

Protect the Possibility

Biographical Recovery and the Nursing Care of Veterans After Life-Altering Injury

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ABSTRACT

Recovery from life-altering injury or illness involves related dimensions of physical function and personal identity. This article uses *clinical recovery* to describe the restoration and protection of function, stability, and health, and *biographical recovery* to describe the reconstruction of identity, autonomy, and agency after disruption. Drawing on a reflective case narrative of the author's cervical spinal cord injury as an active-duty Marine in 2002, the article connects lived experience with medical sociology, social psychology, disability studies, and nursing theory. It proposes that biographical recovery deserves explicit attention alongside clinical outcomes; examines how healthcare interactions and expectations may influence perceived possibilities and participation in decisions; and considers how adaptive recreation, peer connection, and community programs can support meaningful roles. The distinction between clinical prediction and biographical prediction provides a framework for examining the reach and limits of professional judgment. The article offers practice considerations for experienced nurses and identifies questions for research. Its explanations and recommendations are interpretive propositions drawn from a single case and selected literature, and they have not been tested as a model.

KEYWORDS veterans; spinal cord injury; biographical disruption; possible selves; self-efficacy; agency; nursing practice; adaptive sports; peer support

Introduction

In the military phonetic alphabet, the letters O and M are rendered as Oscar Mike, shorthand for "on the move." The phrase usually means that a mobilized military unit is underway during an operation or exercise. It also names a question that can emerge during recovery from catastrophic injury: where does this person go from here? Survival, stabilization, and healing may dominate early care, yet questions about the life ahead are often present from the first days and grow more prominent as the crisis recedes. Nurses and other clinicians who care for veterans work close to that question. They encounter veterans at moments when the facts of a life may have changed suddenly and permanently. They assess what has happened, what can be treated, and what function can be restored.

Meanwhile, the veteran is often conducting a parallel assessment of a different kind. What does this mean for my marriage, my work, and my children? What becomes of the things I planned to do, and of the person I understood myself to be? This article concerns the relationship

between the clinician's assessment of a condition and the patient's assessment of a life. The two proceed together, often through the same interactions. Nursing already attends to personhood, independence, relationships, and meaningful goals; Henderson's (1966) account of nursing assistance, for example, explicitly includes the strength, will, and knowledge needed for independence. The contribution proposed here is a working distinction that makes identity reconstruction visible within that tradition and asks how ordinary encounters may support or constrain it.

The argument follows the three learning objectives of the accompanying conference presentation: distinguishing clinical recovery from the reconstruction of identity, autonomy, and agency; examining how care shapes perceived possibilities and participation in decisions; and considering the contribution of adaptive recreation, peers, and community programs. A final section offers practice considerations and questions for inquiry.

The author's experience anchors the analysis. It offers access to the meaning of recovery as he lived and remembers it, while requiring caution about retrospective inter-

pretation and generalization. The method and limitations sections address those limits.

Method and Case

Approach

This article uses a reflective case narrative informed by autoethnographic approaches that examine personal experience in relation to cultural and theoretical frameworks (Ellis et al., 2011). Episodes from the author's recollections are interpreted through selected concepts concerning identity, self-efficacy, autonomy, and clinical judgment. The article does not report systematic qualitative coding or a comprehensive literature review. Its purpose is to illuminate concepts and generate questions for practice by identifying a possibility worth investigating without establishing its frequency or cause.

The Case

About a month before the injury described below, the author completed the San Diego Marathon. He was twenty-nine and had served twelve years in the United States Marine Corps, having enlisted at seventeen. He had served as a drill instructor and was preparing to join a unit that would later deploy to Afghanistan. His self-understanding was stable and well articulated: Marine, father, leader, athlete, and someone on whom others could depend.

On February 20, 2002, while he was driving on Interstate 5 near Camp Pendleton, a tractor-trailer swerved into his lane to avoid a car cutting across traffic, and his vehicle rolled three times. He sustained a cervical spinal cord injury resulting in quadriplegia. He awoke three days later in the intensive care unit at Scripps Memorial Hospital, intubated and ventilated, with no voluntary movement below the neck. Surgeons stabilized his spine with titanium mesh and rods, and outpatient rehabilitation continued at the San Diego VA Medical Center. Roughly two years of relearning daily life followed. These and other details are drawn in part from the author's memoir, *The Street: Weaponizing Pain, Unlearning Surrender* (Gillums, 2026).

In the years that followed, the author raised children, led veterans' organizations, worked in disability advocacy and disaster response, taught at university, and became a husband, father, and grandfather. None of this undid the injury. The analysis concentrates on an earlier interval, when he was learning to function while still struggling to imagine much of his future. The marathon and the collision were a month apart. Crossing the inte-

rior distance between the man who ran that race and the man who emerged from the vehicle took years, and that crossing is what the following sections examine.

