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Nursing Is an Art
Reflections on Clinical Pedagogy

Nursing Is an Art: Reflections on Clinical Pedagogy
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In Memory

Clara Gilchrist
Faculty Member:
University of Cincinnati College of Nursing
Cincinnati, OH

and

Anna Mae Charles Fretz
Faculty Member: 1952-1976
Goshen College Nursing Program
Goshen, IN

and

Orpah Mosemann
Program Director; 1950 - 1971
Goshen College Nursing Program
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Introductory Comments

Those who fail to learn from history are doomed to repeat it.

Sir Winston Churchill

One day several months ago I woke up thinking about Florence Nightingale – the Lady with the Lamp (1820-1910) during the Crimean War (1853-1856) who made her nursing rounds during the night. Before her arrival, it was often prostitutes who took care of the war-injured. Sanitation was poor. Personal hygiene care was often negligent or missing entirely. Nightingale's arrival (November 4, 1854) in Crimea changed that.[ii]

Nightingale became the founder of modern nursing (19th, 20th centuries). The University of Cincinnati's College of Nursing (my alma mater) had a large bronze bust of her and it was situated on a pedestal where we passed it regularly – usually without really noticing it or thinking about it. But, there she was, a reminder that as graduate nursing students we were being prepared to be the leaders of a new generation of nurses, nurse specialists and nurse educators.

Where Might Florence Lead Us in the Twenty-first Century

Some historical nuances

- A *child of inherited privilege,* as an adult she understood poverty and witnessed its devastating health consequences
- She understood the need for compassionate connectedness with the wounded and the dying
- She witnessed the consequences of war up close as she cared for wounded and dying soldiers
- She understood the need for proper sanitation
- She understood that nursing always has a public health component – even if not immediately visible in any given nursing role
- She understood the usefulness of statistical analysis and good record-keeping systems
- She pioneered the use of visual graphs as educational tools for the public
- She understood the need for self-discipline and self-care

- She understood the need for structure – what we might call institutional administrative hierarchies
- She was a very political animal – returning to England from Crimea, she retreated to her bedroom for a time - from which she emerged to create a new profession for women out of the world's oldest female profession; in doing this, she created professional respectability out of its opposite.
- It was a historical era in which modern medicine and modern nursing and modern public health emerged – separately but in a parallel fashion. Each profession symbiotically needed the others if patients were to be humanely cared for and treated successfully.[iii]
- Nightingale relied upon a pyramidal and hierarchical military model of organization – perhaps because that was the only organizational and systemic model she knew. The physician was the commanding officer giving care orders; nurses were the physician's assistant – taking his orders and implementing them. The nurse, in her turn, supervised nursing assistants and aides. The old custom of nurses standing at attention whenever a physician entered a room (no matter what they – the nurses - were doing) had ended by the mid-twentieth-century but the attitudes of nursing subservience to and dependency upon medicine remained long after. The pyramidal model or hierarchical model prevailed. There were needed exceptions to the implicit subservience rule: witnessing a break in a sterile field, a nurse in the operating room needed to speak up. S/he needed to identify the exact nature of the break and help the physician re-establish a new sterile field. Realizing a dangerous prescription or inappropriate treatment had been ordered and written, the nurse, just like the pharmacist, was expected to contact the physician and challenge the order. But essentially, in outdated language, the nurse was expected to be the physician's handmaiden (a personal maid or servant).
- It was my generation of nurses – the newly emerging baccalaureate degree nurses and clinical nurse specialist practitioners – (and our forward looking professors) who changed this.
- Newly emerging American feminism also added its own values to the changing roles of women professionals. Feminist physicians, feminist nurses and feminist public health officials

created new alliances and new ways of interacting with each other and with patients. The great leaders in twentieth-century health issues for women and their children were women and they established new trajectories of female life and work. Each one of the following women from the United States and Europe was privileged in terms of education and each decided to serve less-privileged individuals. Each, therefore, had a seat-of-the-pants understanding of the underlying systemic issues which affected the public health as well as the health of individuals.

- Florence Nightingale (1820-1910); founder of contemporary nursing
- Elizabeth Blackwell (1821 – 1910); a well-established social reformer, was the first licensed woman physician in the United States.
- Clara Barton (1821-1912); founder of the American Red Cross
- Jane Addams (1860 – 1935); founder of contemporary social work
- Margaret Sanger (1879-1966); advocate for family planning and safe contraception
- Esther Lucille Brown (1899-1990); a social anthropologist whose work in the area of professionalism helped the nursing profession – most especially its baccalaureate and graduate programs - understand its own role in creating and maintaining the nation's public health
- Margaret Mead (1901-1978) and Ruth Benedict (1887–1948); Advocates for cross-cultural understanding as essential for health care providers
- Hildegarde Peplau (1909-1999); a human relations nurse theorist who helped introduce good communication skill training and mental health awareness-raising for nurses across the United States; she was the first published nurse theorist since Nightingale
- Martha Rogers (1914 – 1994): a nurse researcher and public health theorist. She had a strong interest in the natural sciences and brought that interest to her work in nursing theory.

- Madeleine Leininger (1925-2012); a nurse anthropologist who developed the theory and practice of trans-cultural understanding and nursing practices
- Ann C. Wolbert Burgess (1936-); a nurse researcher who opened the study of sexual violence and its traumatic aftermaths as a health and well-being issue
- Helen Erickson (1936 -); a nurse leader in the field of holistic nursing and a role modeling theorist.

Since Nightingale, nursing, therefore, has been a continuously changing or evolving profession and the profession now contains multiple levels of licensure and certification. One place we see change now is that more men are entering the nursing profession. A quick scan of the computer on the question "when did men enter the profession of nursing" reveals they were always present – in military settings they provided care to the dying and wounded in field hospitals and on the battlefield itself.

On a personal level, my undergraduate baccalaureate class (1958-1962) included two men and twenty-three women. One of our classmates died in our junior year from the complications of juvenile diabetes. Years later, as a nurse administrator, I supervised male and female nurses.[iv]

I am part of the generation of nurse leaders, educators, and administrators that benefitted from educational and employment opportunities for women that Florence and her nineteenth-century associates could not have imagined. So, while I seek to honor Florence with what follows, it is not an attempt to return to some golden past. In truth, there was no golden past. This short essay seeks a foundation for a golden future somewhere beyond the historical past and also beyond today (the historical present).

Today's nurses exist in a political and social climate in which the nation's health care system - as a whole - is (and has been for decades) in disarray.[v] My short hand for this reality (in talking with my healing arts colleagues) is this: *the whole damned health care system in the United States is fucked.* The COVID-19 pandemic – as tragic as that is for individuals and families – has done all of us a favor because it has identified the systemic weaknesses of the public health care system in the United States. It has also uncovered the systemic inadequacies of many of the nation's corporate hospital systems.

