Feature Article

Special Article: Leadership in Palliative Nursing

The Nessa Coyle Lectureship

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In 2016, the Hospice and Palliative Nurses Association created the Nessa Coyle Leadership Fund to recognize the career achievements of Nessa Coyle, PhD, RN, as a pioneer in the field of palliative nursing and an exemplar of leadership. The first lectureship recognizing this award was presented at the annual assembly of the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association in February 2017. This article is based on that lectureship and summarizes key leadership themes identified in Dr Coyle's career.

KEY WORDS

communication, ethical issues, family caregivers, mentoring, palliative nursing, presence, suffering

Dr Nessa Coyle began her professional career as a nurse in 1958 and through the 59 years of her nursing career has become a leader in nursing, practicing excellence, researching ways to improve nursing practice, and teaching others the value of palliative nursing. In 2016, the Hospice and Palliative Nurses Association (HPNA) created the Nessa Coyle Leadership Fund to recognize her career achievements as a pioneer in the field of palliative nursing and an exemplar of leadership. The first lectureship recognizing this award was presented at the 2017 annual assembly of the American Academy of Hospice and Palliative Medicine and HPNA.

In preparation for the above lecture, the authors reviewed all of Dr Coyle's career work and from that work identified themes from her practice, teaching, and scholarship. The principles of nursing practice, in the lecture and as detailed more fully herein, represent Dr Coyle's practice and teachings over the course of a long and distinguished career.

THE ROLE OF THE NURSE IN RELIEVING SUFFERING

Dahlin and Giansiracusa,[1] in 2006, stated that "The ability to 'be with' suffering and bear with the sufferer is an art, generally mastered after extensive life experience, self-reflection, and concentrated professional development." Dr Coyle mastered that art and as a nursing leader has taught thousands of nurses the art of being with patients. Early in her career, Dr Coyle recognized that the nurse might not be able to restore function or "fix" the patient's problems, but by assessing patients, diagnosing sources of discomfort, intervening "through presence, listening, and communication," the nurse can work to eliminate the sources of suffering such as pain.[2(pp15,16)] By being present to evaluate the patient and his/her needs and the needs of the family, the nurse, ever vigilant, is able to alter the plan of care, see new problems as they arise, and meet the patient's needs.[2(p16)]

Nurses must continually seek to understand the patient as a unique individual. A remedy that works for one patient may not work for the next; an assumption about how an illness affects one patient may not hold true for another. The nurse must listen, observe, and seek to understand each individual patient and then meet that patient on his/her life's terms. The nurse helps "pick up the pieces" for the patient and family, "put[s] the patient's story together—why the tests, why not the tests, the calcium levels that go up and down—the ongoing therapy that comes to an end."[3] The nurse deals with the realities of the illness and treatment, whether it is "the meaning of the failed chemotherapy, radiation therapy, the struggle around the goals of care, or code status."[3] The nurse is present "to listen as the patient puts his/her new story together."[3] Mark Lazenby, PhD, RN,[4] in *Caring Matters Most: The Ethical Significance of Nursing*, reiterates this important nursing tenet of seeking to understand each patient within his/her life: "Evidence-based guidelines that are derived from rigorous and important trials may not be evidence for everyone. We often cannot see this unless we imagine what it is like for the patient,"[4] seeing each patient in the context of his/her life. Dr Lazenby is one of many nurses who have been mentored by Dr Coyle, and her influence is evident in his scholarship.

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NURSES RELIEVE THE SYMPTOMS OF ILLNESS

A nurse's role in caring for a patient includes being present and attentive to a patient's condition and specifically attending to the symptoms of illness. Pain is a primary symptom that nurses address daily. Dr Coyle studied the pain experiences of 7 patients with advanced cancer and the role of the nurses who worked to reduce their pain and suffering. She described this as "Pain—living with it and the fear of expressing it—can have a profound effect on the final days of the patient's life."[5]

Dr Coyle has taught the important role the nurse plays with regard to pain. First, nurses approach a patient's pain by recognizing it and validating the patient's experience of it: "Pain that is diminished, ignored, or doubted is pain that leads to suffering. Nurses, therefore have a moral imperative to advocate for pain relief, give voice to pain, and reduce suffering" (quoting Greipp, 1992; Ersek and Ferrell, 1994).[2(p49)] Pain relief, however, can be complicated by the patient's fear of expressing it and of the drugs needed to address the pain. Dr Coyle studied the role of opioids in pain relief in the 7 patients with advanced cancer referenced above: "On the one hand, relief from pain was essential to them, but on the other hand, they were troubled with worry that the use of opioid drugs would affect their mental clarity… as the price for pain control."[5] The nurse, in recognizing and giving voice to the pain, is ideally positioned to explain the role of opioids to the patient and his/her family and the important role opioids can play in pain relief and ultimately the patient's remaining quality of life.