PART I

Two Dimensions of Recovery

Two Conversations

Catastrophic injury brings an immediate change in vocabulary: cervical spinal cord injury, quadriplegia, rehabilitation, prognosis, wheelchair, patient. Each term serves a legitimate purpose, since clinical care depends on precision. None of them addressed the question that most preoccupied the author in the early weeks after injury: who am I now?

Medicine could explain what had happened to the spinal cord, which muscles functioned, and what function might reasonably return. The patient was thinking about something else. He wanted to know whether he could still raise his children, work, and lead, and whether he would now be seen primarily as someone who needed help. Two conversations were under way at once, one in which clinicians worked to understand a condition and another in which the patient tried to understand a life. They overlapped constantly, and the tools suited to the first were not always adequate to the second.

A diagnosis can describe a condition without being qualified to describe a life.

Much later, the author arrived at a formulation for this gap: a diagnosis can describe a condition without being qualified to describe a life. The injury was real and its consequences permanent, yet a permanent condition need not be a total one that determines every significant feature of a person's future. Early in recovery, the author conflated the two. The medical frame made that easy through the sheer weight of its explanatory authority, without any ill intent on the part of those who used it.

Biographical Disruption and Loss of Self

Medical sociology offers useful language for this experience. Bury (1982), studying people with chronic illness, introduced the concept of biographical disruption to describe how serious illness breaks the taken-for-granted structures of everyday life and the assumptions on which a person's plans and self-understanding rest. His central

insight was that the disruption extends beyond body and emotion into narrative: the story a person has been telling about his or her life stops cohering.

Charmaz (1983) identified loss of self as a fundamental form of suffering among people with chronic illness, in which valued self-images erode without new ones emerging to replace them. A pain score or functional assessment cannot register that erosion. The present article asks how it may affect engagement in rehabilitation and the meaning patients attach to functional gains.

The Limits of the Restitution Narrative

Frank (1995) identified several narrative types through which people make sense of illness. The dominant type in Western medicine he termed the restitution narrative: yesterday I was healthy, today I am sick, tomorrow I will be healthy again. Much of clinical care is organized around delivering this narrative, and for many conditions it is the right one.

For permanent conditions such as spinal cord injury, exclusive reliance on restitution can become a trap, because the future may not return a person to a former body or way of life. For nearly two years, the author measured the present against the life that existed before February 20, 2002, including his career, his plans, and his assumptions about independence. Looking back, he was grieving a prior definition of himself along with his physical losses. Learning to live with the injury required a story that could accommodate change.

Defining Biographical Recovery

The remainder of the article rests on the following working distinction:

Clinical recovery refers to the restoration and protection of function, stability, and health to the extent possible. It is supported by protocols, milestones, and validated outcome measures.

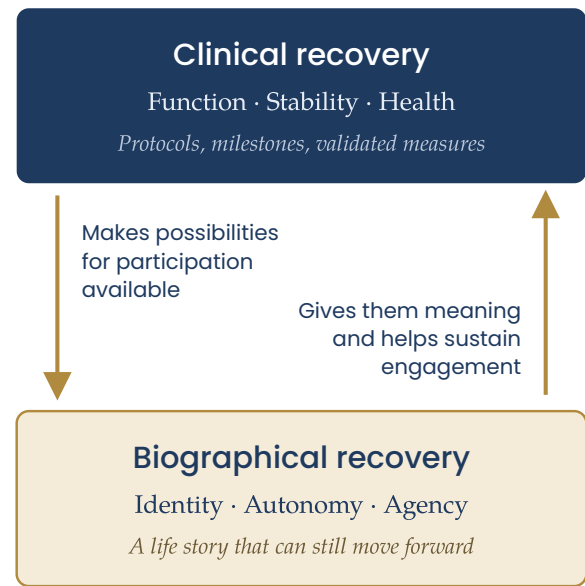
Biographical recovery refers to the reconstruction of identity, autonomy, and agency following disruption: the rebuilding of a life story capable of holding what has happened while still moving forward.

Autonomy here means having a meaningful say in the direction of one's life; agency means being able to act on that direction, whether independently or with assistance. As a working concept, biographical recovery overlaps with established concerns about adjustment, participation, well-being, and self-efficacy. Its contribution is to direct attention to how these come together in the reconstruction of a particular life. As Figure 1 illustrates, the proposed relationship is reciprocal. Clinical recovery can make possibilities for participation available, and bio-

graphical recovery can give those possibilities personal meaning and help sustain engagement in rehabilitation. Both may unfold in the same period, settings, and encounters, although progress in one does not necessarily indicate comparable progress in the other.

Figure 1

Two Dimensions of Recovery: Clinical and Biographical



Note. Conceptual synthesis offered in this article. The reciprocal pathways are proposed and have not been empirically tested.

