

School of Nursing and Midwifery

**The Role of Empowerment in the Care of Patients who
Experience Severe Pain: The Nurse's Perspective**

Susan J Slatyer

**This thesis is presented for the degree of
Doctor of Philosophy
of
Curtin University**

January 2013

DECLARATION

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature:

Date:

ACKNOWLEDGEMENTS

Thank you to all those who have contributed to and supported my doctoral studies.

- ❖ To the participants in this study for so generously giving their time and sharing their experiences.
- ❖ To my cosupervisor and friend Associate Professor Anne Williams for her wisdom and unfailing patience and for mentoring me from a tentative idea for an Honours study to PhD submission. I have been blessed to walk in her footsteps.
- ❖ To my cosupervisor and friend Professor Rene Michael for the sure hand that guided me through the PhD process and for her clarity of vision that helped me to crystallise and communicate my ideas.
- ❖ To Lynn Hellier and Denise Fairclough at Sir Charles Gairdner Hospital for their constant encouragement. Their dedication to providing compassionate expert care to relieve the suffering of those in pain inspired and lit this study.
- ❖ To my fellow apprentice grounded theorist Jo who shared the journey and whose insight, resilience and humour were the perfect travelling companions.
- ❖ To dear friends Prue, Chaff, Marg, Sue, Fi, and Alison who understood when I disappeared under words and deadlines and listened so patiently when I emerged.
- ❖ To Geoff and Dawn who generously loaned me their retreat so that ideas and sentences could blossom.
- ❖ To my family - Mum and Dad, brothers Don and Andrew, beautiful Jane, and Siobhan, and special Meg and Brandt for the rock solid foundation on upon which to build a PhD.
- ❖ Lastly, to my loving and patient husband Kim and children Tom, Grace and Meg who understood when the fridge was empty and the laundry was full. Thank you for always believing in me – especially when I didn't believe in myself.

The conduct of this study was financially supported by the 2006 PhD Scholarship awarded by the Australian Pain Society/Australian Pain Relief Association. Editing support was provided by Dr Naomi Britten and Dr Lisa Lines.

ABSTRACT

Hospitalised patients continue to experience significant levels of pain despite advances in pain management knowledge and techniques. Evidence from nurses practicing in specialty and community settings suggests that caring for patients who experience persisting pain has implications, both personally and professionally. This grounded theory study described and explained the effect of caring for patients who experienced severe pain on nurses working in medical and surgical wards of a Western Australian hospital. Data were collected from a sample of 33 nurses through 30 semi-structured interviews and 93 hours of participant observation. Eleven patients who were experiencing severe pain participated in structured observations. Audio-recordings of interviews and field notes were transcribed verbatim and analysed using the constant comparative method.

The substantive theory of *seeking empowerment to provide comfort* was developed in this grounded theory study. This substantive theory explained the emotional effects on nurses and their response to caring for patients with severe pain. The provision of comfort to patients and the maintenance of the well-being of the nurse were key elements.

Within the context of nurses' shared regard for well-being, a core problem of *feelings of disempowerment* was identified. It was found that nurses who felt able to comfort patients in severe pain experienced feelings of empowerment, which were enjoyable, relaxing and beneficial to their own well-being. In contrast, nurses who felt unable to provide comfort for patients who were suffering with severe pain experienced feelings of disempowerment, which were distressing, frustrating, dissatisfying and, ultimately, exhausting. Four intervening conditions were identified, which influenced the amount of empowerment nurses experienced when caring for patients in pain in this acute hospital. These intervening conditions involved nurses' *levels of empathy, access to effective medication, collaboration with patients and colleagues, and time to care.*

In this study, empowerment was found to be an outcome and a process and the core category that integrated the substantive theory. As an outcome, empowerment was the psychological state nurses experienced when they felt able to

provide comfort. As a process, empowerment was the means by which nurses sought to avoid the shared problem of feelings of disempowerment to enhance their patients' and their own wellness. The process of *seeking empowerment to provide comfort* explained nurses' actions and interactions to avoid feelings of disempowerment by *building connections* with patients and colleagues, *finding alternative ways to comfort* when pain relief was ineffective and *quelling emotional turmoil* to conserve their resources and protect their own well-being. Nurses were shown to progress through these stages as their experiences of disempowerment escalated.

This research illuminates the problem encountered by nurses when they care for patients who experience severe pain and the process they use to manage this problem. A striking finding of this study was the depth of emotional distress experienced by some nurses who felt powerlessness to assist patients in pain. Evidence also emerged of behaviours used by nurses to protect themselves from ongoing feelings of disempowerment. There are significant implications for both patients and nurses in these findings. This study provides direction for interventions to support nurses who practice in acute hospital settings and to facilitate patient comfort and nurse well-being. A number of indications for areas of further research are also provided.

TABLE OF CONTENTS

| | |
|--|------|
| DECLARATION | i |
| ACKNOWLEDGEMENTS | ii |
| ABSTRACT | iii |
| TABLE OF CONTENTS | v |
| LIST OF FIGURES | xiii |
| LIST OF TABLES | xiv |
| LIST OF ABBREVIATIONS | xv |
| GLOSSARY | xvi |
| CHAPTER ONE: BACKGROUND AND PURPOSE | |
| Introduction | 1 |
| Background | 2 |
| The impact of pain | 2 |
| The management of pain | 3 |
| The prevalence of pain in hospitalised patients | 6 |
| The role of nurses in pain relief | 8 |
| Barriers to nurses' pain management | 8 |
| The effect of patients' pain on nurses | 13 |
| Purpose | 22 |
| Objectives | 23 |
| Significance | 23 |
| Summary of Chapter One | 25 |

CHAPTER TWO: METHODOLOGY

| | |
|--|----|
| Introduction | 26 |
| The qualitative approach | 27 |
| The underpinnings of qualitative research | 27 |
| Grounded Theory | 29 |
| Historical context of grounded theory | 29 |
| Current perspectives | 30 |
| Characteristics | 31 |
| Application of the grounded theory method to this study | 33 |
| The researcher | 34 |
| Setting | 35 |
| Participants | 36 |
| <i>Nurse participants</i> | 37 |
| <i>Patient participants</i> | 38 |
| Data collection | 42 |
| <i>Research interviews</i> | 42 |
| <i>Participant observation</i> | 47 |
| <i>Structured observations</i> | 51 |
| <i>Field notes</i> | 53 |
| <i>The reflective journal</i> | 54 |
| <i>Literature as data</i> | 55 |
| Data analysis | 56 |
| <i>Constant comparison</i> | 56 |
| <i>Coding</i> | 57 |

| | |
|---|----|
| <i>Transcription</i> | 57 |
| <i>Open coding</i> | 58 |
| <i>Axial coding</i> | 59 |
| <i>Selective coding</i> | 61 |
| Theoretical sampling | 62 |
| Memo writing and development of the final report | 63 |
| Use of the literature | 67 |
| Trustworthiness and rigour | 68 |
| Ethical considerations | 72 |
| <i>Informed consent</i> | 72 |
| <i>Privacy and confidentiality</i> | 74 |
| <i>Data storage, access and disposal</i> | 75 |
| <i>Minimising risk</i> | 75 |
| Summary of Chapter Two | 76 |
| CHAPTER THREE: FINDINGS | |
| THE CONTEXT OF REGARD FOR WELL-BEING | |
| Introduction | 77 |
| The Definition of Well-being | 78 |
| Nurse Empowerment | 80 |
| Patient Comfort | 83 |
| Nurses' Comfort Provision | 85 |
| Comprehensive assessment | 87 |
| Holistic care | 91 |
| Summary of Chapter Three | 95 |

CHAPTER FOUR: FINDINGS

THE CORE PROBLEM: FEELINGS OF DISEMPOWERMENT

| | |
|--|-----|
| Introduction | 97 |
| Feelings of Disempowerment | 99 |
| Nurses' distress | 102 |
| Nurses' frustration | 103 |
| Nurses' dissatisfaction | 104 |
| Nurses' exhaustion | 105 |
| | |
| Conditions Causing and Influencing Feelings of Disempowerment | 106 |
| Levels of empathy | 107 |
| <i>Nurses' pain experiences</i> | 111 |
| <i>Patient behaviours</i> | 114 |
| <i>Physical pain cues</i> | 120 |
| <i>Summary of levels of empathy</i> | 123 |
| | |
| Access to effective medication | 123 |
| <i>Nurses' knowledge</i> | 127 |
| <i>An effective prescription</i> | 134 |
| <i>Patients' willingness</i> | 135 |
| <i>Patients' analgesic tolerance</i> | 140 |
| <i>Summary of access to effective medication</i> | 145 |
| | |
| Collaboration with patients and colleagues | 146 |
| <i>Collaboration with patients</i> | 146 |
| <i>Collaboration with colleagues</i> | 156 |

| | |
|---|-----|
| <i>Summary of collaboration with patients and colleagues</i> | 171 |
| Time to care | 172 |
| <i>Summary of time to care</i> | 182 |
| Summary of Chapter Four | 182 |
| CHAPTER FIVE: FINDINGS | |
| THE BASIC SOCIAL PSYCHOLOGICAL PROCESS: SEEKING EMPOWERMENT TO PROVIDE COMFORT | |
| Introduction | 185 |
| Seeking Empowerment to Provide Comfort | 186 |
| Stage One: Building Connections | 188 |
| Prioritising patients | 189 |
| Initiating contact | 190 |
| Negotiating differences | 196 |
| <i>Balancing</i> | 196 |
| <i>Defusing</i> | 201 |
| Summary of stage one: Building connections | 204 |
| Stage Two: Finding Alternative Ways to Comfort | 205 |
| Being there | 206 |
| Using nonpharmacological strategies | 210 |
| Summary of stage two: Finding alternative ways to comfort | 212 |

| | |
|---|-----|
| Stage Three: Quelling Emotional Turmoil | 213 |
| Venting | 215 |
| Reappraisal | 217 |
| Disengaging | 220 |
| Summary of stage three: Quelling emotional turmoil | 225 |
| | |
| Summary of Chapter Five | 226 |

CHAPTER SIX: DISCUSSION

| | |
|--|-----|
| Introduction | 228 |
| Overview of the Substantive Theory: Seeking Empowerment to Provide Comfort | 228 |
| | |
| The Substantive Theory of Seeking Empowerment to Provide Comfort and Related Literature | 235 |
| | |
| The substantive theory and literature relating to nurses' pain management | 236 |
| | |
| The substantive theory and literature relating to empowerment | 242 |
| <i>Spreitzer's theory of psychological empowerment</i> | 243 |
| <i>Kanter's theory of structural empowerment</i> | 245 |
| <i>Critical social theory and patient empowerment</i> | 249 |
| | |
| The substantive theory and literature relating to comfort and caring 251 | |
| <i>Kolcaba's theory of comfort</i> | 251 |
| <i>Watson's theory of human caring</i> | 253 |

| | |
|--|------------|
| <i>Parse's theory of nursing: human becoming</i> | 254 |
| <i>Swanson's theory of caring</i> | 255 |
| <i>The attributes of nurse caring</i> | 258 |
| <i>Empathy</i> | 259 |
| <i>Presence</i> | 260 |
| <i>Mutuality</i> | 261 |
| <i>Caring behaviours</i> | 261 |
| <i>Antecedents to nurse caring</i> | 262 |
| <i>Consequences of nurse caring</i> | 263 |
| <i>Aspects of the acute hospital</i> | 263 |
| | |
| The substantive theory and literature relating to stress and coping ... | 267 |
| <i>Stress in the nursing literature</i> | 267 |
| <i>Coping in the nursing literature</i> | 268 |
| <i>Lazarus and Folkman's theory of stress, appraisal and coping</i> | 269 |
| | |
| Summary of the substantive theory related to relevant theories | 272 |
| | |
| Summary of Chapter Six | 273 |
| | |
| CHAPTER SEVEN: CONCLUSIONS AND RECOMMENDATIONS | |
| Introduction | 275 |
| Implications for Clinical Practice | 277 |
| Indications for Further Research | 283 |
| Recommendations for clinical practice | 286 |

| | |
|---|-----|
| Recommendations for further research | 287 |
| Concluding Statement | 288 |

| | |
|-------------------------|-----|
| REFERENCES | 289 |
|-------------------------|-----|

APPENDICES

| | | |
|------------|---|-----|
| APPENDIX A | Patient Consent Form | 311 |
| APPENDIX B | Record of Patient Verbal Consent | 312 |
| APPENDIX C | Short-Form McGill Pain Questionnaire | 313 |
| APPENDIX D | Letter of Permission | 315 |
| APPENDIX E | Staff Consent Form (Observation and Interview) | 316 |
| APPENDIX F | Staff Consent Form (Interview) | 317 |
| APPENDIX G | Nurse Demographic Form | 318 |
| APPENDIX H | Interview guide | 319 |
| APPENDIX I | Sir Charles Gairdner Hospital Ethics Approval | 320 |
| APPENDIX J | Patient Demographic Form | 321 |
| APPENDIX K | Presentations | 322 |
| APPENDIX L | Curtin University Ethics Approval | 324 |
| APPENDIX M | Staff Information Sheet (Observation and Interview) | 325 |
| APPENDIX N | Staff Information Sheet (Interview) | 329 |
| APPENDIX O | Patient Information Sheet | 332 |
| APPENDIX P | Permission to reproduce cartoon | 336 |