Systemic Issues

Justice denied is justice delayed.

The Rev. Dr. Martin Luther King, Jr

The poor have almost no access to health care except via the nation's emergency rooms which are required to provide care. Undocumented immigrants have no access to care in health care systems which require proof of citizenship before the systems will agree to provide care to these individuals and their families. Citizenship and ability to pay: these are the entrance requirements to receive medical care. As an example: I am enrolled in a city-wide health care provider system which also requires documentation of my ability to pay for services in advance of actually receiving those services.

Proof of citizenship and proof of one's ability to pay have become nation-wide systemic barricades that individuals who need care must cross before gaining access to timely and adequate health care. These kinds financial and citizenship prerequisites are omnipresent in the United States Health Care system. They are present in both public and private health care corporations. They are present in for profit and not-for-profit corporations.

People of African and Latin American descent living in the United States have a higher rate of COVID-19 infection, life-threatening illness, and higher death rates. In addition, they are often the targets of gun violence and inadequate or deeply prejudiced law enforcement systems. Amerindians face their own unique interactions with American pandemics and illness and care (or its absence).

In addition, there is systemic and individual discrimination against members of mistrusted and hated world religions such as Islam. Racism, sexism, and heterosexism infect daily care. Episodic violence erupts in cultural climates of systemic prejudice and hatred for the "other."

Fights about women's reproductive freedoms (grounded in conservative Christian religious rhetoric) are endemic in entire regions of the United States. In many politically and religiously conservative regions of the United States – those regions which, on religious grounds, object to

abortions and morning after pills – we are on the verge of returning to a new era of coat hanger abortions.

There will always be women who are desperate and need abortions. The question is whether or not the health care system will be allowed to provide this needed service to women of all ethnicities and religious backgrounds.

The current (2019-2020) COCID-19 pandemic reflects this crisis in our health care system. We are witnessing heroic individuals doing that which even six months ago would have seemed impossible. But, as of May, 2020, the climbing incidence and death rates of COVID-19 patients tell their own story. The nation's health care providers – indeed the entire system – were not prepared for a pandemic (i.e. world-wide) and its subsequent national crisis. Many commentators from inside and outside the health care system repeatedly say that we – as a nation and as a health care system - were not prepared to respond quickly and effectively to a virulent pandemic such as COVID-19.

Wherever there is poverty and social inequity, a pandemic provides us with a socio-cultural mirror that reflects back to us our society's inequities. .

- Infection and death rates are disproportionately high for racial and cultural minorities
- Infection and death rates are disproportionately high for the poor and low-income individuals and communities.
- Infections and death rates are disproportionately high for Amerindians
- The ongoing national plague of homelessness is now complicated by the COVID-19 virus plague.[vi]

Economic disasters for the poor and socially marginalized parallel and go hand-in-hand with health care system disasters.

This personal observation or personal claim of fucked up systems becomes devastatingly true when we look at actual care provided to senior citizens inside assisted living facilities.

- The COVID-9 death rates are disproportionate for the aged who are housed in assisted care living environments when compared with aged adults who live independently or semi-independently

- The death rates are disproportionate for the poorest of the poor. These are individuals with the fewest social and economic resources to protect themselves. They are, in a sense, the canary in the coal mine.

Underlying Issues

Do not be the first or the last to try a new treatment method.

Medical Adage, Twentieth-Century America

It's (hydroxychloroquine) a very strong, powerful medicine but it doesn't kill people.

Donald J. Trump[vii]

In unprecedented ways (inside fucked up systems), an individual patient must become an activist-advocate for safe care every time she or he enters a modern health care facility. She must recognize medical advice dispensed by a sitting president as lies. Needing surgery, for example, the patient had better have an informed family member or friend at the bedside during recovery periods. For millions of Americans, this recommendation is an impossibility. Yet every nurse I know (in my age group and inside our professional guild) can and often will talk privately about this issue of poor and harmful care practices. These personal conversations may provide information about hospitals to avoid or about individual care providers to avoid. In essence, these are insider professional guild conversations: the horror stories are told and warnings issued about systems and providers to avoid at all costs. In my personal experiences to date, these conversations have been a part of my professional life from its beginning moments. It is not uncommon for nurses to ask other nurses about a recommendation for a care provider.

For example, I found my first retina specialist in this manner. As a community mental health practitioner and college professor, I did not know the local ophthalmology guild and retina guild specialists. So, I called a nurse friend who gave me the name of a physician she personally trusted. From that moment in time until this present moment, all of these eye care specialists have first been vetted by someone I trust.

As colleagues and as friends (among ourselves) we often arrange for a personal attendant to go with us to invasive medical procedures.

For example: with my 1995 hysterectomy, for example, I had Jeevan Paul (a senior medical student friend) with me and when he couldn't be with me Mim Martin (a nurse administrator) sat with me. In short, my clinically educated friends guarded me and made certain that I was appropriately cared for by the hospital staff. As soon as I was alert and awake, I resumed my personal watchfulness. Even then I requested friends to help me. Bob Birkey (a clinical social worker) walked with me the first time I did a long walk in the hospital corridors that included – at my insistence – doing stair steps. This was essential to me since on discharge I would immediately need to negotiate a flight of stairs in my home.

In recent hospitalizations, I have requested that monitors be turned so that I can read them. This means making certain that I understand the information as it flows. Years ago I had a heated argument with a physician friend of mine. In some situation or another I was not informing my health care team that I was a nurse administrator. He literally asked me, *are you nuts?* As we argued the question of whether I should humbly be an ordinary patient or known to be part of the nurse-physician guild, he persuaded me that I would get better care if my attending staff knew this professional fact about me. Since then, I notify the admitting person that I am a retired nurse administrator and nurse faculty member.

In a recent hospitalization (2016), my physician friend's wisdom became evident. As each new person took care of me, they "casually" inquired, "You are a nurse? What did you do in your career?" I began to be a participant in my own care in a way that was unprecedented. The monitor was turned in my direction; the quantity of fluids in and out was measured and I was informed about the quantity and ratio. In discharge planning, the attending hospitalist physician asked me, "Are you ready to go home today or do you feel like you need an additional day here?" He and I talked for maybe five minutes about the question and how to measure my readiness for independence. At the end we agreed on one more day of medical care in a hospital setting. I felt more secure on discharge and, indeed, recovery was uneventful.

In another situation, a physician specialist and I consulted together about whether he should remain in control of my medication regime or whether

my primary care practitioner could do this with me. The planned transfer to my ongoing medical care provider worked extremely well and I have not re-visited the specialist.

Being privileged in terms of education and in terms of professional identity resulted in a better level of care. About this reality I now have no doubts. And while I exploit this knowledge on my own behalf, it offends me.

