Suicide: a statement of suffering

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SUICIDE: A STATEMENT OF SUFFERING

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This article is designed to focus on the provision of nursing care in general medical wards following the admission of persons who have attempted suicide or who have a previous history of attempting suicide. The authors explore, analyse and synthesize how nurses, as key players in the health care team, may begin by recognizing the uniqueness of the individual, and by cotravelling therapeutically with the person on part of his or her journey towards recovery and healing. Efforts are made to demonstrate how nurses can influence the health gain of this group of people and their families. Professional attitudes and related ethical aspects, such as autonomy, respect for autonomy and paternalism, are also examined within the context of the nursing care of people who have attempted suicide. The need to enhance sensitive and caring communication skills for nurses who work with this group of people is tentatively considered. Some reasoning about why there may be difficulties in specific areas of communication such as empathy are contested and explored.

Introduction

Suicidal ideations produce features of both a private depression and a public failure.[1] Camus (1913–1960)[2] called suicide 'the only truly philosophical question' and Wittgenstein[3] considered it to be a pivot on which every ethical system turns. Until recently, suicide has been considered as a sin against God by most societies. (However, it must be noted that suicide has been legal in Germany since the Middle Ages.) Today, it still carries a tremendous stigma.[4] It is viewed as 'morally wrong' and the very complex and multifarious nature of the phenomenon of suicide poses great difficulties in its understanding.[5]

The difficulties in trying to understand the act of suicide are illustrated by Heyd and Bloch,[6] who suggested that the primary dilemma occurs over a fundamental belief: the value of life itself. It is this very denial of what is usually accepted as a universally held value that makes suicide such an emotive topic and its definition so value-laden. Likewise, there is no specific biblical term for killing oneself and 'suicide' was the term introduced as late as the seventeenth century to replace the more emotional and incriminatory 'self-homicide'.[7]

Regardless of the perspective chosen to study suicide, for the purpose of this

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article the act of suicide is conceptualized as 'a statement of suffering'. One or several individuals take the final decision to communicate to the rest of us that they are in so much pain that they have lost the will to live.[8] Individuals who attempt or commit suicide are, therefore, overtly communicating at least two key messages: their desperation and their perceived lack of other alternative actions.[9]

Carrigan[10] and Long and Reid[1] stated that people who have attempted suicide often report the 'need to escape'. According to their research, the person's intention may not be to die, but to opt out of that painful period of their life for a while. They assert that these individuals may perhaps desire to kill that crucial phase in their lives, rather than themselves.

Can we, as a society, say we are good at listening to this group of people, truly hearing what it is they are communicating? Do we try to open our eyes and imagine their suffering? Are we sincere when we ask ourselves: what catalysts have we provided to ensure that each and every human being is valued and respected regardless of their race, creed, social or economic status? Are we conscientious about acknowledging the part we have to play, individually and collectively, in trying to reduce the incidence of suicide, or do we only open our eyes to the reality of people's suffering when it affects a person we know or someone close to us?

Statistical background

Experience of 'nursing' on a medical admissions unit demonstrates that numerous persons are admitted following a suicide attempt.[11] Moreover, the UK's *The health of the nation* White Paper[12] recommended that health care providers should aim to implement a target: 'To reduce the overall suicide rate by at least fifteen percent by the year 2000' (p. 2).

It is essential, therefore, to recognize the reality of suicide and attempts of suicide as major issues in contemporary health care. Data from the Central Statistical Office[13] show that 1 in 12 500 of the population in the UK is liable to commit suicide each year. Suicide is the third most common contributor to life years lost after heart disease and cancer.[14]

Collee[15] purports that attempted suicide, however unconvincing that attempt is perceived to be by professionals, is the most common cause of hospital admissions for people under the age of 50 years.

Nurses may continue to strive to reduce the incidence of suicide and of suicidal attempts through epidemiological research, health promotion, sociology, social policy and therapeutic care. This means that they have very important roles to play in primary, secondary and tertiary prevention. Nurses also have a very significant function in providing services appropriate to meeting the needs of the person who attempts suicide, his or her family, and the community. However, it remains clear that some nurses do have difficulty in communicating with and caring for the individual who has attempted suicide and his or her family.[1,4,16–18] An exploration of some of the reasons why this may be so now follows.