LIST OF FIGURES

| | | |
|-----------|--|-----|
| Figure 1 | Coding tree | 60 |
| Figure 2 | Relationship between nurse empowerment, patient comfort and the well-being of nurses and patients | 80 |
| Figure 3 | The core problem and four intervening conditions | 98 |
| Figure 4 | Nurses' empathy and feelings of disempowerment | 110 |
| Figure 5 | Nurses' personal experiences of pain | 113 |
| Figure 6 | Factors contributing to the lack of time to care | 176 |
| Figure 7 | Cartoon appearing in The West Australian newspaper | 179 |
| Figure 8 | Stages of the basic psychological process | 187 |
| Figure 9 | Nurses' strategies to build connections | 189 |
| Figure 10 | Nurses' strategies to find alternative ways to provide comfort | 206 |
| Figure 11 | Illustration of quelling emotional turmoil subcategories | 214 |
| Figure 12 | Nurses' strategies to quell their own emotional turmoil | 215 |
| Figure 13 | The substantive theory of seeking empowerment to provide comfort | 229 |
| Figure 14 | Themes of empowerment in the literature | 244 |

LIST OF TABLES

| | | |
|---------|--|----|
| Table 1 | Types of medical conditions relating to pain | 36 |
| Table 2 | Characteristics of nurse participants | 39 |
| Table 3 | Characteristics of patient participants | 43 |

LIST OF ABBREVIATIONS

APS: Acute Pain Service

CNC: Clinical Nurse Consultant

CNS: Clinical Nurse Specialist

CN: Clinical Nurse

IM: intramuscular

IV: intravenous

IVABs: intravenous antibiotics

NSAID: non-steroidal anti-inflammatory

PCA: patient-controlled analgesia

PRN: pro re nata

RMO: Resident Medical Officer

RN: Registered Nurse

SDN: Staff Development Nurse

Stat: Statim dose

UK: United Kingdom

USA: United States of America

WHO: World Health Organisation

GLOSSARY

Adjuvant analgesic: Medications used primarily for other conditions which are used in combination with analgesics to enhance pain relief (Bryant & Knights, 2011).

Bolus: Single dose of medication delivered via intravenous or epidural route (Bryant & Knights, 2011).

Codeine: Weak opioid (Bryant & Knights, 2011).

Drug tolerance: Steady decrease in effectiveness when medication is given repetitively over time. Commonly seen in patients receiving opioids; tolerance can develop to analgesic, sedation, and nausea and vomiting effects (Bryant & Knights, 2011).

Epidural: Injection of drug into the spinal canal (Bryant & Knights, 2011).

Fentanyl: Highly potent, short acting opioid (Bryant & Knights, 2011).

Gate control theory: Hypothesis that a mechanism occurring in the dorsal horn of spinal cord modifies painful sensations during transmission from peripheral nerve fibres to the brain (Bryant & Knights, 2011).

Intramuscular: Injection of drug into muscle for absorption into bloodstream (Bryant & Knights, 2011).

Intravenous: Injection of analgesic medication directly into bloodstream to achieve rapid circulation to site of painful tissues (Bryant & Knights, 2011).

Ketamine: Anaesthetic drug that can be used as an analgesic at lower doses. Causes less respiratory depression than opioids but side effects can include dizziness and frightening dreams (McCaffery & Pasero, 1999)

Morphine: Opioid considered “gold standard” analgesic drug, widely used clinically (Bryant & Knights, 2011).

Non-steroidal anti-inflammatories: Class of drugs that inhibit prostaglandin and act to reduce pain, inflammation and fever (Bryant & Knights, 2011).

Opioids: Class of analgesic drugs that act on endogenous opioid receptors in the central nervous system to inhibit the transmission of pain and alter emotional

responses to pain. Major side effects include respiratory depression, sedation, nausea and vomiting, constipation, tolerance and dependence (Bryant & Knights, 2011).

Oxycodone: Potent synthetic opioid, administered orally or rectally (Bryant & Knights, 2011).

Oxynorm: Trade name for oxycodone (MIMS Australia Pty Ltd, 2012).

Pain tolerance: The point at which pain becomes unbearable; known to vary between individuals (Bryant & Knights, 2011).

Panadol: Trade name for paracetamol (MIMS Australia Pty Ltd, 2012).

Paracetamol: (named acetaminophen in the USA) Nonopioid sold over the counter in Australia, reduces pain and fever. Adverse and allergic effects are rare when used in therapeutic doses. Effective for mild to moderate pain and often used with opioids to increase analgesia for moderate to severe pain (Bryant & Knights, 2011).

Patient-controlled analgesia: Delivery of medication via subcutaneous or intravenous route using pump device with handset to enable patient to trigger administration of a pre-set dose (Bryant & Knights, 2011).

Pethidine: (named meperidine in the USA) Potent opioid, unsuitable for oral administration (Bryant & Knights, 2011).

Respiratory depression: Significant side effect of opioids involving suppression of the respiratory centre in the brain. Causes breathing to become slow and shallow, may result in death (Bryant & Knights, 2011).

Subcutaneous: Injection of drug beneath the skin to achieve slow absorption and sustained analgesic effect (Bryant & Knights, 2011).

Statim dose: Single dose of medication to be given at once (Bryant & Knights, 2011).

Tramadol: Synthetic analgesic, not related to opioids. Useful for moderate to severe pain and in neuropathic pain (Bryant & Knights, 2011).

Transdermal: Delivery of medication dose through the skin and into the bloodstream. Often formulated as an adhesive patch (Bryant & Knights, 2011).

CHAPTER ONE

Background and Purpose

Introduction

Hospitalised patients in Australia and across the world continue to suffer pain despite significant advances in pain management knowledge and techniques (Murnion, Gnjudic & Hilmer, 2010; Sawyer, Haslam, Daines & Stilos, 2010; Wadensten, Frojd, Swenne, Gordh & Gunningberg, 2011). Additionally, there are indications that nurses, who are central to the relief of pain for patients in acute hospitals, experience anxiety and helplessness when caring for patients in severe pain (Blondal & Halldorsdottir, 2009; Clements & Cummings, 1991; Nagy, 1998).

Investigations focused on nurses working in clinical specialties have demonstrated that patients' pain can not only be detrimental to nurses' emotional well-being, but also that their responses can have implications for pain management practice (de Schepper, Francke & Abu-Saad, 1997; Nagy, 1998, 1999; Wilson & McSherry, 2006). However, there is a dearth of literature exploring how caring for patients in severe pain affects nurses; more specifically, nurses who work in general wards in acute hospitals and their pain management practice.

This study explores the effect of caring for patients who are experiencing severe pain on nurses and implications for their practice. It was undertaken within the context of acute medical and surgical hospital wards in a Western Australian public hospital. Using the grounded theory method, this investigation has sought to describe and explain nurses' emotional responses to caring for patients experiencing severe pain in this practice setting. Chapter One outlines the background to this study, reviews the literature, and details the purpose, objectives and significance of the study.

Background

Pain has a complex and multidimensional nature which is influenced by a person's emotional state, cultural background, previous pain history and coping style (Bryant & Knights, 2011; Dihle, Bjolseth & Solvi, 2006; Macintyre, Schug, Scott, Visser & Walker, 2010; Main, Sullivan & Watson, 2008). Considered more than a processing of neural signals, pain is shaped by individuals and context and, as such, is a subjective human experience (Bendelow, 2006; Davis, 2000; Manias & Williams, 2007; Mann & Carr, 2006). The subjectivity of pain is emphasised in McCaffery and Pasero's definition of pain as "whatever the experiencing person says it is, existing whenever he says it does" (McCaffery & Pasero, 1999, p. 17). These understandings of pain have guided research, education and practice and continue to be widely used (Carr & Christensen, 2010; Dihle et al., 2006; Mann & Carr, 2006).

Pain is defined in a number of ways. The definition of pain used in this study is taken from a publication by the National Health and Medical Research Council of Australia entitled: "Acute Pain Management: Scientific Evidence, 3rd edition" (Macintyre et al., 2010). Pain is described as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Macintyre et al., 2010, p. 1). This definition is also used by the International Association for the Study of Pain (IASP) and is included in its current online resource IASP Taxonomy (International Association for the Study of Pain, 2012). Central to this understanding is the complexity of the pain experience and multidimensional impact on individuals.

The impact of pain.

Pain has been differentiated into acute and chronic on the basis of duration and identifiable cause (Macintyre et al., 2010). Acute pain is likely to be self-limiting and attributable to injury or disease, while chronic pain tends to persist beyond discernible healing and may be related to an ongoing or degenerative condition, or may have no clear cause (Macintyre et al., 2010; Mann & Carr, 2006). Recent evidence suggests these types of pain are not necessarily discrete entities but, rather, exist on a continuum (Macintyre et al., 2010). It has been recognised that sufferers attach meaning to pain, which further influences the pain experience (Davis, 2000).

Specifically, the intensity and site of acute pain may be interpreted as a signal of a life-threatening condition, whereas chronic pain is more likely to be associated with life-limiting conditions which threaten quality of life (Davis, 2000). These interpretations of pain can influence a sufferer's expression of pain and coping ability, thus adding to the complexity of pain management (Mann & Carr, 2006).

The multidimensionality of the pain experience ensures that unrelieved pain has a number of adverse physical and psychological effects for the sufferer (Berry & Dahl, 2000). Underpinned by a physiologic stress response, which is protective in the short-term but harmful in the long-term, ongoing pain affects many organs and systems in the body (Main et al., 2008; Pasero, Paice & McCaffery, 1999).

Undertreated postoperative pain has been linked to complications, slowed recovery and the risk of chronic postsurgical pain, which may be associated with significant disability (Dunwoody, Krenzischek, Pasero, Rathmell & Polomano, 2008; Hickey et al., 2010; Macintyre et al., 2010; Shyu, Chen, Chen, Wu & Su, 2009; Williams & Manias, 2008). Moreover, people who suffer ongoing pain have been found to experience anxiety and depression, helplessness, strain on relationships, economic consequences and diminished quality of life (Davis, 2000; Main et al., 2008). Effective management of pain is therefore crucial to ameliorate the risk of long-term physical and psychological harm, to facilitate healing and to improve quality of life.

The management of pain.

A number of approaches for the management of pain currently exist. Widely accepted guidelines developed in 1992 by the Agency for Health Care Policy and Research emphasised the role of nurses, pain assessment, use of pharmacological and nonpharmacological strategies and organisational support in postoperative pain management (Dihle et al., 2006). Additionally, the World Health Organisation (WHO) has an algorithm for pain treatment in the form of a three step analgesic ladder (World Health Organisation, 2012). Originally developed to simplify pharmacological management of cancer pain for health professionals across the developed and underdeveloped world, this ladder was considered a significant advance in pain management globally (Meldrum, 2005). The stepwise approach has been shown to be effective for the majority of cancer pain and has been

recommended to guide management of chronic pain from end stage renal disease (Davison, 2005; Vargas-Schaffer, 2010; Williams & Manias, 2008).

In Australia, the scientific evidence for the management of acute pain has recently been reviewed, summarised and formulated to support practising clinicians (Macintyre et al., 2010). Recommendations for practice include regular and systematic assessment of pain (preferably using patient self-report and a validated tool to handle subjectivity) as the basis for effective management (Berry & Dahl, 2000; Dihle et al., 2006; Macintyre et al., 2010). Provision of pain relief should integrate frequent pain assessment and reassessment, patient teaching, and pharmacological and nonpharmacological comfort measures supported by an institutional approach with defined lines of responsibility (Bucknall, Manias & Botti, 2007; Dihle et al., 2006; Macintyre et al., 2010). The Australian summary of scientific evidence for the pharmacological management of acute pain developed by Macintyre et al. (2010) is outlined in the next two paragraphs. The WHO analgesic ladder approach for cancer pain relief is then described, followed by an overview of nonpharmacological comfort measures.