There have to be ways individually and collectively that we can work towards these kinds of more nuanced health care interactions for less advantaged individuals and families. The more a patient understands his or her illness (and the plan of care) and the more that she or he cooperates with that plan of care, the more likely it is that she or he will cooperate with the plan of care needed for recovery.

The entire system is fucked: that's an absurd premise in contemporary and technologically advanced societies – but it was my premise at the times of these various hospitalizations and office visits. (It is still my premise today). I would not willingly be a post-op unconscious person without a knowledgeable and skilled guardian present at my bedside. I would not willingly be helpless without an observant watcher. I would not begin moving about without a family member, a caring friend or informed attendant with me.

This essay is a pedagogical essay – one of imaging a pathway to the future it is likely that I will never see. It begins with this awareness of a fucked up and increasingly inept national health care system.

Healing the System

> *What we forget in this country is that people have rights, basic rights: the right to food, the right to decent housing, the right to medical care, the right to education.*
>
> William Sloane Coffin, Jr.[viii]

When I begin to imagine the future in the distance, for example, a healed health care system and a healed nursing profession, Clara Gilchrist's, Anna Mae Charles Fretz' and Orpah Moseman's wisdom guides me.[ix] In their own era of history, they were progressive and forward-looking faculty

members and administrators. They did not become intimidated by problems inside their chosen profession but saw them as opportunities for change and forward movement. They did not see their students as individuals to be trained automatons; rather they saw them as unique individuals to be educated. In short, by teaching us the principles of evidence-based care, they trusted the future of the nursing profession to us. It is now our turn to figure out how to protect the future of the health care professions even as we commit ourselves to providing proper and evidence-based care. Both aspects are essential: the patient must receive the best care possible and the care-giver must look forward to more reliable and more humane levels of care.

A golden future first needs to be imagined and then invented. Planned efforts at change need to be measured step by measured step. Each step must be evaluated for its success and its ability to be a structural foundation for additional steps. Failures and fault lines must be addressed systematically. To do this, we must be data-driven rather than ideology-driven. We must, it seems to me, understand that our narrative to ourselves in the present moment (i.e., *the system is fucked*) – while important – must always be forward looking (*it doesn't have to be this way and I will help to change it)*. In this present moment we are walking a fragile, yet tangible, bridge between the past and the future. What we do today will largely determine what the future will look like in the weeks, months, and years to come.

It is obvious; we must pay attention to facts. We must also pay attention to inherited wisdom. Finally, we must attend to intuitive knowing. These four: an educated intuition, a compassionate forward-looking vision, facts, and inherited wisdom contribute to an informed hunch or hypothesis about what is needed in any given moment of time. Tolkien's comment applies here: *It does not do to leave a dragon out of your calculations if you live near one.*[x] Today's dragon is the COVID-19 virus. We do not know what will be the next dragon in 2025 or 2050.

But we must anticipate that we will continuously live near dragons. That means we must account for them in our work.

We must, therefore, design ways to measure the continuum from dreaming, intuiting, and planning to implementation, stabilization, and evaluation. Even as we envision another future for our professions and health care

systems, we must guide our actions by fact-driven objectives and scientific evaluation methodologies. This means that we must also govern our daily actions by humane and compassionate fact-driven evaluation methodologies. In short, if we hope to create a new golden age for health care in this current century, we must understand and utilize the principles of evaluation as well as the practices and principles of informed and compassionate action.

Just as living in the midst of a pandemic challenges us, so too will future challenges exist. In addition, to science, fact, intuition, we also must design flexible systems that can adapt very rapidly to the demands of the present moment. This means that we must devote considerable attention to the design and implementation of core work groups and facilities. I have come to a personal opinion: cross-training is essential. Every care giver must have a personal bag of tools she or he can utilize as needed.

I think about the all-purpose handy man who does needed house repairs for me. His truck bed is amazing. It is full of tools – buckets and buckets of tools. Whether he is building a set of shelves for me or repairing a toilet, he knows which bag of tools he needs and he is secure in his use of these tools. The same is true of the gardener who tidies up my yard several times a year. He too has a truck bed full of tools – but now these tools are gardening-specific tools. Both men are specialists and yet at very basic levels of work, they help me maintain my home and its health. Each knows his trade. Both “specialists” are needed to keep my home and property repaired and safe.

The goal of a constantly improving health care system is not only a goal of advanced technology – as important as that is. It is a goal that advocates for and implements justice in every aspect of health care. It is a goal that emphasizes compassionate interactions with others – no matter their skin color, their religion, their sexual orientation, their nation-state of origin, or any other human variable that can cause prejudice and discrimination to emerge in the human commons.

We must, to be sure, base our care on the body-self’s own healing wisdom. To do this, we must continue the advances in science that unlock the unknowns of the body’s physiology and psychology. Each health care professional must diligently cultivate two kinds of knowing: scientific and

intuitive. If we do not cooperate with the body's own wisdom, the prospect of healing becomes much more difficult.

We must also anchor our care in each human body's own community. Each person living is both an individual and a cell of a greater humanity. Individual and socio-cultural realities must be understood for individuals to receive optimal care.

We must not only understand the body's anatomy and physiology we must also understand the human person's unique identity, personality, and social location. We must seek to understand the complex networks of human relationships.

The Importance of Re-framing: Moving the Blockades of Resistance

> *Problems that are impossible to change with one paradigm nay be easily solved with a different one.*
>
> Margaret Wheatley[xi]

Cognitive re-framing assists organizations and individuals to look creatively at situations – by changing the vantage point used to describe and discuss them. *The essential idea behind re-framing is that a person's view depends on the frame it is viewed in. When the frame is shifted, the meaning change and thinking and behavior often change with it.*[xii]

In addition, however, to caring for individuals, we must also learn how to care for entire systems – families, for example. In addition, we must actively care for the structures inside of which we provide care on a daily basis. This means we must learn how to understand power and authority in very practical ways. It also usually means that we must continuously be willing to reframe our ideologies of complex human relationships and their concomitant issues of power and authority.

We must learn how to move and shift entire systems on a daily basis. It is no longer adequate for health care professionals to operate on automatic pilot. In a time of crisis, everyone on the health care team must be capable of guiding and providing care. Individual roles of the various professions must be understood and honored but, as much as possible, cross-training

must go on so that each professional understands the limits of his or her own profession as well as the limits of others' professions.

Disciplinary rigidity and orthodoxy does not serve the needs of the clients of our services and it also does not serve the providers of those services.

Let me give a practical example of what I am talking about. Usually I get my annual flu shots in my primary care practitioner's office – administered by a registered nurse. This past year (2019) when I picked up some medication at the local drug store, my pharmacist asked me if I already had my flu shot. For the first time a pharmacist administered my annual flu shot. Thus, I did not need to make a formal appointment with my primary care practitioner – saving both of us time. Clearly my state's licensing bodies had reached some new agreements about who could administer flu shots and in what kinds of institutional settings. Physicians, nurses and pharmacists now administer this prophylactic public health safety measure – for me as well as for my community at large. These kind of systemic changes serve the public welfare and, most likely, provide better protective coverage during flu epidemics. In addition, it addresses beleaguered primary care practitioners allowing them to provide care to people more in need of complex care. It eases systemic issues as well. Rapid and easy access facilitates wider use of these life-saving vaccines.