The author's memoir shows this unevenness. After roughly two years of relearning how to dress, transfer between bed, chair, and car, and manage daily life, he had regained substantial functional independence. He had also become fluent in endurance without a settled sense of what much of that endurance was for (Gillums, 2026). Fatherhood already supplied purpose, as the next section describes, but other parts of his future remained unsettled. Clinical recovery had moved well ahead of biographical recovery, which was underway but uneven. Over time, the emphasis of his rehabilitation moved toward what he was willing to build with what remained. Function still mattered, and he increasingly judged it by the life it allowed him to lead.

Possible Selves

If biographical recovery involves reconstructing a life story, it is reasonable to ask what that story is made of. Markus and Nurius (1986) proposed that self-concept includes possible selves: representations of who one might become, including hoped-for, expected, and feared

selves. They argued that these images work as incentives, giving a person something to move toward and something to move away from, and so shape effort and persistence.

In the author's recollection, the injury abruptly unsettled his possible selves. The Marine preparing for deployment and the marathoner seemed to have vanished, and feared selves took their place: the burden, the man watching life from a window, the father whose children would become his caregivers. A changed body had altered his expectations far beyond the functions it directly affected.

Some hoped-for selves survived, however, and the memoir shows how one of them came to work as the incentive Markus and Nurius described. The author's identity as a father to his son and his two-year-old daughter became an organizing purpose for rehabilitation. He relearned to drive with hand controls, to cook and clean, to take his daughter shopping, and to show up for school events and parent-teacher conferences. Independence mattered, but what drove the work was the wish to be present for her and capable enough to protect her.

The example suggests that assessing which hoped-for selves remain intact, and which relationships sustain them, may be as clinically useful as cataloguing those that have been lost. The question for nursing, then, is which possible selves the patient is sustaining, reconsidering, or abandoning. The disruption of injury may make early encounters especially influential, and nurses' sustained contact places them close to this process. Asking about possible selves makes explicit an aspect of person-centered care that often remains implicit.

PART II

How Care Shapes Perceived Possibility

The Evidence the World Hands Us

Sudden dependence on others heightens sensitivity to how one is perceived. The newly injured person notices when a question about his care is addressed to the person standing beside him, when a stranger offers help before asking whether it is wanted, and when a conversation about the future opens with what probably will not be possible. No single moment of this kind determines a life, but such moments accumulate. So do moments of the opposite kind, when someone expects the patient to decide, offers responsibility, or treats an accommodation as a practical problem to solve.

The author took such encounters as evidence about his continuing competence. With familiar sources of identity disrupted, these interactions helped shape what he thought he could still do. Assumptions often arrive already formed. When the author's honorable discharge certificate came from Headquarters Marine Corps, pride and loss arrived together, and he describes feeling quietly dismissed. In public, strangers frequently thanked him for his service or assumed that an improvised explosive device explained his wheelchair (Gillums, 2026). Such assumptions are usually well meant, yet they supply a story for a person who has not yet been asked for his own.

Fricker's (2007) concept of testimonial injustice helps interpret these encounters. It describes a speaker receiving less credibility than he or she deserves because of prejudice about the speaker's identity. Directing questions to a companion can enact that loss when it reflects an unwarranted assumption about the patient's capacity to understand or respond. Helping a patient communicate differs from bypassing a person who can speak for himself or herself. Nurses can preserve possibility while remaining candid about clinical limits. Research on provider perceptions shows why it is worth examining how judgments about disability enter those conversations.

The Forecasting Gap

Gerhart et al. (1994) surveyed emergency care providers, including physicians, nurses, and emergency medical technicians, about how they imagined life after high-level spinal cord injury, and posed comparable questions to people living with such injuries. Fewer than one in five providers imagined they would be glad to be alive after such an injury, whereas more than nine in ten of the people actually living with spinal cord injury reported being glad to be alive. Providers also substantially underestimated the quality of life that people with these injuries reported.

Iezzoni et al. (2021) surveyed 714 practicing U.S. physicians, more than eight in ten of whom reported that people with significant disability have worse quality of life than people without disability. The sample was limited to physicians, but taken with the earlier emergency-provider study, the finding warrants attention to how assumptions about disability may influence care. Albrecht and Devlieger (1999) described the pattern underlying these findings as the disability paradox: many people with serious and persistent disabilities report good or excellent quality of life, even though outside observers commonly assume their lives must be undesirable.

The focusing illusion offers one possible interpretation. Schkade and Kahneman (1998), studying judgments about life satisfaction in a different context, showed how a salient feature can receive disproportionate weight. By extension, a person imagining quadriplegia may fix on lost function while underestimating the importance of adaptation, relationships, and ordinary routines. Judgments about the future may surface in recommendations, omissions, and the language used to discuss goals. A newly injured patient may also be imagining life without knowledge of later adaptation. The author's account suggests that the pessimistic expectations of clinician and patient can reinforce one another within a single encounter.