Recent evidence has established that opioid medication is “the mainstay of systemic analgesia for the treatment of moderate to severe pain” (Macintyre et al., 2010, p. 57). Morphine is the most widely used of the opioids. Others include buprenorphine, methadone, hydromorphone, fentanyl, pethidine, oxycodone and tramadol. Codeine is classed as a weak opioid. While one opioid is not superior to another, some may be more effective for particular patients. Possible side effects include respiratory depression, nausea and vomiting, constipation, urinary retention, pruritus and confusion. These effects are dose-related and careful titration is required. The likelihood of an adverse event related to opioid use increases in older patients, although genetics and psychological state may play a part (Macintyre et al., 2010).

Nonopioid medications are recommended for use as adjuvants to enhance the analgesic effects of opioids (Macintyre et al., 2010). Classes include non-steroidal anti-inflammatories (NSAIDs), antidepressants and anticonvulsants. The NSAIDs are a useful addition to opioid therapy for acute pain management, decreasing dose requirements and side effects. However, side effects can be significant, whereas

paracetamol, which is a nonopioid sold without a prescription in Australia, has few contraindications and is similarly effective when used regularly. Antidepressants and anticonvulsants are useful for the management of chronic neuropathic pain. Oral administration of analgesics is appropriate for mild to moderate pain as long as the patient has normal gastrointestinal function. The intravenous route is recommended for severe acute pain. Intermittent bolus doses facilitate rapid titration, whilst continuous infusion avoids peaks and troughs in blood levels but does not allow for variations in patients' responses. Other routes include intramuscular, subcutaneous, epidural, rectal and transdermal (Macintyre et al., 2010).

The WHO analgesic ladder provides a set of principles to guide the selection of analgesics to manage cancer, which are also suitable for some chronic conditions (Vargas-Schaffer, 2010; Williams & Manias, 2008). Three simple steps advise treatment of mild pain with administration of a nonopioid such as paracetamol; treatment of moderate pain using a weak opioid with or without nonopioid; and treatment of severe pain with a strong opioid with or without a nonopioid (World Health Organisation, 2012). Supplementation with adjuvant medications, such as antidepressants and anticonvulsants will enhance analgesic effects. This stepped approach has medication administered regularly, commonly described as "around the clock", rather than pro re nata (PRN), meaning "on demand", and is considered 80% to 90% effective (World Health Organisation, 2012).

Current Australian guidelines also recommend supplementing analgesic pain relief with some nonpharmacological strategies (Macintyre et al., 2010). In 2009, preliminary guidelines were developed for the use of nonpharmacological comfort measures for hospitalised patients (Williams, Davies & Griffiths, 2009). Literature exploring the effectiveness of 12 nonpharmacological approaches was reviewed and evidence graded from A, denoting "effectiveness established to a degree that merits application", to E, denoting "effectiveness not established" (Williams et al., 2009, p. 146). While no evidence was graded A, two measures achieved grade B. These were laughter therapy and the use of music. Of the remaining 10 measures, the evidence suggested aromatherapy, reflexology, and the use of heat, cold and repositioning had minimal or no effect. Scientific evidence is strengthening, however, for the benefits of psychological interventions, such as information provision, relaxation, attentional

diversion (distraction) and cognitive behavioural therapies, particularly when used in combination (Macintyre et al., 2010).

There is also evidence to suggest that introduction of an acute pain service and cooperative relationships between those providing patient care can improve pain management (Chung & Lui, 2003; Macintyre et al., 2010; Stadler, Schlander, Braeckman, Nguyen & Boogaerts, 2004; Werner, Soholm, Rotboll-Nielsen & Kehlet, 2002). Many hospitals now have teams of specialised clinicians to direct and support pain management practice (Macintyre et al., 2010). In Australia, these services are many and varied, ranging from nurse-led initiatives to multidisciplinary teams of anaesthetists, senior nurses and pharmacists. While the primary role may be to supervise pain relieving interventions, input is increasingly being sought to manage complex pain problems (Macintyre et al., 2010).

Significant increases in knowledge of pain management have led to the development of comprehensive resources to guide clinical practice. Use of guidelines may vary, however, dependent upon staff communication, access to practitioners with specialised expertise, and the degree of complexity in the practice setting (Macintyre et al., 2010; Manias, Bucknall & Botti, 2005). Evidence that pain remains prevalent in hospitalised patients despite advances in pain relief techniques, suggests there are factors precluding clinicians' implementation of current recommendations in this practice environment.

The prevalence of pain in hospitalised patients.

In 1973, Marks and Sachar published their seminal work reporting that patients in an acute hospital experienced significant levels of pain and distress, despite a prescribed regimen of analgesic medication. Their review of patients' medication charts revealed significant under prescription and administration of opioid analgesia. Since that time, evidence has persisted that hospitalised patients continue to experience pain (Bédard, Purden, Sauvé-Larose, Certosini & Schein, 2006; Chung & Lui, 2003; Mac Lellan, 2004; Sawyer et al., 2010). An example of this was reported in 2004 with pain being the most commonly reported symptom in patients (n=334) in acute care medical and surgical wards across 21 hospitals in the United States of America (USA) (Kris & Dodd, 2004). In the United Kingdom (UK),

26% of patients (n=552) surveyed from 14 hospitals experienced severe pain on movement 24 hours postoperatively (Moss, Taverner, Norton, Lesser & Cole, 2005). In Australia, a study of hospitalised patients (n=58) with chronic kidney disease found 71.7% had experienced moderate to severe pain in the previous 24 hours, with over half (58.8%) reporting moderate to severe pain at the time the data were being collected (Williams & Manias, 2007b).

More recently, in 2011, inpatients (n=759) at a university hospital in Sweden were surveyed (Wadensten et al., 2011). Sixty five percent of patients questioned reported having experienced pain during the previous 24 hours, with 42.1% rating the intensity of this pain at seven or above on a scale of zero to 10, where zero was no pain and 10 was the worst pain imaginable (Wadensten et al., 2011). As further background to the current research, a pilot study of inpatients' (n=186) pain levels was conducted in the study hospital to prepare for a project to implement evidence-based practice changes (Williams et al., 2011). This pilot work revealed that 30% of patients sampled were experiencing moderate to severe pain at rest and 47.3% reported moderate to severe pain upon movement.

There is evidence to suggest that hospital patients not only report significant levels of pain but also tend to be undermedicated in terms of pain relief (Boer, Treebus, Zuurmond & de Lange, 1997; Marks & Sachar, 1973; Schafheutle, Cantrill & Noyce, 2001; Watt-Watson, Stevens, Garfinkel, Streiner & Gallop, 2001; Wilson, 2009). In Australia, a medication chart audit of 100 hospitalised patients compared the amount of analgesic prescribed to the amount administered in the first four postoperative days (Manias, 2003a). The finding revealed that only 7% to 17% of PRN prescribed analgesics had been given. Moreover, the author noted that "PRN analgesic preparations remained popular" (p. 91) despite recommendations that giving regular medication at fixed times controls pain more effectively (Manias, 2003a). Later, a clinical audit conducted in five Victorian hospital renal units deemed pain management was inadequate for almost half of the sample of 58 patients with chronic kidney disease (Williams & Manias, 2007b). In the study hospital, a review of opioid medication administered to postoperative cardiac surgical patients (n=72) in the intensive care unit (ICU) revealed the low levels of total morphine received by the 25 patients who remained in the unit on the second postoperative day (Coventry, Siffleet & Williams, 2006). An additional finding was that 10 of the 43 patients who

had a chest drain removed prior to transfer from the ICU had no documented evidence of receiving any intravenous analgesia prior to the procedure. As bedside nurses are responsible for day-to-day analgesic administration, such findings raise questions about their role in the persistent problem of pain in hospitals.

The role of nurses in pain relief.

The provision of comfort to the patient is regarded as a prime goal of nursing care (Sloman, Rosen, Rom & Shir, 2005). Nurses are usually the first point of contact for hospitalised patients experiencing pain and have a major responsibility to intervene with pain relief (Watt-Watson et al., 2001). Amongst the multidisciplinary team, nurses spend the most time with hospital inpatients and are central to the alleviation of pain in acute care wards (Blondal & Halldorsdottir, 2009; Courtenay & Carey, 2008; Lui, So & Fong, 2008; Richards & Hubbert, 2007; Sloman et al., 2005; Söderhamm & Idvall, 2003).

The role of the nurse in pain management is complex, entailing assessment, selection of pharmacological or nonpharmacological measures, titration of analgesic dosing and evaluation of pain interventions (Bucknall et al., 2007; Manias, 2003a; Manias, Botti & Bucknall, 2002). Apart from providing pain relief, nurses can inform and educate patients and colleagues about how to improve pain management through their frequent interactions (Courtenay & Carey, 2008; Macintyre et al., 2010). Accordingly, nurses are considered central to the provision of analgesia, although evidence indicates they tend to undermedicate patients in pain (Blondal & Halldorsdottir, 2009; Manias, 2003a; Richards & Hubbert, 2007; Watt-Watson, Garfinkel, Gallop, Stevens & Streiner, 2000). This suggests that nurses encounter barriers to effective practice, which contributes to the persisting prevalence of pain experienced by hospital inpatients.

Barriers to nurses' pain management.

Research has explored barriers to the pain management role of nurses. The tendency of nurses to underestimate patients' pain experiences, fear of analgesic side effects, or deficient knowledge of pharmacological and nonpharmacological measures have been suggested as reasons for administration of inadequate analgesia

(Lui et al., 2008; Sloman et al., 2005; Van Niekerk & Martin, 2001). However, evidence is conflicting. For example, a study of Canadian nurses (n=94) found that patients in a surgical cardiovascular unit experienced significant postoperative pain yet received only 47% of analgesic medication prescribed (Watt-Watson et al., 2001). However, another significant finding of that study was the lack of association between nurses' lack of knowledge and patients' pain levels.

A consistent theme in the literature exploring pain management is the failure of nurses to systematically and adequately assess their patients' pain experiences (Bell & Duffy, 2009; Bucknall et al., 2007; Dihle et al., 2006; Kim, Schwartz-Barcott, Tracy, Fortin & Sjöström, 2005; Schafheutle et al., 2001). In an early study, 119 dyads of nurses and their postoperative patients were recruited from four hospitals in the USA (Zalon, 1993). Each patient and corresponding nurse used a visual analogue scale to simultaneously rate the patient's pain. Findings indicated that most nurses underassessed pain, although further analysis revealed a tendency to underestimate severe pain and overestimate mild pain. These results were supported in a later study conducted in four Israeli hospitals (Sloman et al., 2005). Surgical patients (n=95) and their nurses (n=95) independently rated patients' pain using a visual analogue scale and the ratings were compared using paired *t*-tests. Statistical analysis demonstrated that nurses significantly underrated patients' postoperative pain, both at rest ($t=3.498, p \leq 0.001$) and on movement ($t=6.278, p \leq 0.0001$) (Sloman et al., 2005). The studies by Zalon (1993) and Sloman et al (2005) each collected data from a single hospital. However, when considered together, their findings suggest the underassessment of pain by nurses is a significant contributor to the problem of pain experienced by hospitalised patients.

Research in Australia has sought to understand the issues underpinning nurses' inadequate pain assessment (Manias, Bucknall & Botti, 2004). Observation of nurses (n=52) caring for patients in two surgical hospital units over 74 two-hour blocks captured 316 pain activities. No pain assessment was observed in 138 (43.7%) of these activities. Most commonly, nurses omitted pain assessment when patients could not communicate about pain or were having routine medication. Nor were these nurses observed to assess pain when patients with chronic conditions experienced ongoing discomfort. The pain activities which did involve assessment primarily consisted of simple questioning (45.3%), with a numerical pain scale used

in 28 (8.9%) activities. Only four (1.3%) of the activities observed involved complex assessment, while three (0.9%) included a physical evaluation of the wound.

One of the strengths of using observation is the capacity to capture actual practice and this study by Manias et al (2004) effectively measured the frequency and nature of nurses' assessment in a hospital setting. While the presence of an observer may have influenced the behaviours of participants, the presumed effect would be to increase the nurses' focus on pain management, thereby improving their practice. This presumption suggests these findings possibly overestimated the usual assessment activities of nurses. While data were collected from a single hospital, the study findings were strengthened by a large sample and triangulation through extensive observation conducted at multiple times throughout the nurses' day and evening shifts (Manias et al., 2004).

