammed had not resumed nursing, would not drink the Pedialyte from a bottle, and Amal had not known what to do with the suppositories.

Since she had the Pedialyte and suppositories with her, we administered a suppository and mixed Pedialyte in a bottle to try to give him, should he become conscious enough to try to suck. We continued to cool him with cold wet cloths filled with ice. Because he was so dehydrated, his veins were so small. I could not have started an IV, even if I had the equipment and fluids.

Sometime during the confusion, the airplane’s co-pilot came to ask us what we needed to do. I said, “We have two choices: return to Shannon, Ireland or land at the first available airport in North America. This baby will not live until we reach JFK airport in New York.” After
conferring with the captain and radioing for additional instructions, the co-pilot returned and reported we had passed the point-of-no-return and must continue forward.

The next two hours were a blur as we sped over the Atlantic to our new destination, racing against time. We continued to cool Mohammed, worrying that we would cool him too rapidly, or that we couldn’t cool him enough. His temperature slowly dropped; down to 39.9 degrees, then 39.4, on to 38.9, down to 38, then into the 37s. We removed the ice and wet cloths and placed him in a clean dry blanket.

The flight attendant brought us a small, partially full oxygen cylinder with an adult face mask. We had to estimate the flow of oxygen and I had to help others understand we couldn’t place the mask completely over Mohammed’s face; we didn’t know how much flow we had and we incurred the risk of having him rebreathe his own carbon dioxide. He soon regained some color in his face and his capillary refill time returned to normal.

He seemed to be awake and we tried to give him the Pedialyte, but he was too weak to swallow. His dark eyes were huge as he tried to fathom what was going on around him. We gave him to his mother to hold, hoping it would provide some comfort and a sense of security for both of them. She was very frightened-- on her way to a foreign land to meet her husband, unable to speak the local language, and not knowing whether her baby would be dead or alive in the next minute.

I didn’t pay attention to how hot it was in the plane: I thought I was hot because I was working so fast and because of the stress of the moment. However, the heat came back to haunt us later.

The pilot, co-pilot, and chief flight attendant gave regular updates to the passengers about our diversion to Gander, New Foundland, and about Mohammed’s condition. From what I could hear and see, the passengers were understanding and quiet. The mothers and grandmothers in our vicinity gave words of encouragement to Amal and to us, which the flight attendant translated for us. I suggested some Moslem, Hindu, and Christian prayers might be in order as well! The pilot was able to locate Mohammed’s father in New York and get him on a plane to Gander to meet us.

At last, we landed in Gander, where there was an ambulance waiting for us. We hustled Mohammed into the ambulance where they
could get an IV started, get some fluid into him, and give him the correct amount of oxygen. 

While I was helping with paperwork, both for the ambulance and the emigration officials, one of the flight attendants came to me reporting an elderly male patient was not responding well and asked if I would look at him. When I got to the man, he was slumped in his seat, grey, totally unresponsive, chin on his chest and not breathing! As I lifted his head, I thought, “Oh no! This cannot happen twice on the same plane!” He began breathing and his color began to improve. His initial blood pressure was 60/40 mm Hg and his pulse was 30 beats a minute. I tried to analyze whether his rate was really that slow or whether he was in bigeminy or trigeminy. I could only feel a pulse every second or third beat.

Getting an adult into Trendelenburg in a cramped airplane is no small task! However, Nurse Peterson was creative in getting people out of enough center seats so she could get space for him to lie down. Once again, we needed an interpreter and a spokesman for the gentleman, who was East Indian. We discovered he had taken his Beta Blocker (Atenolol) shortly before the problem arose for Mohammed. Our analysis told us the heat in the plane and the excitement of the emergency landing had exacerbated his normal response; he vasodilated and bradied down.

His blood pressure slowly equalized and his heart rate returned to normal. As he became more alert, he was able to converse with us. He refused to get off the plane and said his daughter could take him to a doctor when we got to New York. Nurse Peterson stayed with him as I finished the paperwork for Mohammed so the ambulance could leave. We periodically checked on the gentleman during our flight to JFK and he experienced no further difficulty.