The Expertise Paradox

Experienced nurses bring an essential resource to these encounters. Benner (1984) described how expertise develops through practice, allowing experienced nurses to grasp whole situations that novices must work through rule by rule. Drawing on that account, this article proposes an "expertise paradox": experience that strengthens judgment in one domain may be extended beyond the situations in which it was formed.

Clinical prediction concerns expected function, complications, and the support needed for safety. Experience can strengthen these judgments, although uncertainty remains and should be communicated. Biographical prediction concerns work, relationships, belonging, and the broader course of a life, and it requires a different kind of evidence. One proposed explanation for overconfident biographical prediction is selective exposure. In acute and inpatient settings, clinicians may disproportionately encounter crisis, complications, and readmissions, with fewer chances to see favorable outcomes years later, and their expectations about life after injury can skew accordingly.

The pattern will vary by setting; clinicians providing longitudinal VA or community care may know veterans across decades. Confidence, then, should track the evidence available. Nurses can communicate clinical expectations clearly, acknowledge their uncertainty, and remain cautious about extending them into predictions about the meaning or possibilities of a person's life.

When Discipline Masks Depression

Expectations also shape care through what clinicians, and veterans themselves, expect a veteran's distress to look like. About a year after his injury, during outpatient physical therapy at the San Diego VA, the author was invited to join a support group led by a VA mental health

clinician. The intake screening identified depression. Staying inside, avoiding people, and sleeping through daylight had felt to him like discipline. The screening named them as withdrawal, symptoms he had been treating as choices (Gillums, 2026).

The crash had also left trauma responses. Intrusive imagery and nightmares, made more vivid by medication, became part of daily life, and after the Iraq War began in March 2003, constant news coverage of combat compounded them. In a small VA office, his clinician helped him see how cues such as burned metal, wreckage, and war footage had kept his threat system on permanent alert, so that every intersection felt like an oncoming truck. His instincts worked, she explained, but they had come loose from the present. He describes this translation as the turning point, because once he had language for what was happening, coping became possible (Gillums, 2026).

For nursing, these episodes suggest that military habits of endurance can coexist with distress a veteran struggles to name, that trauma related to the injury can stay salient after the physical crisis has passed, and that an explanation of symptoms can itself strengthen a sense of agency. These observations are meant to sit alongside established screening for depression and posttraumatic stress.

Participation in Decisions About Care and Life Goals

A successful clinical encounter can leave the veteran better informed about the condition, its management, and available resources. An encounter that also serves biographical recovery leaves that person with greater ownership of what happens next: participating in decisions, setting goals that reflect the life the veteran actually wants, and remaining the principal author of that life even when healthcare necessarily plays a larger role in it. Such concerns go to autonomy, a principle already central to clinical ethics and to models of shared decision-making (Elwyn et al., 2012).

Veterans and Agency

Military service can make agency especially salient. Many veterans have experience solving problems, adapting, leading, and contributing within structured systems, and sudden dependence may unsettle those identities. Service experiences differ, however, and military language should be used only when it fits the individual veteran's preferences.

For many patients, the loss of agency first appears in intensive care. The author has no memory of the crash itself. What he identifies as the most terrifying moment of

his life came three days later, when he woke in the ICU at Scripps Memorial Hospital, immobilized in the dark with a ventilator breathing for him. As he experienced it, each attempt to breathe on his own was met and overruled by the machine, and he felt he was suffocating even as it delivered air to his lungs (Gillums, 2026). Loss of agency can begin with the most basic bodily function, and critical care nurses are often the first professionals positioned to ease it. They can orient the patient, explain what the equipment is doing and why, establish some means of communication, and return whatever small measure of control is clinically possible as early as possible.

Military Intent as a Model for Care Planning

Military doctrine offers a concept that translates well to clinical practice. Orders include a statement of commander's intent, a concise expression of the purpose of an operation and its desired end state (U.S. Department of the Army, 2019). The statement exists because plans seldom survive contact with changing conditions. When circumstances shift, subordinates who understand the intent can adapt the plan without waiting for new orders.

Applied to care planning, the analogy places the veteran's purpose at the center. The veteran supplies the intent, and the care team helps develop feasible tactics through shared decisions. Statements might include "I want to get my daughter to school," "I want to work again," or "I want to go fishing with my brother."

Bowel and bladder management, skin protection, transfer training, and equipment selection can then be tied explicitly to that purpose. Goals and plans remain open to revision as the veteran's priorities and clinical circumstances change. For veterans who find this language useful, separating intent from tactics can preserve continuity through setbacks. When a particular activity or method proves inaccessible, the team can look for other ways to serve the underlying purpose.

Within VA, the approach aligns with the Whole Health model, which reorients care around what matters to the veteran and builds personal health plans from the veteran's own mission, aspiration, and purpose (Gaudet & Kligler, 2019). Commander's intent offers military language for the same commitment.