Most recently, nurses' pain assessment practice was evaluated as part of the large survey of 759 Swedish hospital patients, who represented 65% of the 1,112 inpatients on the day (Wadensten et al., 2011). All patients, unless too ill, cognitively impaired or unable to speak Swedish, were asked to report pain being experienced at the time and in the preceding 24 hours using a self-administered questionnaire. This questionnaire was developed for the study and included items designed to capture demographic information, such as patients' age and gender, and three questions asking whether the patient (a) was experiencing pain at the time of the survey, (b) had experienced pain in the previous 24 hours, and (c) had been questioned by staff about their pain in previous 24 hours. Patients who indicated that they were experiencing pain were also asked to rate the intensity of both current pain and the most pain experienced in the previous 24 hours. Of the 494 patients who described previous experiences of pain, 81% remembered having been asked by staff about their pain. However, only 38.7% had used a numerical rating scale to provide a self-assessment of their pain. This study provided a snapshot of patients' experiences in a single hospital. A limitation was the use of an instrument developed for the study. It was also unclear how the survey tool had been validated, although a Numeric Rating Scale used in several previous studies was included. Additionally, patients' recall of nurses' pain assessment activities may have been unreliable. Nevertheless, with a large sample size, moderately high response rates and the inclusion of patients from

multiple clinical units, the findings offer further support for earlier evidence of nurses' inconsistent pain management (Wadensten et al., 2011).

In a qualitative investigation, Iranian nurses (n=26) were found to value their role in pain management but felt that a lack of education and limited authority in the health care system constrained their effectiveness (Rejeh, Ahmadi, Mohammadi, Kazemnejad & Anoosheh, 2009). These nurses subsequently tended to prioritise other activities over pain management. They also described how the lack of time impinged upon their relationships with patients when managing pain (Rejeh et al., 2009). The findings support evidence from an observational study of Australian hospital nurses (n=12) that environmental factors impede nurses' pain management practice (Manias et al., 2002).

In the study by Manias et al. (2002), nurses providing direct patient care in a postsurgical ward were followed over 12 two-hour time periods and 41 pain-related activities were observed. Analysis revealed nurses' focus on assessing surgical pain, primarily when observing other vital signs. A striking finding was the degree to which nurses had to contend with multiple interruptions and the competing needs of other nurses, doctors and patients. Observation captured their consequent tendency to prioritise the various demands on their time and to defer provision of pain management in favour of other tasks (Manias et al., 2002).

Other Australian and international work has further elucidated factors in the practice setting that influence nurses' pain management practice. For example, nurses in Queensland (n=19) participated in focus group discussions and described their frustration at a lack of peer support and difficulty collaborating with doctors (Nash et al., 1999). The theme of problematic communication with the health care team also emerged in a study conducted in a Victorian acute hospital ward (Bolster & Manias, 2010). Observation and interviews with nurses (n=11) and patients (n=25) explored their medication-related interactions. Although not specifically focused on pain management, this study identified barriers to nurses' provision of individualised patient care. Firstly, nurses encountered communication challenges that constrained access to medical staff and pharmacists. Secondly, limited time precluded their engagement and in-depth discussion with patients (Bolster & Manias, 2010). These findings provide recent evidence of two factors in the hospital practice environment,

which have emerged consistently in the literature as barriers to nurses' effective assessment and management of pain (Bell & Duffy, 2009; Blondal & Halldorsdottir, 2009; Manias, 2003b; Manias et al., 2005; Schafheutle et al., 2001; Tapp & Kropp, 2005; Van Niekerk & Martin, 2003). Other organisational factors shown to impede nurses' pain relief include lack of access to specialised staff, treatment modalities and equipment (Schafheutle et al., 2001).

Less concrete influences on nurses' pain management practice and patients' pain outcomes were investigated in one study conducted on three patient care units at a hospital in the USA (Wild & Mitchell, 2000). Fifty nurses working on the medical oncology, critical care and orthopaedic units were sampled to determine the influence of organisational structures and their attitudes toward pain management. Patients' pain experiences and satisfaction with care were also explored. Overall, patients hospitalised on the medical oncology unit, where nurses exhibited significantly stronger attitudes toward keeping patients pain free, reported more favourable pain outcomes. Along with nurses working in the critical care unit, these medical oncology nurses also reported high perceptions of autonomy. In contrast, patients' rating of their pain care were lower on the orthopaedic ward where nurses felt they had less autonomy and input into clinical decision-making. The findings may be limited by the small sample of patients and single study site. Nevertheless, this evidence suggests that nurses' attitudes and levels of autonomy can and do translate to pain management practice (Wild & Mitchell, 2000).

It has been suggested that patients can influence the effectiveness of pain management. A qualitative investigation of postoperative patients' (n=10) experiences of pain and pain relief conducted in the UK revealed that both nurses and their patients contributed to the undertreatment of pain (Carr & Thomas, 1997). That study described two main barriers to effective pain management. Firstly, patients were reluctant to bother nurses who were busy and, secondly, nurses failed to assess systematically their patients' experiences of pain. Comparable research has suggested that patients' stoicism, desire not to be a nuisance or fear of opioid side effects can also underpin a reluctance to report pain and accept analgesia (Clarke et al., 1996; Drayer, Henderson & Reidenberg, 1999; Manias et al., 2002; Schafheutle et al., 2001).

The barriers identified in previous research provide insight into the complexity of pain management for nurses working in acute hospitals. Considering these constraints, it is likely that patients' pain experiences affect the nurses who care for them.

The effect of patients' pain on nurses.

The detrimental physical and psychological effects on patients who suffer with unrelieved pain have been described. Evidence suggests that nurses who feel unable to help patients in persistent pain are also affected (Blomberg, Hylander & Törnkvist, 2008; Blomqvist, 2003; Blondal & Halldorsdottir, 2009; Nagy, 1998). Outcomes for nurses include experiencing anxiety and feelings of helplessness, powerlessness, frustration, disappointment and failure.

An early indication of the detrimental effects caring for patients with severe pain has on nurses is evident in a paper published 20 years ago, which chronicled the implementation of pain protocols in a hospital orthopaedic unit (Clements & Cummings, 1991). The authors, a nurse clinician and the Director of Quality Education and Research at an American hospital, were aware that nurses felt "helpless and hopeless" (p. 77) when unable to provide effective pain relief. Discussion with staff had elicited that nurses relied on observation to determine patients' pain and experienced powerlessness when treatment was ineffective. Nurses' inadequate knowledge of pain management and a lack of protocols to support a consistent team approach were also identified as contributors to poor outcomes. In particular, caring for manipulative patients, who contrived to modify their pain treatments, tended to increase nurses' helplessness (Clements & Cummings, 1991).

In response to these identified problems, a structured process of change was used to introduce education, a multidisciplinary pain team approach and decision-making protocols (Clements & Cummings, 1991). Still, a lack of formal evaluation limited this early work. Anecdotal evidence indicated that there were positive outcomes of change including increased staff cohesiveness, more coordinated care and more consistent pain relief. Nurses' experiences of powerlessness were not distilled through scientific enquiry, but rather were the expert opinion of clinical

leaders. However, this study provides an initial depiction of nurses' helplessness and hopelessness in the face of patients' pain that have been empirically demonstrated in later research.

Research conducted with nurses practicing in community or specialty settings provides further evidence of how patients' pain impacts on nurses. Community health nurses in the Netherlands (n=21) described feeling powerless when caring for cancer patients with pain (de Schepper et al., 1997). In this study, 24 nurses who delivered home care for cancer patients with pain were invited to participate in a qualitative study exploring their perceptions and experiences. Twenty-one nurses (83% response) participated in 20 individual semi-structured interviews and three group interviews involving two or three participants. Nurses were asked about their pain management and the problems and successes they encountered. Broad questioning was used and each participant was asked to recall a case where pain control had been unsuccessful. Data analysis focused on nurses' experiences of powerlessness.

Nurses indicated during the interviews that they often felt at a loss to know what to say or do to help patients in pain (de Schepper et al., 1997). Thematic analysis revealed three contributors to nurses' perceived powerlessness and three coping strategies. Themes describing contributing factors included (a) problems in communication, (b) dilemmas, and (c) the perceived discrepancy between the idealism of complete pain relief and the reality of intractable cancer pain. Problems in communication stemmed from patients' reticence to talk about pain and nurses' reluctance to initiate discussions with either patients or doctors. Nurses described their dilemmas when care was likely to cause pain or when giving analgesics could produce adverse effects.

The powerlessness of nurses crystallised when they realised that eliminating patients' pain was not always achievable (de Schepper et al., 1997). To cope, many nurses described (a) sharing their feelings of inadequacy with patients and colleagues, (b) equipping themselves with new knowledge and skills, and (c) protecting themselves by standing back. Standing back involved thoughtful reflection that renewed perspective or physically delegating care to another clinician.

The study by de Schepper et al. (1997) used a qualitative approach, which was appropriate to explore an area about which little was known. Open questioning and the nurses' selection of exemplar cases allowed concepts and patterns to emerge in the data. However, analysis involved a selective search for indicators of nurses' powerlessness. Arguably, use of a predetermined construct desensitised the researchers to related concepts in the data and may have narrowed the findings. A further limitation was the use of convenience sampling, which relied on nurses' responses to a mailed invitation; although the high response rate suggests that the influence of self-selection on the final sample was minimal. However, it was unclear how the study population and potential participants were determined. Additionally, the report provided no indication of whether saturation of the emergent themes was achieved. Despite the need for caution when considering these findings, the study by de Schepper et al. (1997) offers some empirical support for Clements and Cummings' (1991) anecdotal evidence that patients' pain affects nurses with implications for their practice.

In Australia, the emotional impact of patients' pain on nurses (n=65) working in specialty hospital settings was investigated (Nagy, 1998). This study sought to explore the effect on nurses when caring for two groups of people; burns patients who experienced prolonged pain, and neonates who were unable to communicate their pain experiences. Invitation letters sent to nurses working in four burns units and two neonatal units yielded a sample of 32 burns unit nurses and 33 neonatal nurses (48% response). Data collection involved individual interviews with participants, who were required to speak for at least five minutes in answer to one open-ended question; "what is it like for you to work with patients who are in pain or discomfort?" No other questions were asked. Interviews were transcribed and analysed using three validated quantitative scales to determine the emotional content of the text. The three tools used were (a) the Total Anxiety Scale; (b) the Origin Scale, measuring perceptions of personal control and competence; and (c) the Pawn Scale, measuring helplessness. Interviews that scored highly on each of these scales were then examined qualitatively to further explore the experiences of nurses (Nagy, 1998).

The study by Nagy (1998) revealed that nurses working in both the burns unit and the neonatal unit scored moderately highly on the Total Anxiety Scale. However,

statistical analysis demonstrated that burns nurses were significantly more anxious than neonatal nurses ($F=2.89, p \leq 0.01$). Qualitative findings indicated that nurses in both groups experienced feelings of failure and the perception that patients suffered with unnecessary pain. A further contributor to increased anxiety in burns unit nurses was a vulnerability that came with caring for victims of trauma. In contrast, neonatal nurses' scores on the Origin Scale demonstrated significantly lower perceptions of personal control and competence compared with burns unit nurses ($F=5.81, p=0.02$).

Two themes emerging from Nagy's (1998) qualitative analysis concerned nurses' difficulty in assessing pain and collaborating with medical staff to facilitate analgesia. Findings emphasised that nurses assumed responsibility to manage pain and felt disappointed in themselves and their colleagues when unable to do so. While nurses confronted by burns patients' discernible pain were more anxious, the obvious nature of burns patients' suffering meant that doctors readily supported their pain relief practice. In contrast, neonatal nurses were less aware of their patients' pain. These very young patients were often unable to communicate about pain meaning nurses could be oblivious to their suffering. While this meant that nurses were less anxious, collaboration with medical staff could be problematic. In particular, nurses described difficulty co-opting doctors into prescribing analgesia, which resulted in feelings of decreased control. No significant difference was found between the groups' Pawn Scale scores, which measured perceptions of helplessness and no further analysis of this construct was provided.

Strengths of Nagy's study (1998) included the sampling of two groups of nurses whose patients clearly differed in their ability to communicate pain and triangulation achieved through the recruitment of nurses from multiple clinical units. Moreover, data were collected using validated instruments capable of measuring intangible human experiences, such as anxiety and helplessness. Limitations included the use of convenience sampling and the 48% response rate suggests that selection bias potentially influenced the findings. It was also unclear whether the study was sufficiently powered to produce reliable statistical inferences, or whether emerging categories in the qualitative data were saturated. The lack of probing questions during the interviews suggests saturation may not have been achieved. Nevertheless, this Australian study by Nagy (1998) adds to early evidence of the impact of pain on

nurses and provides more detail about how factors in the practice environment contribute to these experiences.