With pain, however, come other symptoms at the end of life that nurses must address. Nurses may be called on to monitor, assess, and adjust treatment to deliver continuous care to the patient for a multitude of symptoms that sometimes persist and fluctuate in severity, for the benefit of the patient and the family.[6] In her research and teaching, Dr Coyle builds on the classic work of Dr Eric Cassell[7] and reminds nurses that while working to render this continuous treatment the nurse must remember to focus on the person, the patient, who is experiencing the symptom, and not on the symptom itself: "The common element across diseases and symptoms is that suffering is experienced by *people*, not bodily organs. That which threatens the wholeness or the survival of the person results in suffering."[2(p13),7] Dr Lazenby[4] reminds nurses of the same concept and the importance of remembering to treat patients as whole persons: "Patients and families come to us for nursing care. They come to us in their vulnerabilities and ask us to care about them and for them in order to achieve better health and better quality of life as they are sick and dying. But their vulnerabilities do not define them. Our caring about and for our patients opens up a space for them to be people not defined by their vulnerabilities. This opening up of a space for our patients to be people… embodies in us nursing's moral character."[4(p12)]

In relieving the symptoms of illness, nurses, as part of a collaborative team in palliative care, are creating a sacred time for the patient and family. A patient's "values are realized and suffering minimized. Patients' priorities are recognized and not overlooked, families are included in the care and decision making, individual team members are not burdened with unsolved problems, and the team nurtures and is nurtured by the belief that they are facilitating a time of value for the patient."[8]

DEFINING THE PARADIGM OF PALLIATIVE NURSING: TO COMFORT ALWAYS

Dr Coyle first began her nursing practice 59 years ago, long before recognition of palliative care as a specialty. At that time, the health care focus was on "fixing" or "curing." Nurses were well positioned to expand this notion of care, specifically how to respond to a patient's suffering. Over the course of her career, Dr Coyle advocated to change the "fix-it" paradigm.

> …the power structure between medicine and nursing remains lopsided, perhaps influencing the experience of suffering for nurses. In reviewing both lay and professional literature, we are struck by how often the relief of suffering is attributed to the medical profession alone. We believe that this likely represents a broader paradigm in which the relief of suffering is meant to equal the cure of disease—a biomedical perspective that implies that the only true relief of suffering comes from fixing, curing, eliminating, and making free of illness, rather than the quality of a life lived. This paradigm should be rejected; it does not serve society well. But it may also reflect the "invisible" or "silent" aspect of nursing care that can have such a profound ameliorating effect on patient and family suffering.[2(p101)]

Dr Coyle worked to change patient care by defining comfort—seeing patients as people, seeing their illnesses, seeing what was important to them.[2(pp25,26)] In her teaching and her research, Dr Coyle brought comfort to the forefront of nursing practice by focusing on factors that she believed were not being addressed in health care: inadequate physical symptom control, undiagnosed patient depression or anxiety, unaddressed existential distress, untreated psychological distress in family members, unrecognized family fatigue, clinicians' ineffective communication, and unrecognized health care provider fatigue.[9] In identifying these important factors, Dr Coyle and colleagues emphasized that palliative nursing was needed in order to bring comfort and quality of life to patients and

their families. The palliative nursing paradigm shifted from "fixing" and "doing" to "being with." The palliative nurse's mission was reframed and redirected from "fixing" to seeking to understand the roots of the patient's suffering, whether it was anxiety, depression, existential distress, or a family member's fatigue. This type of suffering was not always easy to discern, not reflected in laboratory tests, and not able to be remedied by a drug or a procedure.