Let me give another example. The Salk (1955) and Sabin (1961) anti-polio vaccines came on the United States market. The annual scourge of polio and the fears of parents for their children could now be alleviated. I was a brand new registered nurse when the fire station in my home town – in collaboration with the town's physicians and registered nurses – decided on an immunization protocol or program for the entire town. I was asked to help by volunteering my time and did so. Parking lots and sidewalks became make-shift walk-up clinics in which the Sabin vaccine was administered. As I recall our efforts lasted several weeks. I had just finished a six week stint as a camp nurse in another community – so I was relatively comfortable wearing my white uniform in a non-hospital setting. I felt proud to be of use to people that I knew personally. By my actions and by the actions of a collective group of nurses and physicians, I was helping individuals and an entire community to avoid an outbreak of polio during the next anticipated polio season. Twenty two years old, I saw my participation in this community-wide immunization program as a civic duty and as a professional duty.

As a grade school and high school student (many years before) I had sold cookies and homemade brownies on these same sidewalks. Now I was dispensing a life-saving vaccine. The physicians in my home town, who had cared for the child I once was, became my professional colleagues in a town-wide effort to protect the health of other children and their parents. Now a grown-up and newly licensed professional nurse, I was assisting my community and another generation of children in another way. I was a volunteer in this effort and no citizen was charged for my time and professional expertise. Caring for the individual and for the collective merged in our effort to stop the plague of childhood and adult polio in its tracks.

As I tell these homely stories, I do not recall any specific undergraduate class which taught me about a professional or personal obligation to do this volunteer work in my hometown. Instead, I was improvising upon the principles which the faculty had emphasized in our course work. Prevention plus knowledgeable and compassionate care for those already ill: in the summer of 1962 these were the guiding principles for me.

A third example is an example of stretching professional boundaries when stretching is needed. Several years ago I witnessed an elderly woman trip and fall over a cement parking barrier. It was clear that she was bleeding and it is also clear that she was confused. Her husband was yelling at her for being stupid. I decided to intervene. Not at all tactfully, I asked the husband to shut up and stand back so I could examine his wife's forehead which was bleeding badly. I asked my friend to get some sanitary wipes from my car's trunk and gently cleaned the blood away so I could see nature of the gash. I checked her pupils. I felt and counted her wrist and carotid pulses. Just then a biker-physician rode up on his bike. Seeing what was happening, he stopped to see if he could help. I stepped back because he had more expertise than I did. He examined the woman – repeating much of my earlier quick check. Determining that it was safe for the woman to stand up he and I helped her to her feet – assessing her stability as we did so. We helped her into the car and advised the driver of the car that she should now be seen at a local urgent care center or emergency room where x-rays could be taken. One of the passengers in the car promised me that he would make certain the very angry husband would cooperate with this recommendation. The doctor was wearing biker shorts and I was wearing hiking slacks. Neither of us looked like

professionals. It was our instantaneous command of the situation which marked us as trustworthy. At one point I whispered to the doctor, I am a nurse and that I had just happened upon this accident. At that point we began to work together as a team. There was no competition – just compassion for this aging woman who was now injured and needed more care than we individually or collectively could provide her in a crowded parking lot.

Background to a Proposal for Moving Forward

> *To change the social world, you must change its underlying myth and metaphor system.*
>
> Joseph Campbell

Naming our world's contemporary global plagues is relatively easy: poverty, homelessness, hunger, war, refugee camps for the terrified and destitute, starvation, immigrant children detention camps without parents present, global warming, antibiotic-resistant bacteria and life-threatening viruses, massive migrations from war zones and areas of increasing desertification: these and many other social realities threaten the well-being, safety and health of millions. To provide appropriate care, we must identify the distal and proximal pathology or disease-promoting causations for illness and death. We must, of necessity, seek to understand social disruptions of a magnitude we cannot really imagine unless we confront them directly.

For example, we need to understand the role of poverty in the susceptibility and death rates that we are currently seeing with the COVID-19 virus. To understand this correlation between poverty and death rates, we also need to understand the role of bacteria and viruses in ordinary circumstances. This particular virus is no respecter of persons and yet, we must acknowledge, that old age and poverty seem to facilitate its deadly march through our nation (and other nations as well).

This means we must learn to identify the individual and social matrices and nuances of pathology formation. We must study endemic causes of illness and death (for example, the role of tropical mosquitoes in malaria and dengue fever or the sanitation issues (such as contaminated or inadequate sources of clean water) that underlie death-causing childhood diarrhea in the developing world).

In a global world economy, we must comprehend and grapple with the pandemic potential of killing and maiming viruses – such as those that cause Measles, Ebola, Polio, and COVID – 19. While there are effective vaccines for Measles, Ebola and Polio, it is the world's political instability – particularly in war zones – that create the inequity of life-saving vaccination. There are also ideological prejudices that prevent equal access – where individuals are too intimidated to be treated or to ignorant of the benefits to access the help they need.

The Inner Healer and the Inner Person Needing to Be Healed

> *"I wish it had not happened in my time," said Frodo. "So do I," said Gandalf, "and so do all who live to see in such times. But that is not for them to decide. All we have to decide is what to do with the time given to us."*
>
> J. R. R. Tolkien[xiii]

Parenthetically, every nurse (actually every care-giver) can be taught by those to whom we provide care. Carl Jung talks about the reciprocal archetypes. In this case we – the caregivers - have an internalized the archetype of the patient and we have an internalized archetype of the care provider, i.e., the nurse. Each nurse has an inner patient and each patient has an inner nurse. This is the complex matrix of care: meeting a patient, the care-giving aspect of the professional nurse is activated. But the so-called inferior aspect of the care-needing person (i.e., the aspect of the self needing care) is also activated inside the psyche of the professional. Enactment of both aspects is needed for successful care to be provided. The implications here for self-care by professional are profound.

If we do not care adequately for our own inner self in the care-giving relationship, we will be ineffective. If, however, we are only taking care of the inner self, we will be actively harmful as well as ineffective.[xiv]

Caring for the Whole Person

Without reflection, we go blindly on our way, creating more unintended consequences and failing to achieve anything useful.

Meg Wheatley[xv]

In addition, the emotional and psychological issues of human maturation and acculturation must be studied. My undergraduate college professors called this *learning to care for the whole person: body, spirit, and emotions.* In graduate school, I learned that caring for the whole person often involved knowing about and caring for the sick individual's life history and community. To do this, I needed to know and respect the life history of individuals and the cultural histories of their communities. I needed to learn to respect a wide variety of cultures in order to provide care to the largest number of individuals needing my assistance. There are complex socio-historical and cultural issues which affect the ability of health care systems to function effectively.