Professional reflections: dilemmas in caring

Following the admission to a medical ward of a person who has attempted suicide, one of the first tasks to be undertaken is to assess the patient's emotional and physical needs. The paradox in caring begins when nurses are required to use a nursing model (such as that described by Roper *et al*.[19], to assist in the assessment of each patient. The dilemma persists when the '12 activities of daily living' are used as a guide to assess, plan, implement and evaluate the care of individuals who have just communicated that they have made a serious attempt to take their own lives.

When individuals cannot communicate their suffering through the medium of the spoken word, how do nurses currently convey to them that their nonverbal statement has real meaning, is being listened to and has been heard? The term the '12 activities of daily living' would appear to be in conflict with the distressing message the person is attempting to communicate.

Moreover, the use of a prescribed nursing model communicates to nurses that the filling in of a form, and the systematic scheme of note taking, are professionally driven. Models often yield little more than written accounts of a professionally 'managed' relationship, which produces a 'reality' that is as perfectly matched to the *model* as possible.[20] This type of initial contact treatment approach for the person who has attempted suicide has been described by Palmer[16] as: 'Treatment that tends to focus on the medico-technical aspects of the biological stability with little attention being given to the individual's psychological needs' (p. 8).

Communicating in terms of relating

Continuing with this line of reasoning, it may also convey that the procedure of form filling, that is, the 'I–It' relationship, takes priority over the person in need of care and in need of developing a therapeutic 'I–Thou' relationship.[21]

An examination of Buber's work shows that the crux of his philosophy is grounded in the notion that to be human is to *relate*. As humans, we cannot help but relate in some ways either to objects or to people. The actual relationship that subsequently occurs is called 'the interhuman'.[21] Nursing is located in the interhuman. It is discovered in that special relationship, the interhuman, that transpires between the nurse and the patient and it is not owned by either of them. Rather, it is 'a happening' that is established and maintained in minutes or hours of the lifetimes of two very unique human beings.

In the I–Thou relationship, a decision is made by the nurse to 'be with' the other person in his or her total being and individuality. It is a therapeutic interaction in which there is a giving to each other of what is essentially human. In this form of interaction the nurse does not look at the patient through a medical treatment or nursing model lens that lowers the patient to the focus of analysis, hence reducing the person to a collection of parts. Being present with the patient is a total experience that happens in 'the here and now' and rules out measurement or analysis of the experience. Instead, the dynamic centre of the patient is experienced 'for the other person cannot become the separated object of my

contemplation or even observation' (Buber, p. 70).[21]

Alternatively, in the I–It relationship,[21] the patient is considered an object of knowledge, an object from which the nurse can obtain answers to his or her questions to build up a nursing perspective on the patient's health and life. When this type of 'cold, clinical' interviewing occurs, Davis[22] suggests that the patient becomes frozen in an existential state. As an I–It, the individual is considered to contain information or data that are wanted by the nurse, but there is no need to engage with the presence of the patient in any meaningful way. When the gathering of information becomes more important than making a connection with the presence of the patient, as nurses, we are diminished in our humanity.

Buber[21] also recognizes that human beings fluctuate between the I–It and the I–Thou forms of relationships. All of us at times both treat and are treated as I–Its. This means that we need to take time to reflect on our relationship with ourselves and on our interactions with others.

Patients' perceptions of nursing care

All ethical issues ultimately involve consideration of what is 'right' and 'wrong'. 'Ethics are about ordinary, everyday actions, as well as the higher consideration of their value' (Ellis, p. 13).[23] No service can be evaluated without considering what it *means*, both to the person in receipt of the service and to the person delivering the service. It seems to be a logical step now to examine both patients' and nurses' views on suicide and subsequent nursing care.

Evans *et al*.[17] suggest that the needs and views of patients who have attempted suicide are rarely listened to by nurses. Hence, patients perceive help from health professionals as being ineffective, indicating that nurses do not communicate convincingly and therapeutically with them. The need to be accepted and supported by the nurse is of major importance to the patient, yet attempts by nurses to accept suicidal people as they are in the existential 'here and now' and not as they used to be, or indeed as the nurse would like them to be, are perceived by patients as unsatisfactory.[10]

This difficulty in communicating empathy is supported in another study, which showed that nurses avoided suicidal patients even though these individuals did not want nurses to talk in depth about their problems, but indicated that they would have liked more support and contact with them.[18]

Similarly, avoidance behaviours were found in Pallikathayil and McBride's[24] study which showed that patients felt emotionally saturated and isolated through lack of communication. These feelings were further compounded by the negative attitudes of the professional staff following the suicide attempt. This study also documented patients expressing feelings of social isolation, embarrassment about not being ill, and feelings of being stigmatized.