The assessment of spirituality also fell outside the "fix-it" approach. Dr Coyle taught that to address suffering and to provide comfort, the nurse had to assess the patient's spiritual needs: meaning or purpose, hope, relatedness, forgiveness or acceptance, and transcendence (Kemp, 2006).[2(p26)] In practice, the nurse needed to consider and assess the whole person, not just the patient's physical symptoms or the ailment that brought the patient into the health care system. The nurse was positioned on the frontlines with access and presence, to address all the patient's needs, including those of a spiritual nature. The aim for the nurse was to provide each patient comfort, compassionate, effective care.

COMMUNICATION AS THE ESSENCE OF NURSING

The palliative care nurse facilitates the important conversations that guide a patient's end-of-life care. It is imperative that nurses have effective communication skills to elicit and listen to patients' goals of care, so that the care they render is consistent with the care the patient and family want[10]: "Skilled and compassionate communication by the nurse can help place the patient back at the center of the [important] decision[s]," by facilitating advanced directive completion or in the absence of a directive, ensure that the patient's, surrogate's, or health care agent's wishes are met. A nurse can understand a patient's wishes by understanding the following:

> What are the patient's values and goals?
>
> What would the patient want if he/she could speak for themselves?
>
> What is possible?
>
> How has the patient lived their life?
>
> What constitutes good medical care for the patient?[10]

The communication skills the nurse needs to possess, as elucidated in the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care,[11] include developmentally appropriate and effective sharing of information, active listening, determination of goals and preferences, assistance with medical decision-making, and effective communication with all individuals involved.[11] Patients who have conversations about end-of-life care are more likely to receive care consistent with their preferences. Such conversations are associated with "fewer occurrences of resuscitation, ventilation, death in the intensive care unit; earlier referral to palliative care and hospice services, and better quality of life," as well as a "good death."[10] Patients describe a "good death" as "being in control, being comfortable, having a sense of closure, having trust in care providers, recognizing the impending death, and leaving a legacy."[10]

Nurses need to create time for a narrative interview, which gives patients the opportunity to tell their story and nurses an opportunity to listen to the story. In the narrative interview, the patient is able to describe his/her lived experiences. In "Expressed Desire for Hastened Death in Seven Patients Living With Advanced Cancer: A Phenomenologic Inquiry," Dr Coyle and Sculco found that the narrative interview revealed the patients' experiences of living with advanced cancer and gave the nurses caring for these patients an understanding of what the patients were asking for when they expressed a desire for a hastened death.[12] Dr Coyle teaches that nurses must listen to patients and seek to hear and understand what they are expressing and why. The narrative interview provides this opportunity for a patient to express his/her needs and the nurse to hear those needs and, most importantly, enables the nurse to be guided by the needs the patient expresses. Dr Coyle asserts that patients' need for pain relief must be heard and honored, despite health care professionals' own fears. Otherwise, health care professionals' fear of hastening death or being perceived as hastening death may prevent patients with terminal illness from having the pain control and other symptom relief that they deserve and need. As Dr Coyle described, "Although pain has become recognized in the last several years as an avoidable public health problem, chronic pain continues to exhaust many patients, their families, and health care professionals, leaving them feeling demoralized and disheartened. Unrelieved pain has a devastating effect not only on patients but also on those close to them. It can lead patients to desire death, and family and caregivers to feel that death would indeed be welcome."[13] In "The Hard Work of Living in the Face of Death," Dr Coyle describes "the work of trying to live with advanced cancer at the same time as facing the immediacy of death." She calls it "the existential slap" and describes the struggle to live while asking for death.[14]

Communication is at the core of effective palliative nursing practice. It involves more than eliciting the patient's story and listening as the patient expresses it. Before the patient's story can emerge, the patient and his/her families, at a basic level, need to know how to communicate. Nurses have the ability to empower and educate their patients in

communication skills. Patients with advanced cancer may feel vulnerable, and the nurses who care for them can reduce this vulnerability by teaching patients how to communicate with their doctors and nurses, how to address their pain issues, and how to understand their treatment options. Teaching patients to communicate allows them a voice in their care, which contributes to a better quality of life, care consistent with their preferences, and hopefully a good death.