As I walked off the plane, five hours late, I thought, “This is just like any routine day in ICU. When the shift starts, you have no idea what care you will need to provide. When a trauma patient arrives, you stabilize, assess, stabilize more, assess more, send the patient off to surgery, deal with psychosocial concerns, get an interpreter for families, save lives, then walk out the door. No one out there can possibly understand the drama behind the work we do. You smile when your significant other asks how your day went, and you answer, ‘It was just a routine critical care day.’”
Epilogue

As you can see from the stories you just read, nurses from Brigham Young University truly practice The Healer’s Art. We are our brother=s keeper, caring for the wounded and the weary. We do help and lift another, we do heal as He has healed. Our practice reflects the combination of the art and science of nursing. May we continue to serve the world as it acries for knowledge, skill, compassion, and sensitivity. May we always practice The Healer=s Art.

The Editors
EDITORS

A. Elaine Bond, APRN, DNSc, CCRN
Elaine Bond, an Assistant Professor in Brigham Young University’s College of Nursing, currently teaches Critical Care and Neurological Nursing. She previously developed a Disaster Nursing Course and took students to Amman, Jordan for an International Nursing course. She continues to conduct research on Jordanian women’s and children’s health issues. She was an Adjunct Professor for the Religion Department, teaching Doctrine and Covenants. She encourages nursing students to practice holistically—to look at advocacy, quality of life, and spiritual issues as well as physiological concerns. She is a John A. Widstoe Research Fellow and has a national certification as a critical care nurse. Dr. Bond is a National Red Cross Disaster Nurse and assisted survivors and family members at the Pentagon, following “9-11.” She is a member of American Nurses Association, Utah Nurses Association, American Association of Critical Care Nurses, and Sigma Theta Tau International Honor Society for Nurses. She has authored articles and, with students, co-authored articles related to Critical Care topics. She is a reviewer for Critical Care Nurse. She has spoken at International Conferences in Taiwan and Jordan and at National and Local Conferences in the U.S. She is currently the Relief Society President in her ward.

Barbara Mandleco, RN, PhD
Barbara Mandleco is an Associate Professor and Associate Dean for Research and Scholarship at Brigham young University College of Nursing, Provo, Utah. Dr. Mandleco has been a nurse educator for over 30 years, and has taught Families and Chronic Illness, Nursing Research, Nursing Care of Children in Crisis, and Management of Families. Associate Professor Mandleco received her BSN from the University of Wisconsin–Madison, an M.N. from the University of Florida in Gainesville (Pediatric Nursing), and a Ph.D from Brigham Young University (Family Sciences/Human Development). Dr. Mandleco is a past recipient of the Excellence in Nursing Research Award from the Utah Nurses Association, the Sigma Theta Tau Iota Iota Chapter-at-large Research Award; several Brigham Young University Center for Studies of the Family Research Awards; a
Sigma Theta Tau International Honor Society of Nursing Small Grant, and was inducted into the Western Academy of Nursing in 2000. Associate Professor Mandleco has authored or co-authored two books and several peer reviewed articles and book chapters. She also has served several professional organizations (Phi Kappa Phi, National Council on Family Relations, Sigma Theta Tau) in leadership positions. Her current research interests include families adapting to a child with a chronic condition, the history of children’s hospitals in Utah, and developing innovative methods of teaching undergraduate students.

Myrna L. Warnick, RN, MS
Myrna L. Warnick is currently a Visiting Associate Professor at Brigham Young University in Provo, Utah. While at BYU she has had responsibility for coordination of the Capstone Course. She has taught in the Health Care Administration graduate program and has served on many graduate thesis committees. She has over 30 years experience as a nursing executive in acute care hospitals and was Executive Director of The Center for Nursing Excellence. She has published Nursing 2020: A Study of the Future of Nursing; Problem Oriented Nursing; Being Heroes In Your Everyday Work; and a chapter in Nursing in the New Paradigm as well as nursing journal articles. Mrs. Warnick graduated from the University of Utah with both a Baccalaureate and Master’s Degrees in Nursing. She has served the nursing profession in many positions including President of the Organization for Nurse Executives in California, President of the Hospital Council of Southern California Nurse Administrators Group, Editorial Board Member of Nursing Management and currently Utah Organization of Nurse Leaders board member.
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