Communicating empathy

It is very difficult for a nurse to communicate empathy[25] with another human being who has just made a serious attempt to end his or her own life. Can we

start by trying to imagine what it must feel like to be in so much torment and pain that the involuntary acts of living and breathing have become unbearable and need to be ended? Is it possible to envisage how individuals must feel when they perceive there to be no other way out of the plight into which they are locked? What has happened to make people believe that life is without value and that they as human beings are also of no value? It is very demanding for nurses to try to enter a patient's desolate world of quiet desperation. Perhaps we could begin by reaching out with open hands into their world in the hope that the patient may clasp them.

Trying to communicate empathy with individuals who attempt to take their own lives and making an effort to view their world from their dark and lonely perspective of suffering may be likened to the cognitive dissonance[26] that occurs after some nurses enter nursing. Many nurses choose nursing to help people, to protect them from illness and to preserve life. Suddenly they discover that people (for one reason or another) do die and hence cannot be protected from dying. In this way they touch their own and other peoples' mortality.

Nurses' perceptions of suicide

Many nurses have negative, preconceived ideas about suicide and attempted suicide. The nurses who participated in studies by Patel,[27] Ghodse,[28] and Goldney and Bothill,[29] especially those with initial contact, demonstrated more hostile and unsympathetic feelings towards suicidal patients than towards those with any other medical emergency.

In addition, some nurses' views are instilled by the society in which they live, and to which they are therefore culturally bound. This ideation is encapsulated in the following: 'Attitudes of professionals towards parasuicide individuals create potential communication difficulties.'[30]

Lindars[31] suggests that communication breaks down between the person who has attempted suicide and nurses mainly as the result of nurses' preconceived ideas and outdated beliefs. Self-awareness is lacking in nurses regarding their own feelings about suicide and so they create barriers that result in treatment becoming focused on medical rather than psychological needs.[16,30] Nurses have also been found to avoid discussing key issues surrounding patients who have attempted suicide because of their own feelings of insecurity and powerlessness.[18] 'Nurses appear to remain unable or unprepared to enter into the patient's world of lonely isolation' (Reid and Long, p. 1374).[4] The nurse is the key player (in partnership with medical colleagues) and yet, due to his or her own values, morals and prejudices, a subtle, social defence barrier may be erected by the nurse to protect and defend him or herself from the reality of the patient's suffering.[32]

Preconceived attitudes and ideas, coupled with a paucity of self-awareness, are often connected with the nurse's own religious beliefs, morals and values about life and death issues and about the patient's right to choose what to do, and what not to do, with his or her life.[33] A cycle of blocked or dehumanized communication occurs when the nurse's lack of self-awareness and acceptance of the patient and what he or she wishes to do with his or her life further increases and reinforces the patient's feelings of isolation, alienation and embarrassment.[1]

Ethical issues in nursing care

The classical concepts in nursing ethics, such as autonomy, the principle of respect for autonomy, paternalism, respect for the individual and their rush to die, are everyday issues for nurses who work with people who have been admitted to a medical ward following attempted suicide. For some nurses, this may mean changing their mind-set and adopting the stance that they believe patients are their equals if they are to use ethical theory to their best advantage in care delivery. It is difficult for nurses who value life and the lives of others, and who spend their own lives caring for people, to view as their equals those who do not value life. Nonetheless, we are all equal in the eyes of the Creator and in our humanity. Differences may occur as the result of some of us having the necessary skills, knowledge and material possessions to become and remain more autonomous than others.

Autonomy

One of the often taken for granted assumptions is that within the limits of the law, people, by and large, have the freedom to act as they choose, provided it does not infringe on the rights of others.[34] This is the concept of autonomy. Autonomy may be defined as the capacity to think, decide and act on the basis of rational thought.[35] For Mill[34] and for Bentham[36] the rightness or wrongness of an action, and so of suicide, depends on its consequences.