PRESENCE

"The simple presence of one who is concerned, one who is willing to be a companion and to remain steadfast when there are no easy answers is itself a form of powerful communication that goes beyond words…."[15] Dr Coyle and colleagues have described presence in palliative nursing as hearing the patient's story, creating time for the narrative interview, maintaining presence when there are no answers, controlling symptoms, and seeking to understand the meaning of the symptoms to the patient.[15]

Dr Coyle described in *The Nature of Suffering and the Goals of Nursing* the significance of presence. In the words of an intensive care unit nurse, "Sometimes we can only witness. We cannot fix or do the work of creating meaning. This family responds to support, to ideas, to reframing, but ultimately they have to wrestle with the guilt themselves. We can provide a container, a holding environment of safety so they don't have to do this in isolation. We can keep showing up, even when it's messy and ragged and uncomfortable."[2(p74)]

In a recent presentation, Dr Coyle tells the nurse's story of being with a dying child overseas, the child on a respirator. The child was not sedated, and there was no medication available to relieve the pain. The nurse witnessed the child's eyes "pleading for death to come," the nurse powerless to relieve his suffering. Dr Coyle described the job of that nurse and other palliative care nurses as "Staying by the side of chronically ill and dying individuals, adults and children, who may experience unremitting pain, difficulty in breathing, confusion, loss of meaning, despair, and/or overwhelming grief"[3]; "We are always a presence; we look into their eyes; we bear witness for the patient; we advocate, advocate, advocate."[3] Palliative nurses, even when unable to "fix," are the constant presence alongside patients on their journey, vigilant and able to listen to the patient's story and speak to them and for them, when they cannot use their voice.

Being present as a nurse and what it takes to do so every day take a toll on the nurse and contribute to the nurse's own suffering and search for meaning. "Breitbart (2002) and Chochinov (2006) have addressed patients' search for meaning in their illness. Nurses also seek meaning in their work to sustain their ability to offer *presence* amidst suffering."[2(p88)] Dr Marlene Cohen and Dr Barbara Sarter,[16] in 1992, described the essence of oncology nursing as "…being on the frontlines of a war against death, disfigurement, and intense human suffering. It requires the performance, prioritization, and coordination of multiple complex tasks. It involves handling frequent, unexpected crises, both physiologic and psychological. It carries the rewards of reversing a fatal illness, balanced by the ever-present reality of death. Working with patients with cancer requires constant vigilance in monitoring for sudden problems and life-threatening errors. The cancer nurse's empathy is sharpened by the awareness that 'this could be me or my loved one.' Finally, working with patients with cancer means 'being there' for people in their most private moments of suffering and responding to the heights and depths of their responses to this suffering.[16] Dr Coyle has taught that presence is at the very heart of palliative nursing: how the nurse cares for the patient and family, addresses the patient's suffering and vulnerability, and accompanies the patient and family on their journey, so that no patient needs to travel alone.

ILLNESS AS A FAMILY EXPERIENCE

In her work, Dr Coyle has brought attention to family members' need for care, as they attend to and suffer with their ill loved ones, as part of the family and also individually. In Chow and Coyle,[17] the authors note that the family caregiver absorbs and reflects the patient's suffering: "Family members often become a reflection of the patient's suffering as that reflection is cast back onto the patient. Suffering within families is both an intensely individual experience as each son, daughter, or spouse responds within his/her relationship as well as a collective, shared suffering experience of family (Hickman et al, 2004)."[2(p77)]

The caregiver is the witness to the family member's illness (Horowitz and Lanes, 1992)[2(p79)]: "How a family caregiver deals with observing pain and suffering in a loved one is significantly influenced by the nature of his/her relationship with the ill person (Ferrell, 2001). Therefore, providing support for family caregivers requires an understanding of the specific psychological, social, and spiritual distresses of the caregiver (Borneman et al, 2003)."[2(p80)] The task of understanding and assessing the relationships and suffering of family members falls to the nurse at the bedside of the patient and alongside the family.