A later study conducted in Sweden also revealed nurses' feelings of frustration and powerlessness when unable to assist patients with chronic pain problems (Blomberg et al., 2008). Although not focused on the hospital setting, the findings add to accumulating evidence of the detrimental effect patients' pain can have on nurses. The grounded theory method was used to explain district nurses' (n=20) experience of caring for chronic pain patients. Data were gathered using five focus group interviews and analysed using the constant comparison method and three levels of coding. Three conditions, which influenced nurses' ability to detect and respond to patients' pain, were identified. These conditions involved (a) patient communication and involvement in care, (b) nurses' collaboration with colleagues, and (c) the amount of organisational support nurses received. When conditions facilitated nurses' active assessment of pain and involvement in patient care, they felt competent, "authorised" (p. 2027) and able to meet expectations of pain relief. In contrast, "insufficient" (p. 2027) conditions led to nurses taking a passive role, which meant being alerted to patients' pain by patients, family or doctors and having little involvement in providing a solution (Blomberg et al., 2008). The nurses described a gap between the theory of pain control and the reality of clinical practice that left them feeling powerless and frustrated at the difficulty of caring for patients in pain.

The study by Blomberg et al. (2008) presents a theoretical model, which has yet to be tested in practice. Nevertheless, the findings further flesh out how patients' pain impacts on nurses and pain management practice. While it was conducted in an international community health setting, the importance of communication, collaboration and organisational support resonates with the experiences of hospital clinicians described in earlier studies (Clements & Cummings, 1991; Nagy, 1998) and reflects current guidelines for practice (Macintyre et al., 2010).

More recently, an investigation conducted in Iceland captured the challenge and complexity that hospital nurses encounter when caring for patients in pain (Blondal & Halldorsdottir, 2009). The authors noted the novelty of their approach in taking a "more holistic view" (p. 2902) from the nurse's perspective, to elicit the complexity of their pain management in the acute hospital rather than measuring

discrete aspects of practice. Phenomenology was used to understand nurses' experiences of caring for patients in pain and elucidate factors shaping their responses and actions. Purposive sampling selected nurses (n=10) working in the medical and surgical wards of three Icelandic hospitals from a pool of 20 volunteers who responded to an initial mailed invitation. Data collection involved 20 in-depth, unstructured interviews.

The study by Blondal and Halldorsdottir (2009) emphasises the challenge nurses face with the complexity of pain management. The findings depicted a journey with positive or negative outcomes for both nurse and patient. Nurses were motivated to respond to patients' pain by a moral obligation couched in their knowledge, experience, self-confidence and conviction. Challenges stemmed from (a) difficulty reading patients' verbal and nonverbal communication to assess pain; (b) internal conflicts when caring for difficult patients or those who refused analgesia; (c) collaborating with physicians who held the authority over analgesic orders; and (d) organisational constraints, such as lack of time. Experiences of a theory-practice gap, where clinical experience counted for more than knowledge, were also described.

The findings from this phenomenological study described outcomes for nurses that depended on their patients' experiences of pain relief (Blondal & Halldorsdottir, 2009). Nurses sensed an obligation to alleviate pain and described positive outcomes including enjoyment and satisfaction when they felt effective. In contrast, they experienced "profound distress and frustration" (p. 2902) when patients' pain persisted. Nurses' experiences of powerlessness and hopelessness at witnessing patients' suffering with pain were also captured. Consequent coping strategies included soliciting support and assistance from other clinicians; focusing on collaboration with patients; and taking comfort from continuing to try.

Nurses' successful provision of pain relief was found to benefit their well-being through a sense of empowerment in the study by Blondal and Halldorsdottir (2009). Factors motivating nurses to relieve pain and experiences of goal fulfilment were major elements in nurses' enjoyment and satisfaction. The contrasting experience of powerlessness when unable to alleviate patients' severe pain was also emphasised in the findings. The use of a phenomenological approach highlighted

how nurses' interactions and the practice environment influenced their responses to patients. Qualitative enquiry was used to investigate in-depth an issue about which little was understood. As a result, the complexity of nurses' pain management and the human experience of caring for distressed people emerged.

While these qualitative findings cannot be generalised to populations in other contexts, the study by Blondal and Halldorsdottir (2009) was strengthened by inclusion of nurses from both medical and surgical wards in three hospitals. However, a limitation was the sampling strategy, which included volunteers in the first instance. This approach may have resulted in a high proportion of nurses being sampled who had a particular interest in pain or who found the issue challenging. Without observational data, there is also no indication of whether nurses' responses reflect actual practice. Notwithstanding these reservations, the aim of this study was to understand how nurses experienced the challenge of pain management in the acute hospital. The findings suggest this aim was achieved. The research supports previous evidence that patients' pain affects nurses and builds on earlier work by demonstrating how hospital nurses working in medical and surgical wards experience pain management.

An understanding of nurses' vulnerability to their patients' pain may lie in models of professional caring, which provide the context for nurses' pain management practice. A prominent theme in the literature exploring caring in nursing has been the relationship between nurse and patient through which goals of care are enacted (Brilowski & Wender, 2005; Fealy, 1995). The concept of entering into a relationship implies that both nurse and patient make an emotional investment that enriches care and has consequences for both parties (Brilowski & Wender, 2005). Patients have reported feeling empowered, and having decreased physical discomfort and an increased sense of security and healing from nurses' care (Berg, Skott & Danielson, 2006; Halldórsdóttir & Hamrin, 1997; Hartrick, 1997; Williams & Irurita, 2006). Additionally, nurses have described feelings of pride, fulfilment and recognition when they effectively care for patients (Bush & Barr, 1997; Richards & Hubbert, 2007).

While the mutuality of caring brings rewards for nurses when patients improve, an investment in the caring relationship can render the carer vulnerable to

loss when patient outcomes are poor (Spichiger, Wallhagen & Benner, 2005). In terms of pain management, the findings from both Nagy (1998) and Blondal and Halldorsdottir (2009) suggest that nurses often willingly try to help patients in pain and feel ineffective, disappointed and less confident when unsuccessful.

A few studies have indicated that nurses' emotional responses can affect their relationships with patients in pain. In the study described earlier of Dutch community health nurses (n=21) who cared for cancer patients in pain, nurses demonstrated a tendency to stand back as a response to feelings of powerlessness (de Schepper et al., 1997). This standing back could facilitate nurses' reflection and renewed engagement with patients. However, such distancing could also become a permanent solution for stress if a nurse made the decision to work elsewhere.

The tendency for nurses to distance themselves from patients' pain was also reported in another investigation of nurses (n=32) working in five Australian hospital burns units conducted by Nagy (1999). Qualitative interviewing was used to explore nurses' coping when their burns treatments, while therapeutic, inflicted pain. Participants were asked a single open-ended question about the experience of causing pain when providing care. Interviews were transcribed and content analysis used to identify text where nurses described thoughts and actions related to the need to cause patients pain. Relevant text was categorised to determine nurses' coping strategies. Themes describing four major strategies emerged in the analysis: (a) distancing from pain, (b) engaging with pain, (c) seeking support, and (d) "reconstructing the nurses' role" (Nagy, 1999, p. 1429). The most common strategy identified in this study of burns unit nurses was distancing, which involved nurses removing themselves physically or emotionally from the spectre of patients' pain (Nagy, 1999). Physical distancing included taking a break or delegating care to another nurse. Emotional distancing involved cognitive strategies, such as focusing on the task, rather than the suffering person. While this strategy of distancing protected nurses, some were less aware of patients' needs.

The findings of Nagy's (1999) study indicated that nurses who engaged with pain by focusing on patients' discomfort, rather than away from it, were more satisfied and able to cope. The strategy of seeking support by connecting with patients and colleagues was also identified, while some nurses reconstructed their

roles by accepting that caring could mean causing pain. Seeing the situation in this way enabled nurses to perceive themselves more positively. The need for nurses to receive emotional support, which was not always available, emerged strongly in the findings of this study. Similarly to Nagy's (1998) earlier work, probing questions were not used during the interviews with nurses. This suggests that categories in the data were not saturated, which limits the study findings.

Further evidence that exposure to patients in pain has implications for nurses' practice emerged in a later study conducted in the USA (Wilson & McSherry, 2006). In this investigation, oncology/hospice nurses (n=35), who were considered specialists in pain management, and district nurses (n=37), who were considered generalists, speculated on the pain levels of hypothetical patients. An instrument containing six clinical vignettes was developed and distributed to 100 nurses in their workplaces. Eighty five questionnaires were returned (85% response). Nurses with less than one year's experience in their area and any district nurses who had attended pain management education were excluded.

Participants in the study by Wilson and McSherry (2006) were asked to consider the vignettes and use a five point Likert scale to rate the amount of pain each the patient might be experiencing. Opportunity to write short statements explaining the ratings was also provided. Statistical analysis of the scale scores using a Mann-Whitney *U*-test revealed that specialist oncology/hospice nurses inferred significantly lower pain levels than generalist district nurses (observed $U=176$, $z = -5.345$, $p < 0.01$). The conclusion was drawn that oncology/hospice nurses were frequently exposed to suffering with pain and minimised patients' experiences to protect themselves from feelings of helplessness and inadequacy (Wilson & McSherry, 2006).

Limitations of Wilson and McSherry's (2006) study included the use of single site and an unvalidated instrument. Two of the six vignettes had been used previously in another survey. The researchers designed the other four vignettes. No information was provided to indicate how the sample size was determined or whether the study was sufficiently powered to infer a statistically significant difference between the groups' scale scores. The authors also acknowledged that nurses' hypothetical ratings may not reflect actual practice. Nevertheless, this study suggests

that nurses may be influenced by their previous exposures to patients in pain. Strengths of the study included the use of two homogenous nursing groups for comparison, which were clearly delineated along educational and experiential lines. This study design also facilitated inferences about nurses' knowledge and experiences to explain variation in the data.

To summarise, the literature presents persisting evidence that patients who are hospitalised in surgical and medical acute care wards continue to experience unrelieved pain. Similarly, research has demonstrated that hospital inpatients commonly receive less medication than prescribed. Nurses who spend most time with hospitalised patients are central to effective pain management as they select and titrate analgesics to best meet patient needs. Accordingly, in an effort to explain the continuing undertreatment of pain, numerous studies have investigated aspects of nurses' pain management practice. The roles of inconsistent assessment, problematic communication with patients and medical staff, and ward organisation in nurses' pain management practices have been described.

Evidence suggests there are negative outcomes for both nurse and patient when a patient's pain goes unrelieved. While persistent pain can involve delayed healing, chronic pain, anxiety and diminished quality of life for patients; nurses can experience anxiety, helplessness, frustration and inadequacy. Moreover, research indicates that nurses use a variety of strategies to cope with these experiences. To date, few studies have explored the interrelationship between factors influencing nurses' pain management practice in the acute hospital. Furthermore, there have been none which have used a grounded theory approach to explore how the experience of caring for patients with severe pain affects nurses and shapes their responses.

Purpose

The purpose of this study was to explore and describe the care of patients who experience severe pain from the perspective of nurses who practice in medical and surgical wards of an acute hospital. Severe pain was described as pain which was self-reported by patients as a numerical score of seven or greater on a scale of zero to 10, where zero represents no pain and 10 represents the worst pain imaginable.

Objectives.

The research objectives guiding this study are to:

- ❖ Explore and describe the nurse's perceptions of severe pain.
- ❖ Explore and describe the nurses' actions and interactions relating to the care of patients experiencing severe pain.
- ❖ Explore and describe the emotional responses of nurses who care for patients who experience severe pain in the acute hospital and the coping strategies used.
- ❖ Identify the contexts and conditions in which severe pain is experienced and identify the factors that enhance or inhibit effective pain management in the acute hospital.
- ❖ Develop a substantive theory explaining the nature and process of caring for patients who experience severe pain from the nurse's perspective.

Significance.

Allowing patients to suffer with pain has been described as unethical and unprofessional (Bell & Duffy, 2009). In an effort to improve clinical practice, there has been considerable research effort expended to investigate the role of nurses in the pain management of patients and persisting problem of high levels of pain experienced by hospitalised patients. A number of descriptive studies have identified deficiencies in nurses' knowledge, attitudes and beliefs, and practices that constrain effective pain management practice (Dihle et al., 2006; Manias et al., 2005; Schafheutle et al., 2001; Watt-Watson et al., 2001; Wild & Mitchell, 2000). Additional research has investigated the role of patients and constraints in the clinical environment in nurses' undermedication of pain (Bédard et al., 2006; Carr, 2002; Carr & Thomas, 1997; Manias et al., 2002; Manias & Williams, 2007; Willson, 2000).

Research has suggested that forces in the practice environment influence pain management. However, further investigation is warranted to investigate how factors related to nurses, patients and the complex clinical setting produce outcomes for patients and the nurses who care for them (Dihle et al., 2006; Lauzon Clabo, 2008;

Manias et al., 2005; Williams & Manias, 2008). Moreover, it has been suggested that using naturalistic methods to explore the complexity and human relationships involved in decision-making about pain is appropriate to further this knowledge (Botti, Bucknall & Manias, 2004).

The current study has used interview and observation to elucidate factors influencing nurses and their pain management as they practice in medical and surgical hospital wards. Using this approach allowed the researcher to capture the clinical reality for nurses working in this setting, bringing relationships with patients and colleagues, as well as structural constraints into perspective.