There are two distinct types of consequences. The first occurs when one person harms another person, thus decreasing the other person's autonomy. The second arises when short-term autonomy, such as the right to kill oneself, dissolves long-term autonomy. In this instance, for example, if the suicide is successful, the person has no autonomy at all. Although Mill[34] does not specifically discuss suicide, certain inferences may be drawn from his argument. His distinction between actions that affect others and actions that affect only oneself is a complex one. He recognized this and proactively expressed what he believed others might object to by saying: 'No person is an entirely isolated being; it is impossible for a person to do anything seriously or permanently hurtful to himself, without mischief reaching to at least his near connections, and often far beyond' (p. 213).[34]

The complex nature of Mill's argument moves when he discusses the rights and obligations of others to interfere in sabotaging actions directed against others. He suggested that the sort of conduct that warrants interference by others is that which violates society or an individual's life, or which disables a person. Others have a duty to act 'in the person's best interest' or in such a way that seeks 'to restrain a person's freedom to formulate and carry out his or her own sabotaging plans'. Mill[34] says that there is 'a distinct and assignable obligation on people to perform some definite duty incumbent on him [her] to protect the public' and to ensure the best possible outcome for the majority (p. 11).

Furthermore, he comes fascinatingly near the topic of suicide when he discusses the application of his theory of liberty, considering how far liberty may legitimately be invaded for the prevention of crime or accident. Concerning crime, he thought that, if any individual, public or private, sees someone else evidently preparing to commit a crime, they are not bound to look on inactively until the

crime is committed, but they may interfere to prevent it.

Similarly, regarding the prevention of accidents, if someone is attempting to cross a bridge that is unsafe, others may warn the individual or grasp him or her, or turn the person back without any infringement on his or her liberty, for liberty, according to Mill, is applicable to all the people concerned in the scenario. It consists of doing what 'the helping person' also desires. In the context of suicide, what if the person on the bridge did desire to jump into the river with the intent to die? Mill's[34] remarks suggest that he might regard it as proper to attempt to dissuade (at least some) prospective suicides. However, whereas we may, according to Mill, merely warn the person of the danger, the individual may already know the risk and still intend to take it. To suggest how onlookers might cope with this dilemma, Mill (p. 116)[34] continues by stating that people may intervene more forcibly in the case of 'someone who is a child or delirious or in some state of excitement or absorption incompatible with the full use of the reflecting faculty'.

Certain cases of prospective suicide might well fit, or at the very least, appear plausibly to fit, one or other of those descriptions, but, even when defined like this, does Mill's[34] principle of individual liberty give nurses sufficient scope for intervening to deter a suicide attempt to the extent to which most people, in following their moral intuitions, would want to do?

Downie and Calman (p. 44)[37] assert that, 'Whatever else morality may be, it is at least a set of principles which helps us to live together in society more harmoniously and co-operatively than we could do without it.' This means that, in terms of co-operating with others, there must be very few people who would consider it to be morally acceptable to stand by and allow a suicide to take place if they found themselves in the position to prevent it. Yet Mill's account of individual liberty provides little scope for justifying interventions on prospective suicides who are adults, rational and self-commanding, in the ways specified by him.[34]

If nurses were to follow this line of reasoning it suggests that, regarding such individuals, interventions should cease or should not be attempted at all. This deduction, however, fails to recognize a large part of what motivates the spontaneous, almost reflex intervention on the part of a person suddenly confronted with what he or she thinks is the imminent suicide of another. Initially, the person may not have this first thought that here is someone who may not have 'full use of the reflecting faculty' but think and believe that a segment of something valuable in itself, namely life, is about to be destroyed. This is a separate and quite different kind of justification for intervening from the one based on the possibility of the suiciding person being in an irrational state.

In summary, it can be said here that the principle of autonomy for this group of patients can actually raise more problems than it can resolve. This, however, should not prevent us from entering into dialogue about the phenomenon.

Moreover, many of the issues about suicide that are of special importance and that provoke the greatest moral complexity about it, and about the patient's subsequent nursing care, are precisely those that Mill[34] disregarded: the nature of the act of self-killing; its relationship to the person's thoughts about God and the sanctity and meaning of life; and the significance of suicide as an act that passes a judgment on life. Nevertheless, within the context of suicide, the principle of

autonomy needs to be embraced in order to stimulate dialogue, raise awareness and enhance patient care.