Specifically, the nurse begins by recognizing the caregiver's exhaustion and can begin an assessment of caregiver health and suffering. The caregiver may reflect physical exhaustion or report being unable to sleep. The nurse pays close attention to whether the caregiver's health is being compromised by the stresses of caring for his/her loved one or whether the amount of time required for care is causing social isolation—by necessity or by the caregiver's own choice to isolate himself/herself. The nurse can train the caregiver on how best to care for the loved one. Given

today's medical realities, patients spend less time in the hospital, and caregivers are called upon to render more care for their loved ones in the home. In addition, the nurse is able to support the caregiver by helping locate practical resources and assistance: financial, social support, or assistance with scheduling appointments. The nurse can apprise the caregiver of formal professional support groups or individual psychotherapists and cognitive behavioral therapists who can help the caregiver build the necessary skills to deal with the loved one's illness. Nurses extend their caring nature and skills to family members, who may be suffering along with their loved ones. Nurses "have the ability to bring a sense of humanity even in the most difficult of circumstances."[2(p41)] Just as the nurse is present for the patient, the nurse is also present for the family member in need of compassion, kindness, and comfort in a very stressful time. Last, nurses manage the patient's symptoms and in so doing ease the concern and the burden of the family caregiver. The patient's and caregiver's reliance on one another can directly affect outcomes, and the palliative nurse's involvement in managing symptoms and navigating transitions of care directly affects the caregiver's well-being.

There are unique struggles of the long-distance family caregiver. "More than 7 million Americans are distant caregivers, and the number is expected to grow as baby boomers and their parents age."[2(p84)] Whereas family caregivers in the local setting with their loved one have the ability to locate and utilize resources that are in their community—resources the nurses can apprise them of—distant caregivers are at a distinct disadvantage. Dr Polly Mazanec,[18] another nurse influenced by Dr Coyle's scholarship, points to the fact that distant caregivers are at greater risk of caregiver burden and suffering related to limited access to resources, education, and support and the challenges inherent in rendering care from a distance.

ETHICAL ISSUES INHERENT IN THE SCOPE OF PALLIATIVE NURSING

In her research, nursing practice, and teaching, Dr Coyle identifies ethical issues prevalent in palliative nursing—issues that the practicing nurse confronts regularly in caring for patients. In addition to bringing the issues to the forefront, Dr Coyle has sought to identify resources palliative nurses can use to navigate the ethical dilemmas. In "Ethical Issues Experienced by Hospice and Palliative Nurses," Dr Coyle and colleagues discuss 129 responses to a survey distributed online to HPNA members to identify common ethical issues that confront palliative nurses and the resources available to assist in resolving the dilemmas.[19] From the survey responses, Dr Coyle and colleagues identify the following ethical dilemmas: inadequate communication; medical futility and the provision of nonbeneficial care; respecting patient autonomy; protecting patients' rights; issues surrounding symptom management and the use of opioids; decision making, capacity, and lack of a surrogate in decision making; and discontinuing life-prolonging therapies.[19]

Dr Coyle also identified ethical approaches to the issues that arise in palliative nursing practice. Often, the focus by both physicians and nurses is narrow, centering on autonomy, beneficence, nonmalfeasance, and justice (Stanley and Zoloth-Dorfman, 2006).[2(p27)] Dr Coyle suggested an alternate approach that Farley et al (1990) and feminist scholarship recognized as valuable—that of care, respect, and compassion.[2(p27)] To render the most support and compassionate care, palliative nurses should focus on "transcending a place of obligation, so we can determine our moral obligation as compassionate witnesses."[2(p28)] Dr Daniel Sulmasy characterized this approach as "treating all patients as people first."[2(p28)] He challenged the medical profession to evaluate itself and to restore a sense of the sacred to health care. "To heal a person, one must first be a person," Dr Sulmasy quotes Jewish philosopher and theologian Abraham Heschel.[2(p28)]

One of the most common ethical issues nurses confront in palliative care is that of hastened death. In "Case Presentation: Dying at Home" (1998)[20] and "Commentary: Entrusting Families With Care,"[21] Dr Coyle relates the concern that a patient, in the course of his own terminal care, or his family, might contribute to or cause a hastened death. She describes a particular patient as "very involved in planning his own terminal care."[20] The rescue doses of morphine that the patient and family have access to pose an ethical risk. Might the patient's distress combine with the family's distress and cause an escalation of doses?[20] The question turns on the nurses' ability to do a palliative care assessment over the telephone, to have the necessary information to allow the patient to die at home while the nurse is able to exercise his/her professional and ethical responsibility. The nurse's assessment of an individual patient and his/her situation includes the amount of care available in the home and the limitations of that care, symptom control and the level of responsibility the family assumes, and the availability of a resource person and what he/she can provide. Dr Coyle concludes, "At the heart of these questions are goals of care, patient autonomy, informed choice, recognition by staff of what they can and cannot control, and nurse/physician education in palliative care assessment over the telephone."[21]