The author already used military frames in rehabilitation. The hospital room became his squad bay, the therapy gym his quarterdeck, and each attempt to reclaim movement a Crucible with no ceremony at the end (Gillums, 2026). That language sustained effort without

always clarifying its purpose. Anchoring the plan to what he wanted his life to contain gave the work a more personal direction.

The Agency Ledger

The same principle operates in routine care. When clinically feasible, letting a patient choose which task comes first, when care happens, or who is present can reinforce a sense of agency, and making those decisions on the patient's behalf without need may diminish it. This article calls that running accumulation of experiences the "agency ledger." It reduces to a practical question: which decisions can this patient meaningfully make today?

The Dignity of Risk

Perske (1972), writing about people with intellectual disabilities, introduced the concept of the dignity of risk. He observed that overprotection, however well intended, can deny people the right to take reasonable chances, to fail, and to learn from failure. Protecting a person from all risk also protects that person from growth. The principle has since been applied across disability services and long-term care, and it is especially apt for injured veterans, who once accepted considerable risk as a condition of their profession.

Treat the injury; protect the possibility.

Telling a patient, "This will be difficult," leaves the decision with the patient; concluding, "This is not for someone like you," takes it away. A clinician can explain risk without eliminating choice, provide assistance without presuming helplessness, and recognize disability without making it the organizing fact of a person's existence. Some losses are permanent and some possibilities genuinely close, and care cannot pretend otherwise. Its obligation is to avoid adding limits that the injury itself has not imposed. The title of this article compresses the principle into a single phrase: treat the injury; protect the possibility.

PART III

Adaptive Recreation, Peer Connection, and Community Programs

An Illustrative Episode

Some years after his injury, the author was encouraged to try adaptive skiing. The suggestion struck him as implausible, since skiing seemed to presuppose the ability to walk. He nevertheless found himself in Aspen, Colorado,

in a sit-ski. He began on the easiest terrain, progressed to intermediate runs, and by the end of the day was asking about an expert run. That morning he had doubted whether he belonged on the mountain at all; by afternoon he was bored with the easy way down. Nothing about his spinal cord or the mountain had changed in those hours, only the evidence he had about himself.

The day exposed a flaw in the reasoning he had applied to his own life for years. He had treated what he could no longer do as evidence about everything else. Genuine limits existed, and still do, but he had let the known ones settle questions he had never tested. The day mattered less for the skiing than for the curiosity it revived, which took the form of a question more productive than any inventory of losses: what else had he decided without finding out?

Self-efficacy and Its Sources

Bandura's (1977) theory of self-efficacy accounts for this experience with some precision. Self-efficacy refers to a person's belief in his or her capacity to accomplish a particular task, and it strongly influences whether a person attempts the task, how much effort is invested, and how long effort persists in the face of difficulty. Bandura identified four sources of self-efficacy beliefs:

- *Mastery experiences*, or direct experiences of success, which Bandura regarded as the most influential source.
- *Vicarious experiences*, or observing similar others succeed, which are most persuasive when the model closely resembles the observer.
- *Verbal persuasion* from people whose judgment the individual trusts.
- *Physiological and emotional states*, and the way a person interprets them.

Adaptive sports can draw on all four. Achievable challenges and successful attempts furnish mastery experiences, peers provide credible examples, coaches communicate realistic expectations, and supported participation may change how a person reads exertion. The benefits are not automatic, since difficulty, pain, exclusion, or a poorly matched activity can undermine confidence. Much depends on matching opportunities to the person's interests, capacities, and goals.

The skiing led the author to reconsider assumptions well beyond athletics, though whether such confidence transfers to employment, relationships, higher education, or other domains will vary from person to person. A use-

ful test for any activity is whether it gives the individual new evidence about a possibility he or she had dismissed.

Basic Psychological Needs

Self-determination theory (Ryan & Deci, 2000) adds a complementary perspective through the needs for autonomy, competence, and relatedness. Inpatient routines can constrain choices, assessments may emphasize deficits, and opportunities for peer connection can be limited, even where nurses and rehabilitation teams work actively to support all three needs. A community team may extend that work through chosen challenges, shared activity, and belonging. For some veterans, membership on a team carries particular meaning after the loss of a military unit.

Complementing Clinical Care

Adaptive sports programs operated by the Department of Veterans Affairs and by community organizations, including the Oscar Mike Foundation and Paralyzed Veterans of America, depend on clinical care. Skin protection, bladder management, and shoulder preservation help make participation sustainable. In turn, a personally meaningful activity may give a veteran a clearer reason to follow a demanding regimen.

Restoring Meaningful Roles

Community programs can widen the roles available during recovery. A person known primarily as a patient in an inpatient setting may become a teammate, competitor, mentor, or organizer elsewhere. Clinical settings can also sustain family roles and support peer relationships, as the author's experience of fatherhood shows. The settings differ in the range and context of opportunities they offer, and the boundary between them is porous.