The COVID-19 virus is a great teacher because it is world-wide. The virus doesn't care if you are a Christian or a Hindu;' it doesn't care if your skin color is brown or white; it doesn't care about the shape of your eyelids; it doesn't care about your financial capital. It doesn't care if you are well-educated or if you are illiterate. And yet having said that: we also know that these kinds of social dimensions in a human life or a community do affect the level of care that individuals and entire communities receive.

Poverty

The world is a dangerous place, not because of those who do evil but because of those who look on and do nothing.

Albert Einstein[xvi]

For example, one of the patients assigned to me during my graduate school years was an economically and educationally impoverished mid-life white woman from Appalachia. She needed radiation therapy and was refusing to give consent. My task was to see if I could understand her resistance so that the medical radiology team could treat her. I began to stop by her bedside – just to talk – on a regular basis. As I got to know her, she revealed her intense fear – indeed terror - of being all alone in the radiology treatment room. She saw radiation as dangerous – threatening

her life. But, as I learned to know her, I realized it was the isolation that bothered her more than her fears of radiation. I taught her a bit about medical radiology – emphasizing that it was a life-saving rather than malicious and murderous technology. Once I decoded her terror, I promised her that I would go with her to the radiology lab and would talk with her on a microphone from the safety of the radiology staff room. I talked about the protective gear she would wear so that the treatment would be very specifically targeted to her growing tumor.

She finally agreed to the life-saving treatment. I kept my promise and went with her to the radiology lab for these treatments. I helped her get onto the table, held her hand as the radiology team prepped her and then, as agreed, left the room but immediately began to talk to her by microphone – telling her what would happen next. I was, in essence, a nurse cheerleader or health coach for her so that she could access her own courage. At the conclusion of the treatment, I went back with her to her room and we talked about what had just happened to her. I answered her questions and talked about what would happen the next morning. I took care to use ordinary language rather than professional language in these conversations – always translating to her what I'd witnessed and explaining the next step in her care. In addition, I paid attention to her language usage and where I could, I used her language system and vocabulary rather than nursing or medical jargon. After several treatments, she was an old hand at what she needed to do, she climbed on the table easily and willingly and one day told me I should help someone else like I had helped her. Clearly, she had grown into her own and, while I would talk with her on the ward, she no longer needed me to calm her fears. I know I learned more from her than she did from me about the interrelationships of terror, fear, anxiety, and the ability to withstand the stress of frightening medical treatments. She has become a life-long teacher for me – long after those intense several weeks when I was her emotional and spiritual lifeline to the world of high-technology medical care.

Cultural Diversity

In our every deliberation, we must consider the impact of our decision on the next seven generations.

Iroquois Philosophy[xvii]

Living in the state of Arizona, for example, I have needed (and continue to need) to learn about and live alongside of a wide diversity of cultures. Arizona is one of the fastest growing states in the United States. As one aspect of that growth, it houses a large number of undocumented immigrants. Interim census statistics for 2009 showed the state's diversity.

29.0%	Hispanic and Latinos
4.5%	Amerindian (4.1% non-Hispanic Indians)
2.3 %	Asian
3.4%	Blacks (3.3% non-Hispanic blacks)
76.4%	White (59.6% non-Hispanic whites)
.01%	Pacific Islanders
2.4%	Bi-racial, multi-racial[xviii]

One quarter of Arizona's total land mass is occupied by Amerindian tribes and nations. The two largest nations are the Navajo nation in the northern part of the state and the Tohono O'Odham nation in the southern part of the state.

Arizona has twenty two federally-recognized Amerindian tribes – each with its own unique language, regional location, history, culture and tribal identity.[xix] These tribes range from the O'Odham, Jocomo and Jano tribes in the southern counties to the Navajo, Paiute and Hopi tribes in the northern counties. Amerindian forms of tribal medicine and healing practices are regularly performed inside the state. They exist alongside of Euro-American medical care practices. Along the Southern border with Mexico, cuanderismo is practiced on both sides of the border. Tribal shamans are part of the community's response to intra-culture and inter-culture problems.

Religious Diversity

When Immigrants come, the freedom to practice their faith is a guarantee. They may have trouble with their neighbors, but freedom of religion is part of the blueprint for America, and that is the recipe for the religious diversity that we have today.

Diane L. Eck[xx]

God is not a Christian: nor a Jew, Muslim, Hindu….

Desmond Tutu[xxi]

One of the most volatile issues in American (as in USA) politics today is the issue of religious diversity and the need for religious tolerance. For health care workers, this can be a complex minefield as health care providers need to understand religious diversity in order to provide physical and emotional care.

In our accounting of health care issues, we must also mention the violence of inter-religious hatred-inspired terrorist violence among members of the world religions. The quantity of inter-religious hatred and violence is on the increase – particularly where the involved religious groups interface with each other in a context of ancient prejudices and hatred.

For example: my ethnic religious group believes that infant baptism is not valid – a minority position inside the borders of Christianity. Yet, when I was a student nurse in the newborn nursery, I was taught how to baptize newborn infants if they were in danger of dying before a priest could be called to do the baptism. I often pondered the question: *what would I do if this decision needed to be made on my watch?* Never faced with the need to make this decision, nevertheless, my intuitive inner feeling was that I would indeed baptize the infant in order to prevent a level of suffering and spiritual anguish in the child's parents – a level of preventable suffering that would automatically happen if their child died in an unbaptized state. The medical and nursing principle of *doing no harm* had to take precedence over my internal beliefs that baptism was a religious ritual designed for adults.

Climate Change

> *The eyes of all future generations are upon you. And if you choose to fail us, I say – we will never forgive you.*
>
> Greta Thunberg[xxii]

Did I mention global warming? The interface of economic issues with ecological climate change issues continues to affect the health and welfare of the least advantaged among us. In recent years we have seen dangerous fires in Australia and in the United States. We have seen wild storms that destroy the environment and structures. As the arctic ice cap melts, we will continue to witness severe storms and other natural disasters which destroy property and land alike.

If all life is interconnected, then what happens to any one of us affects all of us. It is impossible to measure such a claim. It functions, therefore, as a belief statement about the needed solidarity of each human being with other human beings; the needed solidarity with other life forms – indeed with the ecosystem as a whole.

Global climate change activists are warning us about the canaries in the mine – those endangered species world-wide. The effects of climate change upon health care systems and individuals become evident in areas of desertification – where entire communities must migrate in order to live.