Evidence of consequences for nurses from patients' experiences of unrelieved pain is accumulating, although research to date has focused on nurses working in community or specialty settings (Blomberg et al., 2008; de Schepper et al., 1997; Nagy, 1998, 1999; Wilson & McSherry, 2006). Numerous studies have investigated aspects of nurses' management of pain in surgical hospital units, in which nurses can be expected to be regularly managing patients' pain (Bucknall et al., 2007; Carr, 2002; Dihle et al., 2006; Mac Lellan, 2004; Manias et al., 2004, 2005; Rejeh et al., 2009; Richards & Hubbert, 2007; Sloman et al., 2005). Patients hospitalised with medical conditions however, also experience significant pain (Dix, Sandhar, Murdoch & MacIntyre, 2004).

Medical wards were identified as areas of need in a survey of 225 hospitals in the UK, when nursing and medical staff were found to lack awareness of patients' pain and of guidelines for pain assessment and treatment (Chang, Maney, Mehta & Langford, 2010). Most recently, a hospital-wide survey conducted in Sweden (n=759) found that patients on thorax/oncology/medical wards reported higher levels of present pain than patients on wards in the surgical division (Wadensten et al., 2011).

The current study aims to enter the nurse's world to access the reality of clinical pain management for nurses working in both surgical and medical wards of an acute hospital. The intention is to capture the gamut of pain problems managed by nurses and the range of human interactions, which underpins nurses' pain management in this setting. This approach broadens the scope of knowledge about how nurses deal with the clinical problems they encounter in everyday acute hospital

practice. In doing so, this study elicits an in-depth view of nurses' experiences and perceptions of pain management, allowing the interplay of personal and environmental factors to emerge.

It is anticipated that the substantive theory developed in this research will increase understanding of how nurses are affected by patients' experiences of pain, a phenomenon widely reported in acute care settings. This is particularly relevant in the current healthcare climate, in which trends predict higher acuity patients, shortened length of hospital stays and inconsistent staffing (Chang et al., 2006; To, Davies, Sincock & Whitehead, 2010). Moreover, this study will broaden the focus of research to date beyond community settings and clinical specialties to incorporate acute hospital wards.

Summary of Chapter One

Chapter One has outlined the background, purpose and significance of this study. Literature from Australia and around the world, which demonstrates that hospitalised patients continue to experience significant levels of pain and are undermedicated for pain, was presented. Accumulating evidence that nurses are affected by patients' suffering with pain and that there are implications for effective pain management was also discussed. It was noted that, while much research has focused upon discrete elements of nurses' practice, few studies have taken an in-depth and holistic view of the issue from the perspective of nurses in acute hospitals. The current study is needed to identify the influences within the practice environment, the impact on nurses, and the processes used to manage the effects of patients' suffering with pain.

Chapter Two will describe the rationale for selecting a qualitative approach and grounded theory. Characteristics of the grounded theory method of inquiry will be outlined and its practical application for this current study will be described. The findings will then be presented in Chapters Three, Four and Five. In Chapter Six, the substantive theory of *seeking empowerment to provide comfort* will be considered in terms of other literature and existing theories. Conclusions and recommendations from this research will be discussed in Chapter Seven.

CHAPTER TWO

Methodology

Introduction

There are many ways to answer a research problem. Qualitative inquiry was chosen for this study for its ability to provide a fresh perspective on the phenomenon of nurses caring for patients who experience severe pain in the acute hospital. Grounded theory method (Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used to explore, describe and explain what is happening when nurses care for patients experiencing severe pain in the social world of the acute hospital ward. This approach is both inductive and deductive, where flexible data collection and analytic procedures generate explanatory theory that is grounded in the data (Charmaz, 2006; Cooney, 2010; Glaser, 1998, 1992; Glaser & Strauss, 1967; Morse, 2009; Strauss & Corbin, 1998).

The grounded theory method requires that the researcher comes to the study without preconceptions to allow participants' perspectives to emerge (Gezeljeh & Ememi, 2009). When initial ideas and tentative theory are tested with subsequently collected data, an "inductive-deductive interplay" (p. 335) eventually explains the phenomenon under investigation (McGhee, Marland & Atkinson, 2007). This approach was deemed suitable to investigate the effects on nurses of caring for patients who experience severe pain because it focuses on participants' interactions and elicits a basic social process within a situational context and intervening conditions.

This chapter will provide an overview of the qualitative research approach and delineate the theoretical underpinnings of the current study. The grounded theory method of inquiry will be explained in terms of its historical development, current perspectives and characteristics. A detailed description of the practical application of

the method to the current study will follow, including the procedures used to collect and analyse the data as well as issues regarding ethics, trustworthiness and rigour. The setting of the research and details about participants will also be described.

The qualitative approach.

Qualitative research cuts across many disciplines and encompasses multiple traditions, research perspectives, methods and approaches (Denzin & Lincoln, 2005). This approach aims to explore, describe and explain, with an emphasis on discovery and the generation of ideas and theory (Hesse-Biber & Leavy, 2006). With an inherent flexibility, qualitative inquiry facilitates a focus upon naturally occurring events, natural settings and prolonged time frames, which is well placed to capture process (Miles & Huberman, 1994). Moreover, a strength of qualitative research lies in the capacity for rich description and understanding of social life (Walker & Myrick, 2006). Potential limitations include the difficulty of establishing adequate reliability and validity, when data are subjective or collected from single contexts, and the need to spend extended periods of time in the field (Burns, 2000).

In clinical research, the qualitative researcher is encouraged to enter a biomedical world with multiple perspectives to include practitioners and patients and allow truth to be emergent (Miller & Crabtree, 2005). From this viewpoint, the qualitative researcher can identify fundamental questions, which confront clinicians and patients in the practice environment (Miller & Crabtree, 2005). Qualitative inquiry has become more prominent as an approach to inquiry in the field of nursing (Holloway & Fulbrook, 2001). This is because qualitative methods are regarded as appropriate to explore complex problems when explanatory theory is nonexistent or incomplete, to empower individuals and to understand context (Creswell, 2007).

The underpinnings of qualitative research.

The interpretive nature of qualitative research means that it is guided by the researcher's beliefs and understanding of the world and how to study it (Denzin & Lincoln, 2005). Therefore, the researcher must clarify the epistemologies, theoretical perspectives and methods underlying the research process (Crotty, 1998). Using these criteria, this current study is underpinned by (a) the epistemology of

constructionism, (b) the theoretical perspective of symbolic interactionism, (c) the grounded theory approach (Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1998), and (d) the methods of interview and participant observation.

Epistemology concerns knowing, what can be known, how we know and the relationship between the researcher and knowledge (Crotty, 1998; Denzin & Lincoln, 2005). Crotty (1998) offers *constructionism* as an epistemological stance that underpins much of qualitative inquiry; in which human beings construct knowledge and meaningful reality, from interactions with each other and their worlds. With some variation in language, other authors describe a constructionist epistemological perspective, in which meaning is constructed as individuals engage with the world, creating understanding between researcher and researched (Creswell, 2007; Denzin & Lincoln, 2005; Hesse-Biber & Leavy, 2006). Research underpinned by this epistemology relies on participants' views and focuses on individuals' interactions where they live and work, which are interpreted by the researcher to make sense of them (Creswell, 2007).

The epistemological stance of constructionism is embedded in the theoretical perspective of *symbolic interactionism*, which in turn informs the methodology of grounded theory (Crotty, 1998). Symbolic interactionism was developed in the 1960s by Blumer, a student of the earlier philosopher and social psychologist Herbert Mead (Crotty, 1998). Central to the history of symbolic interactionism is the idea of pragmatism as “a theory of knowing, truth, science and meaning” (p. 84), where the self is a social object and truth is characterised by consequences and what works (Denzin, 2004). From this position emerged the notion in symbolic interactionism of “putting oneself in the place of another” (p.75), the core idea in this theoretical perspective (Crotty, 1998).

With the publication of “Symbolic Interactionism: Perspective and Method” in 1969, Blumer offered a view of an interpretive self that is developed through continual social interaction (Crooks, 2001; Denzin, 2004). The basic assumption is that human beings act on the basis of meaning derived from social interaction with others, which is modified by an interpretive process used to handle things that are encountered in the social world (Crooks, 2001; Crotty, 1998; Denzin, 2004). Language is central and symbolic interactionism presupposes that human beings

construct reality and self through dynamic and interpretive interaction as they think and make choices about their actions (Charmaz, 2006; Crotty, 1998). Research embedded within symbolic interactionism moves inquiry away from caution and towards processes that illuminate aspects that have been neglected by traditional views (Crooks, 2001).

Symbolic interactionism informs a variety of methodological approaches, including grounded theory, ethnography and biography (Bloor & Wood, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1998), and has contributed to many fields of social science (Denzin, 2004). The grounded theory method was chosen for this study because it was viewed as the most appropriate methodology, for epistemological reasons, for exploring the phenomenon under study.

Grounded Theory

The term “grounded theory” has been referred to as both a method and product of research inquiry (Charmaz, 2006).

Historical context of grounded theory.

Grounded theory emerged in the 1960s when sociologists Barney Glaser and Anselm Strauss investigated the phenomenon of people dying in hospitals and published their seminal work “The Discovery of Grounded Theory” (Glaser & Strauss, 1967). This research was ground breaking because it articulated systematic strategies for qualitative inquiry and challenged the dominant deductive approach to theorising by generating, rather than verifying theory (Charmaz, 2006; Walker & Myrick, 2006). The quantitatively trained Glaser collaborated with Strauss, who embraced symbolic interactionism and ethnography, to unite positivism with pragmatism and field research (Charmaz, 2006; Stern, 2009). Glaser instilled grounded theory with rigorous codifying of the data, while Strauss brought inquiry that focused on interaction, meaning, process and action (Charmaz, 2006). With a common focus on social psychological processes in particular settings or experience, these founders proposed that completed grounded theory could explain process and the conditions influencing its emergence and variation (Charmaz, 2006).

The mentoring of Glaser and Strauss has led to grounded theory being described as the most frequently employed method of qualitative enquiry, which is widely used in many social disciplines including nursing (Morse, 2009). The evolution of grounded theory however, highlighted differences between Glaser and Strauss, and by the 1990s two versions of the method emerged (Morse, 2009). Strauss's collaboration with Corbin produced the "Basics of Qualitative Research Analysis", which was published in 1990 and revised in 1998 (Strauss & Corbin, 1998). Glaser responded with publications from his own Sociology Press (Glaser, 1978, 1992; Stern, 2009; Walker & Myrick, 2006). The process of data analysis is at the heart of the divide between Glaserian and Straussian grounded theory (Melia, 1996; Walker & Myrick, 2006). Particular points of difference include coding procedures, perceptions of forcing versus emergence and the verification versus generation of theory (Walker & Myrick, 2006).

Current perspectives.

The students of Glaser and Strauss have continued the evolution of grounded theory (Morse, 2009). Charmaz, an early doctoral student at the University of California, San Francisco, developed a constructivist version of grounded theory, in which the multiple perspectives of researcher and participant are recognised and where data are not discovered but constructed (Charmaz, 2009). Clarke developed a version of grounded theory, which she referred to as situational analysis (Clarke, 2009). This approach accepts that people outside the research setting influence participants and must be included in the analysis (Clarke, 2009; Creswell, 2007; Mills, Chapman, Bonner & Francis, 2007).

Corbin maintained that the version of grounded theory that she developed with Strauss retained the "pragmatist/interactionist perspective" (Corbin, 2009, p. 38). However, she acknowledged that since Strauss's death in 1996 she has come to accept firstly that multiple realities must be taken into account, and secondly that theory is constructed rather than emergent from participants' stories (Corbin, 2009). She recognised that despite the development of various approaches to grounded theory, certain uniting characteristics are apparent. These common aspects include

comparative analysis, theoretical sampling, memo writing and theoretical saturation, all of which develop concepts with properties to generate theory.

Characteristics.

As a research approach that is both inductive and deductive, grounded theory builds theoretical understanding from data collected in the field to interpret what is happening and to illuminate relationships and social structures (Charmaz, 2006; Glaser, 1992; Glaser & Strauss, 1967; McGhee et al., 2007; Strauss & Corbin, 1998). Grounded theory is regarded as a suitable method of inquiry when explanatory theory is not available or is inadequate (Creswell, 2007). Theory provides a framework that explicates, explains, and enables making predictions about phenomena (Charmaz, 1994). Typically, inquiry using grounded theory results in a generation of theory that is substantive because it explains the experience of a particular population or setting (Charmaz, 2006; Creswell, 2007; Walker & Myrick, 2006).