On physician-assisted suicide, Dr Coyle speaks to the importance of palliative care as a part of the ethical debate. "The debate has brought into focus just how inadequately we care for the dying,"[22] with few doctors and nurses specifically trained to care for dying patients. Dr Coyle concluded in 2004, "It seems premature to consider legalization of clinician-assisted suicide or euthanasia, as a right of the terminally ill, before palliative care, and all that it encompasses is widely available and also a right."[22]

In her research on hastened death, Dr Coyle reminds nurses of a very real risk that can and does compromise a patient's end-of-life care. In health care professionals' fear of hastening death, many patients with terminal illness are at risk of not having their needs met[22]: "A clear understanding by health care professionals of the ethical issues in end-of-life care is essential so that patients can be fully confident that they do not have to fear uncontrolled pain or shortness of breath at the end of life, or of being trapped by continuing life-preserving technology that they no longer choose or want. It is essential that the differences between good palliative care and clinician-assisted suicide or euthanasia are understood."[22] This statement remains as valid today as when Dr Coyle expressed it in 2004.

MENTORING PRESENT AND FUTURE GENERATIONS OF NURSES

In the beginning of her career, Dr Coyle found that nursing education lacked a philosophy of its own, role modeling, recognition for behaviors such as compassion and presence, and any meaningful communication beyond "patient teaching." Listening and witnessing suffering were not taught or recognized in nursing training. Not until nurses were able to witness true nursing by a seasoned colleague did they become aware of important nursing tenets such as presence[2(p15)]:

> …Yet somewhere on the journey to our learning "healing" instead of "teaching," many of us had the profound gift of witnessing true nursing by a seasoned and compassionate colleague. Watching a nurse who is fully present, who listens carefully and says little but provides the sufferer the opportunity of "voice" as described by Reich (1987, 1989), is a true education. Such mentors teach us that silencing or stifling the voice of suffering serves only to intensify it.[2(p15)]

Dr Lazenby describes caring as the heart of nursing practice.

> Caring is a way of life. We cannot merely say that we care or read about caring in a textbook, nodding our heads in agreement: We must live and practice in such a way as to show we care. Through our nursing practice, we show our patients and their communities, to our colleagues in nursing and in other health care professions, and to our families and friends that we care. Perhaps most important, we must show it to each other, for it is from nurses who care that we learn to care.[4(pp125,126)]

Lazenby continues:

> What motivates us is not a set of reasons or a rational process that leads us to inviolable principles. What motivates us is caring. Caring for and about other human beings, and that which sustains human life, is the deep root of nursing ethics from which grows our acts of nursing care.[4(pp125,126)]

In her practice, Dr Coyle has shown that some important nursing practices are not learned in the classroom or from textbooks. Some of these practices are learned from observing the behavior modeled by seasoned nurses: "Nurses are guided by ethical perspectives that extend beyond professional codes and call upon basic human kindness and compassion as they are called to embrace spirituality in its most global sense…. "The expert nurse knows that much redemption happens when a hostile family member assists in a bath"… or when a "frightened husband"..."spoon-feed[s] his spouse a few sips of soup...."[2(pp40,41)]

CONCLUSION

Dr Coyle has practiced as a nurse for 59 years and in her nursing career has taught other nurses at Memorial Sloan Kettering and all over the world. She has traveled with and taught alongside other instructors as part of the End-of-Life Nursing Consortium throughout the United States and in countries around the world. The Nessa Coyle Leadership Fund was initiated in 2016 in honor of her career and her work. She has used her energy and her imagination to create hope and a better quality of life for many suffering patients over the course of her lifetime. Dr Lazenby has said:

> Nursing imagination establishes the hope of health promoted, health restored, or life safely passing. When we are able to help our patients achieve that, through our imagination, we have resisted the threat of becoming an automaton. This is the ethical significance of imagination in our everyday lives as nurses…. Through the habit of imagination, we preserve our patients' humanity in the world of automation and technology. We preserve our own as well.[4(p93)]

Dr Coyle has preserved her patients' humanity and the humanity of the thousands of nurses she has taught and mentored over the course of her long and distinguished career.

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