The author's later work shows how roles can develop before confidence is secure. Newly injured veterans became allies who saw hope in him while he was still trying to locate it in himself (Gillums, 2026). Through Paralyzed Veterans of America, he found a mentor in Homer S. Townsend Jr., a retired Marine and paralyzed veteran who, in Bandura's terms, offered a credible example of a life beyond the author's current expectations. Townsend taught him to amplify veterans' voices instead of speaking for them, and the author later succeeded him as executive director. Peer, mentee, mentor, and leader became roles through which his sense of himself continued to change.

That work also brought the author into contact with veterans who later died by suicide, overdose, or premature death, including some whose care had proceeded according to protocol (Gillums, 2026). These losses inform his concern about what happens beyond clinical milestones. They do not establish that incomplete biographical recovery caused those deaths or that any particular intervention would have prevented them, but they raise questions about connection and continuity of support that deserve study.

Implications for Referral

Two practice considerations follow. Peers and adaptive activities may offer purposeful opportunities to test capabilities and occupy meaningful roles, and referral should account for the veteran's interests, readiness, access, and clinical needs. Teams can, and often do, arrange peer contact during rehabilitation itself, so that discharge paperwork is not the veteran's first introduction to it. The documentary *Sum Function*, directed by Oscar Mike founder Noah Currier, follows an all-veteran wheelchair rugby team. Viewers might ask what choices the participants make, what roles become available to them, and what new evidence about themselves they encounter.

Implications for Nursing Practice

Continuity With Nursing's Tradition

The proposed distinction extends nursing's longstanding concern with the conditions in which a person can recover. Nightingale (1859) emphasized the environment for healing, and Henderson (1966) placed independence within nursing's central purpose. Biographical recovery asks how that concern includes the person's continuing authority over identity and future goals. Such authority can coexist with extensive assistance and does not depend on doing everything without help.

Contemporary care environments make this distinction consequential. Electronic documentation, digital access requirements, fragmented treatment plans, and reliance on family assistance can influence whose account of the patient prevails and which futures remain available for consideration. Nurses are positioned to notice when an apparent limitation reflects the organization of care, when assistance begins to displace authority, or when clinical progress leaves little room for meaningful participation. The practice question becomes: Where might competent, well-intentioned care unintentionally narrow the life a veteran believes is available?

Practice Considerations

The following considerations draw on the frameworks discussed above. The examples illustrate proposed applications rather than validated interventions. They extend familiar nursing practices by attending to how routine encounters and systems of care may shape a veteran's understanding of who they can become.

Assess possible selves alongside current state. Ask what matters to the veteran, which future roles feel uncertain, and which possibilities may already have been abandoned. A patient approaching discharge may identify only goals involving medications, transfers, and avoiding readmission. Although these goals are important, their prominence does not establish that work, intimacy, parenting, or community participation no longer matter. The patient may have inferred that such subjects fall outside the conversation.

A nurse might ask, "Are there things you have stopped bringing up because you assumed they were no longer possible?" If a veteran identifies dating or returning to a parental role, the immediate task is to acknowledge the concern and, with permission, identify an appropriate opportunity to explore it. The veteran should determine how much to discuss and when. A care plan can appear individualized while containing only the possibilities the patient believes clinicians will endorse.

Distinguish clinical from biographical prediction. Explain expected function and risk with confidence proportionate to the evidence. Avoid extending those judgments into unsupported conclusions about work, relationships, decision-making, or the value of a future life. Examine whether an observed difficulty reflects the person's capacity, the conditions of assessment, or an interaction between them.

For example, missed video appointments may be interpreted as an inability to manage care independently. Asking the veteran to demonstrate the process may reveal that the difficulty lies in completing device authentication with impaired hand function. The nurse can document the distinction: "Veteran accurately describes appointment schedule and purpose; requires assistance completing authentication because of hand-function limitations." Accessibility support or another appointment method may then address the actual barrier. Performance within an inaccessible system should not become an unexamined prediction about the person's broader capacity.

Choose language that preserves possibility without sacrificing accuracy. Describe limitations precisely, including their context and relevant uncertainty. Where adaptation is feasible, discuss how an activity might

change. Where it is not, explain the limitation and explore the purpose the activity served without assuming that an alternative will have equivalent meaning.

Apply the same precision to documentation. A veteran described as “unmotivated” after declining therapy may be avoiding a session scheduled during bowel care because of concern about an accident. Recording the behavior, explanation, and proposed response provides more useful information: “Declined scheduled session because of concern about bowel urgency; requests therapy after bowel care; scheduling review requested.” Research suggests that stigmatizing chart language can influence subsequent clinicians’ attitudes and decisions (Goddu et al., 2018). When reviewing copied or AI-generated summaries, nurses can check whether a specific observation has become a generalized judgment. Documentation should support continuity without allowing a temporary circumstance to harden into a presumed identity.