Drug Cartels and Smuggling

> *People are dying because the first casualty in war is the truth, and the war on drugs is no different.*
>
> Dominic Milton Trout[xxiii]

And there is the violent scourge of the international drug cartels which both create and cater to addictions. The motivations of these various cartels appear to be mostly about financial gain. Our collective inability to slow the demand for illegal drugs is one seedbed for the violence of the world's various drug cartels. The politicization of this issue means that medical services – such as clean needle exchanges – are neglected or actively prohibited.

The Border Wall and Migrant Deaths in the American Sonoran Desert

Any man's death diminishes me because I am involved in mankind.

John Donne[xxiv]

Migration from Central America and Mexico can involve dangerous hikes through mountain passes and open deserts – locations where shelter, food and water are often nonexistent. Social organizations such as the Southern Arizona's group Humane Borders[xxv] provide water stations and challenge laws which forbid providing humanitarian aid to migrants. In addition, Humane Borders partners with people of faith from many denominations to map the number of deaths each year as these statistics become available.

In addition to Humane Borders, a wide coalition of religious groups resists the criminalization of individuals and groups who provide life-saving humanitarian aid.[xxvi] Coalitions of groups and individuals such as No More Deaths seek immigration reforms which respect the basic humanity of every individual.[xxvii] A wide variety of churches and other religious groups have declared themselves in the sanctuary movement. One church I visited several years ago had this sign on the door: *No guns allowed on church property.* A second sign clarified the first: *If you are a police officer or border patrol officer, you must have a search warrant to enter.* In addition, this church maintains a water station on its property – where anyone in need can get water in a hot climate. It also maintains a food pantry where food is available.

Affinity Violence

As long as people use violence to combat violence, we will always have violence.

Michael Berg[xxviii]

Finally, there is affinity violence – an endemic world-wide set of interrelated phenomena that takes many forms: childhood experiences of physical, emotional, and sexual abuse; childhood and adolescent abandonment and

insufficient care; date rape and stalking; sexual harassment; spouse abuse; elder abuse; school shootings, and workplace gender harassment.

Each of these experiences changes human lives. Each also negatively affects the social communities in which they occur.

The emergence of sexual, physical and emotional violence inside any particular religious group is also a factor to be identified. This is particularly true when adult spiritual leaders sexually, physically or emotionally violate and abuse children and adolescents or vulnerable adults.

Thinking Out Loud to Myself

> *People don't like change; people like control. We like control more than anything? Right!* [*But*] *if you don't change, you don't grow.*
>
> New York State Governor Andrew M. Cuomo
> April 26, 2020 COVID – 19 Briefing from Albany

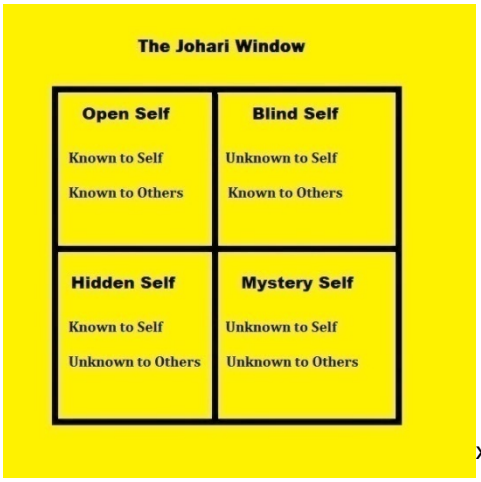
No individual nurse can address all of these complex social health issues. But, that said, nursing as a profession both can and should. So, how do we prepare nurses to understand these issues and how do we prepare them to address them in useful and helpful ways? Education!

Professor Clara Gilchrist (University of Cincinnati College of Nursing) taught her students to think in outcome objectives. What, in measureable and behavioral terms, are the outcomes we want students to accomplish in our educational programs? What, as care providers do we want our clients and patients to achieve? What do we want or need them to do or to show us in order for them to demonstrate restored health? The question is pertinent as we envision a golden future. How will we measure progress towards any stated goal?

The National Training Laboratories Model

The National Training Laboratories (NTL) summer intensive programs taught me to think in experiential, process-oriented, interdisciplinary, and collaborative manners. In their summer intensives, we met with others to learn group leadership skills for managing institutions and programs. In these extended encounter group meetings, we learned about our own

personal share of craziness as well as that of others. More importantly, we learned about our own and each other's abilities and strengths. Collectively we worked inside the model of the Johari Window.



[xxix]

Effective work teams, we learned, worked in environments where the open self – predominated. Thus, game-playing and power struggles were minimized and people learned to trust and then to rely on each other. Individual strengths and weaknesses became visible not only to individuals but to the whole.

This open self is the self known to both the self *and* to the others on the team. Thus, the working group had a shared awareness of the strengths and limitations of every member of the team. This creates work environments where the whole is greater than the sum of its parts. Serendipity happens naturally.[xxx]

In the years since my mid-twenties when I first worked with others using the Johari Window as a model, I have found it to provide me with guidance about how to get collective work done in an efficient and effective manner. As a heavy duty introvert, I needed to grow comfortable with people actually knowing who I was by recognizing my core values and beliefs, and by seeing my unique set of skills. In such a manner, the team could compensate for my limitations, lack of skill or inexperience in a particular arena of work.

As I learned to trust others, I also learned to trust myself. As people learn to know each other and to trust each other, they become more and more capable of efficiency and also more open to generating synchronicity; for

example, the solution of a problem by something or someone outside the realm of the ordinary or the expected.

In my life experience synchronicity is a trickster – showing up when least expected – often after an intense period of work in which results are scant if present at all. Then, all of a sudden the external or internal world shifts and a new solution appears. One example of this historically, is Archimedes - the scientist, who on stepping into his drawn bath figured out the formula for the displacement of water – an essential element of contemporary ship building. [xxxi]

Another example is the "accidental" discovery of penicillin in 1928. Returning from a two week vacation Alexander Fleming noticed that a petri dish containing a staphylococcal organism demonstrated that the staphylococcal growth had been stopped by the accidental, unexpected and unplanned presence of mold growing in the dish. Fleming's observation eventually led to the antibiotic era of modern medicine.[xxxii]

The WICHEN/NTL Model

WICHEN (Western Interstate Commission on Higher Education-Nursing) and NLN (National League for Nursing) seminars in nursing administration taught me about the management and economics of American health care systems. These seminars for nurse administrators met twice a year throughout the Western region of the United States. Younger nurse administrators – such as I was then – were teamed up with and mentored by seasoned nurse administrators. Mentor friendships provided a relationship in which troublesome management issues and difficult supervisory relationships could be confidentially discussed. In addition, these bi-annual seminars included lectures (and assigned homework) by important health care economists and management consultants who provided a glimpse into the state of health care laws and their diverse impacts on the American health care system. No graduate credits were issued but these continuing education gatherings were important to seasoned health care providers as well as to beginners. We were encouraged to visit each other's work environments when possible which I found particularly useful.