When using grounded theory the researcher enters the research field without preconceived ideas or hypotheses and seeks to systematically generate theory grounded in the data (Glaser, 1978; Strauss & Corbin, 1998). In essence, the grounded theorist seeks to identify a core variable in the data, which constitutes the main concern of the participants (Glaser, 1978). This encapsulates what is going on in the data and accounts for a pattern of behaviour (Artinian, 2009; Glaser, 1978). Participants' actions and interactions occur within a framework of conditions or situational context, and the analyst searches for process by looking at these in terms of movement and change (Strauss & Corbin, 1998).

Data are collected systematically from multiple sources and an inherent flexibility facilitates the gathering of data from sources likely to advance emerging ideas and concepts (Charmaz, 2006). Theoretical sampling, in which data collection and analysis are concurrent, guides the researcher to gather further data to develop and connect categories (Charmaz, 2006; Glaser, 1978, 1992; Glaser & Strauss, 1967). Sampling continues until categories are saturated, meaning that no new information is emerging in the data (Glaser, 1992; Strauss & Corbin, 1998).

Analysis of the data involves coding procedures, which are described as “the pivotal link between data and developing an emergent theory to explain these data” (Charmaz, 2006, p. 46). Through coding, raw data are conceptualised and theoretically connected to yield explanatory theory (Glaser, 1992; Glaser & Strauss, 1967). Coding is undertaken in three stages. The first stage, referred to as *open coding*, breaks data down to incidents by examining texts line by line to generate categories and describe their properties (Glaser, 1992). Secondly, *axial coding* develops the categories and their properties and elicits the relationships between them (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Lastly, *selective coding* integrates the theory through the sorting and relating of the categories around the core category (Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

The use of constant comparison, in which incidents are compared to other incidents or emerging concepts in the data to generate categories is at the core of grounded theory (Charmaz, 2006; Glaser, 1992; Glaser & Strauss, 1967). Memoing, when the researcher records thoughts, reflections and ideas about the analytic process, is regarded as essential to generation of theory (Glaser, 1992; Glaser & Strauss, 1967). In essence, coding and memoing allow the data to be fractured and then put back together in a coherent story (Glaser, 1998). Once the theory has stabilised, relevant literature is also sampled for comparison and fit to the emergent theory (Glaser, 1992; Glaser & Strauss, 1967; Wuest, 2000).

In grounded theory, the researcher has been described as the research instrument who unavoidably brings his or her own “worldview . . . into the mix” (Stern, 2009, p. 58). Grounded theory is inevitably influenced by the human being who is generating the theory (Glaser, 1978). It is the researcher’s theoretical sensitivity, described by Glaser (1978) as the “long term biographical and conceptual build up that makes him quite wise about the data” (p. 2), which informs and increases receptiveness to the emerging theory. Theoretical sensitivity helps the researcher sort out what is relevant in the data and to be fully open to the emerging theory (Hernandez, 2010; McCann & Clark, 2003; Walls, Parahoo & Fleming, 2010).

Certain techniques increase the researcher’s sensitivity to the data (Charmaz, 2006; Glaser, 1978). A strategy to increase theoretical sensitivity is to use a reflective

journal to explore personal feelings, values and conflicts through writing (Strauss & Corbin, 1998). The recommendation is to use the journal before and during data collection, data analysis and report writing.

Strengths of grounded theory include the provision of tools for analysing processes and a capacity to illuminate change and the underlying processes in social groups (Morse, 2009). Artinian (2009) lauds the capacity of grounded theory to move analysis from descriptive to conceptual. This benefits researchers who are able to develop their limited knowledge into a solid understanding of explanatory theory in a substantive area.

Challenges associated with this approach include: (a) the requirement for the researcher to set aside ideas so that participants are experts and theory can emerge; (b) difficulty determining when categories are fully saturated; and (c) the need to omit data not relevant to the core category lest it overwhelm explanation with description (Artinian, 2009; Creswell, 2007; Wuest, 2000). Further potential weaknesses include confusion about the meaning of terms such as theory, category and saturation, and the ease of setting on analytic categories before fully exploring events and meanings in the data (Charmaz, 1994).

Application of the grounded theory method to this study.

While the researcher is aware of the continuing debate concerning grounded theory, this study is guided by Glaser's and Strauss's original approach (Glaser & Strauss, 1967). The researcher decided to retain this hybrid inductive and deductive approach rather than adopt Glaser's purely inductive version or Strauss's more constructivist and prescriptive version with its additional analytic techniques (Birks, Chapman & Francis, 2006). In choosing the Glaser's and Strauss's classic grounded theory, the researcher sought to employ a straightforward approach to data analysis using procedures that elicit meaning from the data and elevate codes through conceptual levels to formulate theory "grounded" in the data (Birks et al., 2006). Using this approach, a substantive theory was developed which explained the importance of empowerment to nurses' ability to provide comfort for patients who experience severe pain. A description of the application of this method to the study

will now be presented. The application is based on the researcher's interpretation of Glaser's and Strauss's descriptions of conducting grounded theory research.

Detailed explanation of the methods involved in the research process enhances others' ability to make judgments about the reliability and validity of the approach (Burns, 2000). This description will present information about the researcher, setting, sampling, participants, data collection and analysis methods, use of the literature, and issues of trustworthiness, rigour and ethics. Finally, an overview of the findings is presented.

The researcher

The researcher came to this topic after encountering numerous challenges in caring for patients in severe pain. Originally hospital trained and with several years of experience in paediatric and adult medical and surgical settings, the researcher took a hiatus from nursing for over 10 years. She returned to clinical practice as a registered nurse in rural hospital situated in a rapidly growing area of the south west of Western Australia. With a busy Emergency Department, operating theatres, radiology department and 44 acute care beds, including a high dependency unit, this hospital admitted adult and paediatric patients with a range of medical, surgical and psychiatric conditions. Patient care was managed by local General Practitioners who were contactable by phone. There was one general surgeon in town and a number of visiting specialists who performed elective surgical procedures. Acutely unwell patients, such as those with cardiovascular conditions or compound fractures could be cared for in the hospital until transported to the nearest regional centre or flown to Perth.

The researcher found that her greatest challenge upon her return to the bedside was the area of pain management. She was struck by how many more opioid and adjuvant nonopioid medications were prescribed in combination to treat patients' pain. The pivotal role of the nurse in the selection and titration of these medications for best analgesic effect was apparent. In this context, the researcher felt challenged firstly about the choice and timing of medication and secondly about how much medication to give in order to relieve pain without compromising patients' safety, particularly of those who were elderly, demanding or nearing end of life.

The invitation to commence an honours project after returning to Perth provided the researcher with an opportunity to investigate other nurses' experiences of caring for patients in pain. A qualitative study of 10 registered nurses at a Perth tertiary hospital was undertaken. This revealed the complexity of hospital nurses' role in pain management, difficulties experienced by less experienced practitioners and their need for support to develop clinical decision-making skills. The challenge for nurses of providing effective pain relief when managing a heavy workload, and when patients were confused, elderly, or had a history of substance abuse was also evident. The findings of that small qualitative study and the researcher's ongoing experiences in her own clinical practice provided the impetus for the current study which has sought to understand the phenomenon of caring for patients who experience severe pain from the perspective of nurses who work of medical and surgical hospital wards.

Setting.

This study was conducted in a major tertiary hospital in Western Australia, one of three located in the state capital city of Perth. The state has a land area of 2,529,880 km² and had a population of 2.239 million in August 2011, of which approximately three quarters lived in Perth (Australian Bureau of Statistics, 2012). The hospital has over 600 beds and provides extensive trauma, emergency, medical, surgical and comprehensive cancer services. Recognised as a major teaching hospital, it has a well-established programme for newly graduated nurses, which provides support and development for the first or second years of registered practice.

Data were collected from four wards providing acute care for medical and surgical patients. These four wards treated patients from the clinical specialties of (a) renal/hepatology, (b) orthopaedics, (c) respiratory, and (d) eye/ear/plastics. This last ward also treated patients who were under the care of pain management physicians. Table 1 provides an indication of the types of medical conditions relating to pain represented on each ward. As well as regular education sessions, each ward was structured to provide nurses with day-to-day senior clinician and peer support, and clinical skill development.

Table 1.

Types of medical conditions relating to pain on four included wards.

| Ward | Medical conditions represented |
|------------------|--|
| Renal/hepatology | Cancer, neuropathies, transplant surgery, end stage liver disease |
| Orthopaedic | Bone fractures, joint replacement surgery, back injury, acute sciatica |
| Eye/Ear/Plastics | Necrotising fasciitis, Skin grafting, cellulitis, tonsillectomy |
| Respiratory | Palliative conditions, mesothelioma, procedural drain insertion |

Participants.

The current study was conducted from the perspective of nurses who cared for patients experiencing episodes of severe pain in this acute hospital. The main informants were nurses working in the four acute wards, who participated in semi-structured interviews, or who were observed during participant observation of interactions occurring in the clinical environment. Data were also collected from nurses and patients during structured observations of nurses who were in the process of caring for patients experiencing severe pain. Each structured observation involved one patient, who self-reported pain at an intensity of seven or more on a numerical scale of zero to 10, and the nurse allocated to provide his or her care (see page 51 for a more detailed explanation about structured observations).

Initially, the researcher invited nurses to participate who were likely to be sources of rich data because they cared for patients experiencing severe pain in this acute hospital (Glaser, 1978). When nurses were caring for a patient experiencing severe pain during a period of field observation, the patient was also invited to

participate in a structured observation. *Selection criteria* for nurse participants were: nurses who worked in the acute hospital, cared for patients who experienced severe pain and consented to be included.

It must be stressed that although both patients and nurses participated, this study focused on the nurse's perspective. The inclusion of patients facilitated structured observations of nurses. As data were collected and analysed, theoretical sampling directed further participant recruitment to facilitate collection of data that would develop emerging concepts and themes. Sample size was not predetermined but rather continued until analytic categories in the data and their properties were saturated (Glaser, 1978). The final sample included 33 nurse participants and 11 patient participants.

Nurse participants.

Seven of the 33 sampled nurses participated in both a structured observation and a semi-structured interview. One nurse participated in two structured observations and an interview. Twenty-three nurses were interviewed only, and three nurses were observed only.

Nurse participants were invited to be interviewed after having participated in a structured observation, or having been identified as having recently cared for patients experiencing severe pain by senior nursing staff or the researcher. Thirty-three nurses were invited to participate in an interview and three declined the invitation. Two of these nurses had participated in a structured observation and declined to be subsequently interviewed. Another nurse initially agreed to an interview on the proviso it was not tape-recorded, but later declined.

One structured observation was in progress when the shift change occurred and, therefore, included two nurses. While the nurse who provided the majority of care also participated in an interview, the second nurse who had been observed for only a short time when the patient's pain had settled, was not invited to be interviewed. In all but one case, the researcher issued invitations to nurses to participate in an interview in person during periods of participant observation. One night duty nurse, who had been identified by day staff as having relevant experience, was invited by telephone during a shift and interviewed face-to-face at the

conclusion of her shift. Nurses participated in structured observations when they were caring for a patient who was experiencing severe pain and when both met the inclusion criteria.

The sample of nurse participants included 30 females and three males. The majority (n=20) were Level One Registered Nurses, responsible for delivering direct patient care (Western Australian Department of Health, 2011). Of these, 11 nurses were graduates in their first 12 to 18 months of practice. Eight participants held promotional positions of Level Two Clinical Nurses and were responsible for direct patient care and the overall quality of nursing care delivery. Three nurses held Level Three Staff Development Nurse positions and implemented education and support. There were also four enrolled nurses, which included one graduate, who delivered direct patient care under supervision of registered nurses.

Participants' length of experience on the ward ranged from three weeks to 15 years, with the majority having practiced there for less than six months. Most nurses (n=23) were Bachelor prepared and two held postgraduate qualifications. One nurse had experience in a relieving position as an Acute Pain Clinical Nurse Consultant, but no others had any specialised pain management education apart from hospital study days. Characteristics of nurse participants are described in Table 2.

Patient participants.

Eleven patients participated in a structured observation. Recruitment of patient participants occurred during periods of participant observation on the wards. Upon arrival onto the ward, the researcher made herself known to the duty staff and asked to be notified if any patients were experiencing severe pain and were likely to meet the selection criteria. *Selection criteria* for patient participants were: patients who were experiencing severe pain; aged 18 years or older; could understand, speak read and write English; and consented to be included.