Anchor care plans to the veteran’s intent. Elicit a statement of the veteran’s goals in their own words and explain how relevant elements of the clinical plan support those goals. Where the Whole Health personal health plan is in use, it offers a place to record that intent. Also consider whether the combined demands of care leave sufficient time and energy to pursue it.

A veteran seeking part-time employment may receive individually reasonable recommendations from several specialties that collectively occupy much of the working week. Asking, “Walk me through what following all our recommendations requires. Where would work fit?” can expose a conflict that remains invisible within separate clinical encounters. The nurse can bring specific scheduling conflicts, duplicated tasks, and opportunities for clinically appropriate simplification to the team. Research on treatment burden identifies poor coordination and demanding care routines as potential constraints on patients’ capacity to manage their health (May et al., 2014). A plan’s relationship to the veteran’s goals therefore requires attention to both its intended benefits and the workload it creates.

Attend to the agency ledger. Offer genuine choices within routine care wherever safety permits, direct questions to the patient when companions are present, and distinguish assistance with tasks from authority over decisions.

A spouse may efficiently manage portal messages, equipment orders, and appointments while clinicians gradually begin seeking the spouse’s preferences instead of the veteran’s. A private check-in can clarify whether this arrangement remains consistent with the veteran’s

wishes: “Which parts of your care would you like someone else to carry out, and which decisions do you want to remain yours?” With permission, document communication preferences and clarify roles through established processes. The veteran may prefer extensive delegation while retaining control over priorities and decisions. The relevant question is whether assistance operates on the veteran’s terms, rather than how many tasks the veteran performs alone.

Honor the dignity of risk. Explain the benefits, uncertainties, and potential harms of an activity, while also examining the consequences of continued restriction. A veteran who wants to resume a community meeting may encounter legitimate concerns about fatigue, falls, transportation, or skin protection. Staying home may become the default without equivalent attention to the loss of belonging or meaningful responsibility.

The nurse can ask, “We have discussed what might happen if you attend. What does continuing to miss it mean for you?” Where clinically appropriate, this information can inform a supported trial with agreed assistance, duration, contingency arrangements, and follow-up. Restrictions should be reassessed as circumstances change. Respect for informed choice requires attention to decision-making capacity and current clinical needs, alongside recognition that nonparticipation also carries consequences.

Explore peer and community opportunities. Match opportunities to the future the veteran is trying to imagine, as well as to interests, readiness, accessibility, and support needs. Shared diagnosis or military experience alone may not establish a useful match.

A veteran seeking reassurance about parenting or employment may leave a conversation with an accomplished adaptive athlete feeling further from an attainable future. Before arranging contact, ask, “What would you want to learn from someone living with a similar condition?” The answer may point toward a peer who raises children, manages personal assistance while working, or navigates services in a rural community. With the veteran’s consent, coordinate the connection and revisit its usefulness: “Did that conversation make your own future easier to picture?” Peer contact is most relevant to biographical recovery when it helps the veteran explore a future that is personally meaningful, without creating another standard against which to feel inadequate.

The contribution proposed here is an explicit extension of nursing assessment: examining how care itself influences the futures a veteran considers possible. For nurses, this adds a practical interpretive lens for distin-

guishing impaired capacity from inaccessible systems, disengagement from treatment burden, and chosen assistance from displaced authority. It addresses a contemporary challenge: as care becomes more digitally mediated, specialized, and reliant on automated summaries, clinically useful information can become separated from the person's intentions and circumstances. The anticipated outcome is care that supports both clinical recovery and the veteran's ability to shape a meaningful life. As nursing practice evolves, this approach positions nurses to recognize when systems designed to support recovery are inadvertently constraining it, and to make the veteran's continuing authorship of life an explicit consideration in care.

The Future Patient

Clinicians may never meet the person whose possibilities they helped preserve: the veteran who returns to school, resumes parenting in a new way, or eventually sits beside someone newly injured. A nurse may remember as an ordinary shift what a patient remembers twenty years later as a turning point. Without that later feedback, humility is needed in both directions, since some consequences of care remain unseen and the meaning a patient gives an encounter may exceed what the clinician intended.

Response to the Learning Objectives

The article addresses the three learning objectives by moving from conceptual understanding to practical recognition and application. First, it distinguishes clinical recovery from biographical recovery, explaining why improved function does not necessarily restore identity, purpose, belonging, or authority over one's future. Its discussion of assistance also demonstrates that physical dependence can coexist with autonomy. This gives nurses a framework for recognizing when measurable clinical progress and the veteran's experience of recovery diverge.