By the time I was thirty five years old, I had the equivalent of a graduate degree in health care systems management. I had seen the best and

maybe the worst of an over-stressed and deeply politicized health care system.

A Temporary Diversion

What has been will be again
What has been done will be done again
There is nothing new under the sun.

Ecclesiastes 1:9 NIV

My syllabi for student learning were based on measurable behavioral outcomes. My teacher, Clara Gilchrist, was a graduate of the University of Chicago and I benefitted from her brilliance and competency. When I met her, Gilchrist was an old woman and I never saw her inside a hospital setting. Her specialist's world was curriculum formation and measureable outcome pedagogy. Perhaps more than any other teacher, she shaped my world view about (1) nursing administration and (2) classroom pedagogy. Leaving her classroom, I saw nursing not only as a profession which provided direct care. I saw it as a profession with a pedagogical mandate. I saw it as a visionary profession – where we looked straight at our culture's health care system problems and then began to dream about what might be.

In short, a visionary health care system is one that is honest about its problems but never overwhelmed by them. The golden future always lures us forward even as we encounter and learn from today's problems and failures.

By the time I left the University Arizona Colleges of Medicine and Nursing in 1976 my clinical skills, my pedagogical skills, and my administrative skills were well-honed. They were the foundation on which I would continue to add specific professional skills as my life's locations and professional identities moved and changed.

My clinical intuition has guided me for my professional and post-retirement personal life. I trust it. It protects me in my personal life; it helps me to be helpful to others who ask me for help. It enables me to be kind when I most want to be snarky.

In addition, my administrative intuitions allowed me to seek out new teachers and new information systems throughout my life. Without even knowing the word *futurist* I became one.

If one knows one's goals – i.e., the golden city of the open future – then one can design a curriculum or a program or a health care system that moves one in that direction. Planning objectives and measurable goals are the framework upon which planned change develops and is evaluated. Outcome goals need to be flexible but precise enough so that as the cultural situation changes, one's outcome goals can be evaluated and tweaked.

Now, while we can envision the golden future for nursing as a profession, it is important to note that the pathway to that future will never be a direct and easy one. Human systems do not always operate the way we hope they will. There must be a continuous system of analysis – of gathering data in light of contemporary problems and in light of change efforts. The journey to a different – i.e., golden future – means changing contemporary world views and challenging contemporary shibboleths. It means developing new technologies. It means addressing the underlying world view issues.

If, for example, New York State's Governor Andrew Cuomo is right when he addresses people's dislike of change (and I believe he is), then our change efforts will need to address this dislike head-on. Communication skills will be essential as change agents address the needed changes we must make together if we are collectively going to change the dysfunctional aspects of our health care systems and those of our professional guilds.

Bushwhacking Our Way

> *Change always involves a dark night when everything falls apart. Yet, if this period of dissolution is used to create new meaning, then chaos ends and a new order emerges.*
>
> Margaret Wheatley[xxxiii]

In hiking rough terrains, as when we bushwhack open a path towards the future, we are traveling in a place where the trees and ground vegetation (bushes, grasses, etc.) whack you as you move into this untraveled and undomesticated terrain. The human forest operates in much the same

manner. Resistance to change is as common as our impulses towards change. Both forces must be considered: the desire to move towards a better future and the human tendency to resist change. A therapeutic adage often helps me: *we human beings often prefer the suffering we know to an unknown future without suffering*

The online blog *section hiker* defines bushwhacking as *off trail hiking.*[xxxiv] It offers the novice hiker advice about this kind of exploration into the unknown. In short there is no trail and there are no marking cairns or guideposts to direct the hiker towards his or her ultimate destination. A good topographic map and a compass are essential equipment. Also needed are sturdy hiking shoes, a lightweight tent and a comfortable sleeping bag. Essential preparatory work is also needed. I am going to summarize some aspects of this essay because it functions so well as a metaphor for systemic change in corrupted, undomesticated, out-of-control, and non-accountable and irrational systems.

- Fundamental skills include knowledge about how to use a topographic map and a compass; this skill allows you to know where you are located in the current moment. The author advises keeping the compass securely attached to your body at all times. He recommends having two or three compasses and provides seat-of-the-pants wisdom about never losing the compass due to carelessness. .
- Have two copies of your map with you that are stored in different locations of your gear in case you lose one. Keep the map well-marked and up-to-date as you move forward.
- Wear tear-resistant gear, safety goggles, and a cap with a visor to protect your body when the terrain gets rough
- Make certain you have some way to communicate to the outside world in dangerous situations where you (or a member of your group) need rescuing. My shorthand for this is keep track of your progress on a regular basis – know where you are at all times.
- Keep a pencil and notebook with you so you can record important information.. My shorthand for this is quite simple: human memory is very fallible and can, at any time, be replaced by wishful thinking.
- Begin to bushwhack from a well-defined location and well-established landmark. My shorthand for this is that if we don't know where we begin, we can't measure our progress.

- Establish your final destination by examining other trails in the same area and establish a rough timeline for arriving at your destination. My shorthand for this involves the need to survey what we know before we begin. This often involves collaboration with others.
- Make certain you know where true north is. What I ask is the golden future we envision? What is the beacon light that lures us to begin a program of planned change?
- Bushwhacking takes more energy than trail hiking so carry extra water, food, and snacks; very useful are water purifying bottles in case you run out of drinking water – a very likely possibility. In my experience, planned change must take account of planned resistance – whether this is due to an absence of resources or to human resistances to anything new.
- Know when you need to take a break or a rest period.
- In doing group hikes, standardize everyone's definition of true north – know how to find the polar star but be prepared for stormy nights when it is not visible to the naked eye. In planned change efforts that involve group work, paying attention to individual needs and beliefs and values become important.
- Record the time you begin your work; take periodic time checks on your progress so you can estimate the time remaining before you can expect to reach your destination
- Do not trespass on other's private land – academic and professional plagiarism build ill-will and mistrust. If you are building on the work of others, acknowledge them and their work.
- Avoid bushwhacking in the dark; it is disorienting and dangerous
- Don't get separated from your group; stay within an easy talking distance for the duration of the hike. My shorthand for this is simple: making certain that people are on the same page – or at least in the same chapter – is essential for progress to happen.

In reading this expert's advice for bushwhacking, allow it to function as a metaphor system for your unconscious mind – that mind which constantly monitors our internal biological behavior and our external social behavior. Spend time away from this essay – doing something else unrelated to it. Pay attention to the internal chatter of the noisy mind – allowing it to play with these metaphors. See what, if anything, emerges that might be of potential value in re-designing dysfunctional social systems such as America's health care system.