Respect for autonomy

In order to advance the argument, it is crucial to attempt to distinguish the principle of autonomy from the principle of respect for autonomy, which is the moral requirement to respect other people's autonomy. Mill[38] argued for the moral obligation to respect people's autonomy (except when to do so would injure others) on the utilitarian grounds that such respect would be of benefit to human welfare.

Alternatively, Kant[39] viewed autonomy and respect for autonomy as a necessary feature of a rational agency and of being a rational agent (being). Rational beings necessarily have wills, according to Kant,[39] and thus are, by their nature, ends in themselves as distinct from mere means. This is true subjectively and objectively, in that this is how human beings conceive their own existence.[37]

Part of what respect for autonomy implies in practical nursing terms means that nurses may not interfere with people's lives without their consent. Not imposing interference on other people necessitates that 'people [nurses] act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means but always at the same time as an end' (Kant, p. 115).[39]

Nonetheless, because of the nature of their admission into hospital, patients who have attempted suicide are not awarded the opportunity to exercise free will.[8] Decisions and actions are, therefore, taken by nurses in the 'best interest of the patient' and in accordance with the nurse's duty to care.[40] This suggests that we, as professionals, know what actions to take that are in the patient's best interests. It also gives us permission to impose our decisions upon this group of people without first consulting them, let alone it being against their will. Whether or not these decisions are designed to be beneficial, professionals end up treating this group of people 'as things or as animals, or as children, but not as rational agents, not as ends in themselves' (Lockwood, p. 115).[35]

In practical terms, most nurses regard their actions in terms of doing the best they can, rather than deliberately setting out to infringe on patients' rights of autonomy.[41] However, what happens when the 'care' begins with the nurse experiencing hostile and negative feelings towards the patient, as research shows?[27–29] Is it possible for nurses who hold and show these negative feelings towards this group of patients to act in those patients' best interests, to hold two opposing feelings at the same time?

Self-awareness programmes may help, along with theoretical and experiential discussion. Attitudes may change if nurses attempt to recognize where the patients are coming from, in terms of the depth of their pain and suffering. After such self-awareness programmes, those nurses who previously felt hostile may begin to act appropriately and communicate therapeutically. Consequently, patients may feel more comfortable, confident and content with the life and death decisions nurses make and take on their behalf. This is nursing paternalism.

Nursing paternalism

Acting for someone's benefit, not necessarily against but without his or her explicit consent, appears to happen frequently in the hospital setting. It places nurses in an ideal position to display their power and control over the vulnerable. Some may also come to believe that they are best placed to advise patients how to live their lives.

The paradox, conspicuously inherent within the UK *Code of professional conduct*,[40] may also be invoked by some nurses who may claim to have the professional power to protect their decisions and their subsequent actions by using the caveat that they are acting in the best interests of the patient.[40]

One of the most ambiguous dilemmas to be faced while nursing the person who has attempted suicide, in terms of nursing ethics, is probably about making decisions regarding what are the proper limits to paternalism and to the exercise of autonomy. Is it possible for nurses to cotravel emotionally and spiritually with their patients to a depth of exploration and self-awareness that they themselves have feared to enter and uncover? I would argue that it is not. It is very difficult for those of us who have previously thought that life was not worth living to imagine that our thoughts and feelings may be similar to those of some other people. It must be even more demanding for those people who have never had a single thought about ending it all. Perhaps we are expecting too much from nurses. Some may fear that if they think about its meaning too profoundly, they themselves may also wish to die.

Principle of beneficence

One way of trying to comprehend the relationship between the nurse and the patient is to conceptualize it in terms of the principle of beneficence, which can be used to depict the primary obligation in both medicine and nursing. Beauchamp and Childress (p. 44)[42] suggest that 'throughout the history of healing, the health professional's obligations and virtues, as expressed in codes and didactic writings on ethics have been understood in terms of the professional's commitments to beneficence.'

Until relatively recently, nurses have relied almost exclusively on their own judgement about patient's needs for care, information and consultation. Nursing staff made many decisions based on their observations and on acquired professional knowledge. Within the context of suicide, nursing care was founded largely on their experiences with other suicidal patients who had previously passed through their care.