Second, the article identifies how healthcare interactions, expectations, and assumptions can influence a veteran's perception of future possibilities and participation in decisions. This objective receives the most extended treatment. The practice examples illustrate how inaccessible technology can be mistaken for impaired capacity, documentation can perpetuate judgments, treatment demands can crowd out meaningful goals, and caregiver assistance can unintentionally displace the veteran's voice. These examples help nurses recognize specific ways that well-intentioned care may constrain agency and identify feasible opportunities to respond.

Third, the article describes how peer connection and community participation can complement clinical care by helping veterans imagine and explore meaningful futures. Its emphasis on matching peers to the veteran's interests and anticipated roles explains why shared diagnosis alone may be insufficient. Part III also describes how adaptive recreation provides opportunities to test capabilities, revise assumptions, and carry discoveries into other areas of life. Nurses can help make that connection by asking what the veteran learned through participation and where else that learning might apply.

Together, these elements establish a coherent educational progression: distinguishing dimensions of recovery, recognizing how care influences them, and identifying experiences that support meaningful participation. The article provides content aligned with the learning objectives; demonstrating that learners achieved them would require an application exercise or discussion in which participants identify a barrier and propose a response that supports both clinical care and the veteran's intent.

Limitations and Directions for Inquiry

The central case is a single, retrospective, first-person account, subject to the reconstructive nature of memory and to the particular circumstances of one person's injury, military career, social supports, and access to resources. The author's eventual trajectory, including leadership roles and policy work, is not typical. The article should not be read as implying that such outcomes are available to everyone or that their absence reflects insufficient effort. Many veterans face barriers that no reframing can overcome, including secondary complications, financial strain, inaccessible environments, and co-occurring conditions such as traumatic brain injury or posttraumatic stress.

The memoir that supplies many biographical details is explicit on this point. It notes that memory is selective and fallible, that dialogue and sequences of events may be reconstructed or condensed for narrative clarity, and that identifying details of other people have been altered (Gillums, 2026). The case should be read in that light, as faithful to experience as it was lived and understood and unsuited to serve as an objective clinical record.

The theoretical frameworks drawn upon were developed in varied populations and settings, and their application here is interpretive and untested. The quality-of-life findings cited concern specific provider groups and

time periods, and the physician survey in particular should not be generalized to nursing without direct study.

Research could examine how perceptions of life after disability vary across nursing settings and levels of experience, and whether exposure to long-term outcomes changes those perceptions. Studies could test whether attention to possible selves, or care plans anchored to a veteran's intent, influences engagement, self-efficacy, or participation. The timing and accessibility of peer and adaptive recreation opportunities also warrant investigation. Finally, further development of the biographical recovery concept should begin by examining its overlap with existing constructs and measures before any distinct instrument is proposed.

Conclusion

For years after his injury, the author evaluated his recovery by asking how much of his former life he could reclaim. The measure made February 19, 2002, the permanent standard against which every later day was judged and found wanting. A more productive question eventually replaced it: what can be built from here?

Frank (1995) described a quest narrative in which a person meets suffering directly and seeks to make something of it, and he cautioned against idealizing such narratives. Stories of adversity are sometimes told as though suffering becomes worthwhile when something impressive follows, a premise this article rejects. The author would have preferred not to break his neck. What the injury left intact was a particular kind of authority: the power to decide what the injury would be permitted to mean about the rest of his life. That authority, more than any restored function, became his measure of independence.

Recovery is often imagined as a return to the person who existed before injury. Sometimes such a return is possible; often the task is to find a way forward. Nurses cannot choose that direction for patients or guarantee where it leads. They can help keep clinical realities from hardening into unsupported verdicts about a whole life, while recognizing that material barriers require practical action as well as changed expectations.

In practice, that means treating what medicine can treat, being candid about what has changed, pursuing and protecting attainable function, and matching predictions to the evidence, with particular caution before declaring the boundaries of a life still being written. The

veteran receiving care remains a person deciding what comes next, and care can support the ability to make one decision, then another. Oscar Mike: on the move.

Questions for Reflection and Discussion

The following questions are offered for readers preparing for the presentation or continuing to engage with its themes afterward.

- 1 Think of a veteran you cared for during the early phase of a life-altering injury or illness. What possible selves do you believe that person was holding onto or abandoning, and what evidence from the care environment might have influenced that process?
- 2 In your own practice, where does clinical prediction end and biographical prediction begin? Can you recall a time when experience led you to a biographical prediction that later proved mistaken, in either direction?
- 3 How might your practice setting shape the sample of outcomes on which your expertise is calibrated? Which long-term outcomes are you least likely to see?
- 4 What would it take to incorporate a veteran's statement of intent into care planning on your unit? What obstacles, institutional or cultural, would need to be addressed?
- 5 Identify three routine care decisions in your setting that could safely be offered to patients as genuine choices.
- 6 How does the principle of the dignity of risk interact with your professional obligations regarding safety? Where do you locate the boundary?
- 7 At what point in the care continuum does your setting currently introduce peer mentors or community programs? What would be required to introduce them earlier?

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