There is no doubt in my mind at all that when we talk about a golden future for the American health care system (and nursing in particular), that we are in a social bushwhacking situation. We have a dim glimpse of our destination (a system that is systemically healthy in a just and equitable society). We have, perhaps, a glimpse of the nature of the forest and brush that we must traverse. But we do not know how we are going to find our way until we begin to walk. And, until we begin, we have no idea about the length of the journey so we must prepare ourselves for hardship and difficulty. It is possible that we may lose our way or our sense of ourselves and need to be rescued. But, if we never begin, we will never know what is possible.

I doubt Florence knew what she would encounter in Crimea as she prepared to leave England for a war zone; I know the first nurse rape trauma researchers had no idea about the extent of sexual violence in American communities and institutions. They began, however, where they were with the data that was in front of them; with the circumstances and opportunities they created for themselves and others. Forty years later we are well on our way to understanding the incidence of affinity violence. And we know much more about the nature of trauma in the wake of this violence. The task of ending affinity violence eludes us – in part, I think, because our society is so used to solving its problems with violence. It is habitual in our internalized metaphors and myths to see violence as the solution.

In the midst of several simultaneous pandemics (Ebola, Polio, COVID-19) and in a world of endemic injustice and poverty, we must begin where we are in order to move towards that golden future where we should be for all world citizens to have access to health care that is culturally appropriate and scientifically accurate.

There is a caveat to all of this: we bring our whole selves to the table when we begin to engage in serious thinking and work that involves other people's lives. The Buddhists of the world are correct: everyone suffers during a lifetime. What is most needed in a world of suffering individuals and communities is compassion – first of all for the self; secondly for others. Compassion is not pity. It is, rather, an embodied and empathic awareness of suffering accompanied by the wisdom of the instinctual empathic desire to bring disease and dysease into balance with joy, love and happiness.

Compassion enables us to intuit another's suffering. I believe it also enables us when we enter the toxic forests of our culture and begin to bushwhack open a new path to the future.

I will end with attorney Lynn Abrahams comment about these matters: *You don't advance by being comfortable. You take a risk.* [xxxv]

Endnotes

[i] https://commons.wikimedia.org/wiki/File:Florence_Nightingale_CDV_by_H_Lenthall.jpg. Retrieved May 1, 2020 from Wikipedia Commons

[ii] Nightingale lived during the reign of Queen Victoria (1819-1901) who reigned from 1837-1901. We know that era as the Victorian era.

[iii] Note: a parallel transition was happening in medicine as barber-surgeons yielded way to university and medically prepared surgeons over the centuries. Once the Catholic Church stopped restricting and punishing the dissection and study of human cadavers, science began to set up the path for the development of modern medicine. Medical science - not the church and its hierarchy - took charge of sick and wounded people.

[iv] Medicine, during mid-century (1950 and forward) was experiencing a similar reality. Primarily a male profession, during the last century women began entering medical school in every growing numbers. Elizabeth Blackwell (1821-1910) was the first woman physician in the United States

[v] On September 10, 2019, the Associated Press reported that 27.5 million people in the United States (9.5% of the population) were without health insurance. That number represented an increase of 1.9 million people or an increase of 0.5%. Retrieved May 4, 2020 from https://www.nbcnews.com/politics/politics-news/number-americans-without-health-insurance-rises-1st-time-decade-n1052016

[vi] As of April 26, 2020, there were nearly one million confirmed cases of the virus in the United States; there were 55,000 confirmed deaths inside the USA borders; black citizens and non-black Hispanic citizens were disproportionately represented in these COVID totals. In addition, poor

individuals and impoverished communities also have at higher risk for becoming ill and for dying with the COVID-19 virus. As I write this, the states are ramping up their testing capacities and protocols and this data will become more self-evident, the more accurate our data.

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[ix] Clara Gilchrist was my professor at the University of Cincinnati in southern Ohio during my graduate work in psychiatric-community mental health nursing. She was a specialist in curriculum development.

[x] Tolkien, J. R. R. Retrieved May 11, 2020 from https://www.goodreads.com/quotes/5699-it-does-not-do-to-leave-a-live-dragon-out;

See also Ragland, M (UD). Twelve Quotes and Lessons from the Hobbitt Retrieved May 11, 2020 from http://mattragland.com/12-quotes-and-lessons-from-the-hobbit

[xi] Wheatley, M. Retrieved May 9, 2020 from https://www.google.com/search?rlz=1C1CHBF_enUS703US703&sxsrf=ALeKk01YhjCfziNEinMZIZ3esj6aMaXbSQ:1589057688173&q=meg+wheatley+quotes&stick=H4sIAAAAAAAAAONgFuLUz9U3MDM2zSlRQjC1xLOTrfQLUvMLclKBVFFxfp5VYWI-SeoiVuHc1HSF8ozUxJKc1EoFsGAxAO_QOvpHAAAA&sa=X&ved=2ahUKEwjPw5-Y1afpAhWSvZ4KHftCCXsQMTAXegQIEBAC&biw=1251&bih=742

[xii] Morin, A. (February 26, 2020). *Using Cognitive Re-framing for Mental Health.* Retrieved May 14, 2020 from the Very/Well Mind blog; https://www.verywellmind.com/reframing-defined-2610419

[xiii] Retrieved May 12, 2020 from https://www.goodreads.com/author/quotes/656983.J_R_R_Tolkien

[xiv] Guggenbuhl-Craig, A. (1991). (J. R. Haule, Trans.). *Power in the Helping Professions*. Woodstock, CT: Spring Publications.

[xv] Wheatley, M. Retrieved May 9, 2020 from https://www.google.com/search?rlz=1C1CHBF_enUS703US703&sxsrf=ALeKk01YhjCfziNEinMZIZ3esj6aMaXbSQ:1589057688173&q=meg+wheatley+quotes&stick=H4sIAAAAAAAAAONgFuLUz9U3MDM2zSlRQjC1xLOTrfQLUvMLclKBVFFxfp5VYWI-SeoiVuHc1HSF8ozUxJKc1EoFsGAxAO_QOvpHAAAA&sa=X&ved=2ahUKEwjPw5-Y1afpAhWSvZ4KHftCCXsQMTAXegQIEBAC&biw=1251&bih=742

[xvi] Retrieved May 17, 2020 from https://philosiblog.com/2011/11/29/the-world-is-a-dangerous-place-to-live-not-because-of-the-people-who-are-evil-but-because-of-the-people-who-dont-do-anything-about-it/

[xvii] Contemporary phrasing of an ancient Iroquois belief and way of life Retrieved May 12, 2020 from https://www.ictinc.ca/blog/seventh-generation-principle

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[xxviii] https://www.wiseoldsayings.com/violence-quotes/. Note Michael Berg is the father of a man who was beheaded and killed in Iraq. For information see, https://www.cnn.com/2006/WORLD/meast/06/08/berg.interview/. Both items retrieved May 18, 2020.

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[xxxi] Archimedes bath legend: Retrieved May 12, 2020 from https://www.juliantrubin.com/bigten/archimedesprinciple.html

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