A new paradigm

Recent changes in the profession's philosophy and the ideological shift towards working with and for people may go some way in trying to appease this dilemma.[43] Working together may also result in challenging the primacy of the obligation of beneficence over the principle of autonomy. In ethical terms, nursing may begin by adopting care planning programmes that give patients

opportunities at all stages of the healing process to make decisions about what should and should not happen to them. This way of working cultivates mutual understanding and generosity of spirit, as well as the sharing of mutual goals that generate from within the patient's frame of reference. Such facilitation would allow patients who have attempted suicide to work through their paining, suffering and distress, at their own speed and when they are ready. This type of therapeutic work takes time. It suggests that patients are given structured opportunities to work through the healing process, and discover the truth and value of self, at best resulting in the patient's peace of mind.[44] This is not work that can be achieved by nurses on the patients' behalf.

Working together

Such an approach places a heavy responsibility on the professional involved in minimizing personal prejudices and enhancing communication and counselling skills.[16,30] Programmes in self-awareness, advanced communication skills and different counselling approaches should be ongoing, as it has been found that basic training is not sufficient.[4] In addition, the quality of the nurse–patient relationship is an important component of therapeutic care.[45,46] Nurse education could begin by identifying nurses' own needs and problems and by empowering them to empower their patients.

The family as the central focus of care

The family members, too, need to be proactively cared for; they may require counselling or education to empower them to comprehend and manage the situation. Palmer[16] reports that the family often feels inadequate as a result of the self-destructive action. Conrad[47] suggests that a caring and supportive family helps to reduce further suicidal behaviour. It is important, therefore, to involve the family in all aspects of care.[14,16] However, the patient's views about family involvement should be respected. Experience shows that caring for the family is not always possible in the hospital setting. This is due mainly to time constraints and the well worn phrase 'lack of resources'. This problem could be redressed by involving community psychiatric nurses and other members of the primary health care team as soon as possible after admission.

Conclusion

In conclusion some key concepts can be recommended to be applied to the practical situation of nursing care of the suicidal patient. Nurse education may shift focus slightly by examining the impact and aftermath of all contemporary life crises such as suicide and attempted suicide on individuals and their carers. The necessity to promote advanced, sensitive, therapeutic communication skills and enhanced self-awareness is paramount in supporting both the people who attempt suicide and their families.[48]

The frameworks and models currently used in the assessment of need may require to be reviewed, as assessment has been identified as the key to care.[4]

Moller[49] suggests that the therapeutic care of parasuicide individuals should not follow a uniformed procedure. However, if nursing models need to be used, consideration may be given to using alternative models such as King's model of nursing,[50] which embraces the specific needs of the individual patient in a holistic way.[10] Encouraging a holistic approach to care will enable nurses to 'tune in' and engage therapeutically with their patients.[51]

Some thought may be given to adopting different counselling approaches to care.[4] For example, Rogers,[52] in his humanistic approach to counselling, asserts that 'unconditional positive regard' has to be conveyed to empower patients to explore their motivations prior to the suicidal attempt and to help to remove 'growth blocks'. A humanistic approach, therefore, might be encouraged to restore equilibrium to individuals' lives.[52] Coinciding with Rogers, Maslow[44] stresses that the hierarchy of needs of patients must also be realized to help to 'nudge' them forward towards self-actualization. By communicating empathy, nurses may give patients an opportunity to explore and work through 'growth blocks', such as their repressed emotional pain, guilt, anger, resentment or shame.[44,52,53]

UItimately, it is the personal quality of the nurse that determines the way forward for the patient. A nurse who has worked through his or her own 'growth blocks'[25] will have the therapeutic presence to facilitate the healing and growth of the person in need of care.[54]

To achieve continuity and improve care, discharge planning and follow-up care may be initiated in the admission period. When working in the community, some voluntary and social services could also be involved (with the person's permission).

In addition, it is strongly recommended to management that a community psychiatric nurse (CPN) should be affiliated to accident and emergency departments and expedient referrals made to the CPN following admission. Their main role would be to counsel and nurture individuals and the families involved in the trauma. Tschudin[55] suggests that nurturing takes place initially when patients and relatives are in a state of shock or numbness.[56] The medical admission ward may be the first point of contact for the person concerned and, consequently, the crucial point at which therapy and healing may begin. Finally, clinical supervision is also essential for the maintenance of safe and effective nursing practice.[57,58]

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