Potential patient participants were identified by nursing staff and approached by the researcher, who provided them with information about the study and an invitation to participate. Those who indicated their assent were asked to complete a pain assessment to indicate the severity of the pain experience. Potential participants

who were assessed to be experiencing severe pain were asked to provide informed consent for their inclusion (see Appendix A). Those who were distressed with pain

Table 2

Characteristics of Nurse Participants

| Characteristic | (n=33) |
|--|--------|
| Gender | |
| Male | 3 |
| Female | 30 |
| Position | |
| Staff Development Nurse | 3 |
| Clinical Nurse | 8 |
| Registered Nurse | 7 |
| Registered Nurse (Graduate) | 11 |
| Enrolled Nurse | 3 |
| Enrolled Nurse (Graduate) | 1 |
| Length of time on ward | |
| 0-6 months | 13 |
| 7-12 months | 2 |
| 1-3 years | 4 |
| 4-6 years | 6 |
| 6 years + | 8 |
| Highest qualification | |
| Enrolled Nurse diploma | 4 |
| Registered Nurse: hospital diploma | 4 |
| Registered Nurse: Bachelor prepared | 23 |
| Registered Nurse: Postgraduate certificate | 2 |
| Previous pain management education | |
| Nil (pre-registration education only) | 12 |
| Hospital in-service study days | 20 |
| Relief Acute Pain Nurse Consultant | 1 |

were given the option of providing verbal consent in the first instance and signing a consent form later when their pain settled. A record was made, witnessed by a family or staff member (see Appendix B), and kept with the study records. Further information about the procedure for obtaining patient consent is provided in the later section discussing ethical issues in this study.

In the current study, severe pain was defined as pain that was verbally self-rated by patients as seven or more on a numerical scale of zero to 10 (McCaffery & Pasero, 1999). On this scale, a score of zero equates to no pain and 10 represents worst pain imaginable, with a score of four to six regarded as moderate pain and seven or greater signifying severe pain (Cepeda, Africano, Polo, Alcalá & Carr, 2003).

Initially the intention was for the researcher to assess patients' pain using the Short-Form McGill Pain Questionnaire (Melzack, 1987). This tool is included in Appendix C. Permission to use the tool, obtained from the author, Professor Ronald Melzack, is included in Appendix D. The Short-Form McGill Pain Questionnaire has been widely used in research and found to be reliable and valid (Dudgeon, Raubertas & Rosenthal, 1993; Gridley & van den Dolder, 2001; McCaffery & Pasero, 1999; Stewart, Knight, Palmer & Highton, 1994). However, patients who participated in this study found it difficult to complete this pain assessment tool as evidenced by the following excerpts from field notes taken during observation periods. In general, patients were able to indicate pain intensity using a verbal or visual pain scale, but were reluctant to answer the numerous questions about the quality of their pain using pain descriptors. The following excerpt is from field notes made during Observation One:

30/05/2007

I asked the patient to mark with a pen on the Present Pain Intensity - Visual Analogue Scale to indicate where his pain was at that time. He took the pen and put a mark about 1cm from the Worst Pain end of the scale. I then asked him to describe his pain using the descriptors in the questionnaire. I progressed through the first three descriptors. However he did not respond to these and instead said "it's just there. It's just there. I can't get away from it." The patient remained on his side looking out of the window, while I asked these questions and the tone of his voice indicated to me that he did not wish to use these descriptors about his pain. Only the Present Pain Intensity –

Visual Analogue Scale from the questionnaire was used. Patient rated pain at nine out of 10 on this score. (Observation 1)

The patient who was the subject of Observation Three demonstrated a similar reluctance. The excerpt from the field notes included below documents the researcher's growing awareness that the patient was in pain and her consequent unsuccessful attempt to administer the Short-Form McGill Pain Questionnaire in preparation for a possible structured observation:

25/10/2007

[The patient was] slumped to the left in the chair and mostly had her eyes shut. She did not speak. While making the patient's bed and cutting up her toast I noticed she was moaning. I asked her if she was sore. She said "yes." I asked her to put a number out of 10 on her pain and she answered "nine" . . . (later, in preparation for potential observation) . . . I commenced the [Short-Form] McGill Pain Questionnaire. She responded to the first question about the quality. I asked the first question about the quality of pain – whether the patient would describe her pain as throbbing. She said that it did and I asked her if it was mild, moderate or severe. She answered that it was "very severe." I then asked her if the pain was "stabbing" and she closed her eyes and nodded. She turned her head away from me and in doing so indicated that she did not want to answer any more questions. I asked her to mark on the Present Pain Index where her pain was on the line from one to 10. She refused and shut her eyes again. (Observation 3)

These reactions were typical of patients' responses when asked to complete this questionnaire. Only one patient, who had a history of chronic pain, readily used this tool to describe their pain.

Being sensitive to patients' physical and emotional condition, and not wishing to exacerbate distress, upon encountering any resistance the researcher desisted from administering the Short-Form McGill Pain Questionnaire. Patients' self-reported verbal pain scores of seven or greater on a zero to 10 scale were accepted as evidence of their severe pain. This revised strategy was selected upon the basis that patient self-report of pain using a pain rating scale was designated most important on a well-accepted hierarchy of measures of pain intensity (McCaffery & Pasero, 1999).

When a patient was deemed to have met the selection criteria for this study, the nurse allocated to care for that patient during the period of observation was located, given information about the study and also invited to participate. Nurses

who indicated their assent were asked to sign a Consent Form (see Appendix E). Structured observations commenced when both the nurse and the patient provided informed consent.

The sample of patient participants (n=11) included six males and five females. Patient participants ranged in age from 45 to 83 years. Four patients were hospitalised with problems relating to orthopaedic conditions; two patients were diagnosed with cancer; two patients had ear, nose or throat conditions; and two patients were receiving plastic surgical care for either necrotising fasciitis or a chronic leg wound. One patient had been admitted with abdominal pain. Patient characteristics are described in Table 3.

Data collection.

The focus of data collection in grounded theory is to identify participants' main concern, along with factors influencing processing of the problem (Glaser, 1992; Wuest, 2000). Interview and observation are widely used in grounded theory research to gain access to and understanding of participants' worlds and to collect data that will build explanatory theory (Artinian, 2009; Holloway & Fulbrook, 2001; Wuest, 2000). A description of the data collection methods of semi-structured interviews and participant observation used in this study follows.

Research interviews.

Interviewing is a common method of data collection in qualitative inquiry, which elicits responses from research participants to obtain factual information, and to explore attitudes, beliefs and perspectives about particular topics (Nieswiadomy, 2008). The use of interviewing to collect data is well suited to grounded theory as it is "open-ended yet directed, shaped yet emergent" (Charmaz, 2006, p. 28).

First developed as a method of social survey in the late nineteenth century, interviewing evolved through its use during World War I, when it was used for psychological testing, and also through its popularity in clinical settings (Fontana & Frey, 2005). During the 1920s, interviewing and observation were incorporated into the studies of Mead upon whose ideas symbolic interactionism was developed (Crotty, 1998; Fontana & Frey, 2005). Although interviewing took on a quantitative

Table 3
Characteristics of Patient Participants

| Characteristic | (n=11) |
|-------------------|--------|
| Gender | |
| Male | 6 |
| Female | 5 |
| Age (years) | |
| 41-50 | 2 |
| 51-60 | 2 |
| 61-70 | 2 |
| 71-80 | 4 |
| 81-90 | 1 |
| Diagnosis | |
| Abdominal pain | 1 |
| Orthopaedic | 4 |
| Plastics surgical | 2 |
| Oncology | 2 |
| Ear/Nose/throat | 2 |

flavour from the 1950s to 1990s, over recent times new directions in qualitative interviewing have given respondents a greater voice and recognised the researcher-participant relationship (Fontana & Frey, 2005).

Issues concerning power structures and the differing social positions of researcher and participant abound; however the interview is now seen as a collaboration through which researcher and participant mutually construct a story (Barbour & Schostak, 2005; Fontana & Frey, 2005). As such, interviewing offers a means to develop understanding from the participant's perspective (Kvale, 1996,

2007; Starks & Brown Trinidad, 2007). Strengths associated with the use of interviews include the capacity to obtain usable, in-depth data that is authentic to participants' worlds, as well as the opportunity to incorporate nonverbal communication (Holloway & Fulbrook, 2001; Nieswiadomy, 2008). Challenges include logistical problems and the influence of the interaction on participants' answers (Nieswiadomy, 2008).

Interviews can be classified as structured, semi-structured or unstructured (Nieswiadomy, 2008). Structured interviews elicit information through prescribed questions with little interaction between researcher and participant. In contrast, researchers using unstructured interviews begin with only a general guideline and have considerable freedom to explore issues (Nieswiadomy, 2008). Semi-structured interviews are between the two extremes. The researcher develops a number of guiding questions, but also has scope to include exploratory probing questions to facilitate the collection of rich and comparable data (Nieswiadomy, 2008). Open-ended questioning provides flexibility into semi-structured interviewing, enabling participants to contribute extended narratives and descriptions to illuminate their world (Artinian, 2009; Barbour & Schostak, 2005; Rubin & Rubin, 2004). Therefore, semi-structured interviewing suits the grounded theory approach, which requires flexibility and provision to explore in-depth, aspects of life with which participants have considerable experience (Charmaz, 2006).

In the current study, 30 semi-structured interviews were conducted with nurses. All occurred at a time convenient to the nurse in a private room, either close to the ward area or in research-dedicated offices within the hospital. Participants provided written consent before commencing each interview (see Appendix F) and were asked to provide some demographic information (see Appendix G). For those nurse participants who were also observed, interviews were conducted within a week of the observation when experiences and perceptions were still fresh and recall was likely to be accurate. To reassure and develop trust, participants were assured of strict confidentiality as ethically required.

The researcher conveyed a professional, engaging communication style during the interviews through the use of active listening techniques (Kvale, 1996). Active listening has been described as the key to gathering rich data as the researcher

encourages the participant to talk and ascribe meaning (Kvale, 1996; Silverman, 2006; Wengraf, 2001). Nonverbal gestures were used to communicate interest including sitting quietly, leaning forward, nodding and using short utterances such as “mmm” to urge the participant to continue (Rubin & Rubin, 2004; Wengraf, 2001). The researcher allowed pauses and maintained a focus on participants’ answers (Wengraf, 2001).

Some aspects of participants’ answers were followed up to manage the conversation, keep dialogue flowing, and explore emerging ideas (Kvale, 1996; Rubin & Rubin, 2004; Silverman, 2006). Attention was paid not only to what was said but also to what was not said. Nonverbal signals from participants were also attended to including pauses, tone of voice, laughter, expressions, and body language in order to hear nuances of meaning (Kvale, 1996).

Each interview was tape-recorded using a small digital recorder and back-up mini cassette recorder, positioned unobtrusively (Nieswiadomy, 2008). Audio recording negated the need for copious note taking during the interview, which enabled the researcher to focus on the participant and use nonverbal prompts to encourage expansion on relevant points (Rubin & Rubin, 2004). Participants’ nonverbal signals, such as pauses and tone of voice, were also captured by audio recording and in field notes compiled after each interview to document the flavour of the interaction (Kvale, 1996, 2007). The researcher drew on previous experience and literature pertaining to interviewing to facilitate safe and productive interactions (Kvale, 1996). Pilot interviews were not conducted, in line with the view that the developmental nature of qualitative interviewing renders this optional (Holloway & Fulbrook, 2001).

Rapport between researcher and participant is considered essential when conducting an interview as familiarity with the researcher is likely to enhance trust and openness, and encourage in-depth answers from participants (Fontana & Frey, 2005; Rubin & Rubin, 2004). In this study, participant observation conducted in tandem with interviewing, developed familiarity and rapport between the researcher and nurses. Episodes of participant observation afforded the researcher the opportunity to acquaint potential nurse participants with the study and facilitate recruitment.

An interview guide consisting of 11 open-ended questions (see Appendix H) was developed to guide early interviews (Artinian, 2009; Charmaz, 2006). This schedule of questions helped to render the research topic into terms that participants were able to discuss (Artinian, 2009; Charmaz, 2006; Rubin & Rubin, 2004). Questions were framed in order to elicit participants' experiences and perspectives. Interviews commenced with a broad opening question (Rubin & Rubin, 2004). If a nurse had recently cared for a patient who had been experiencing severe pain, the opening question was a request to describe that experience. Otherwise, a general question was asked. Early interviews opened with: "Can I ask you what severe pain means to you?" In later interviews, this category was saturated and the opening question was amended to encourage participants to relate a recent relevant experience. For example, the interview with N24 opened with: "Can you think of any times when you have looked after someone who has had a lot of pain? And it may have gone well or maybe not? Can you tell me a bit about [that]?"

In all interviews, follow-up questioning sought to elicit participants' main concerns through clarification, description and exploration of their thoughts, feelings and experiences (Artinian, 2009). As the project progressed, questions became more focused to advance the emerging theoretical framework, which is congruent with the grounded theory imperative (Charmaz, 2006). Interviews closed with a general inquiry about whether participants wished to add anything further.

Neutrality in interviewing is understood to be impossible because researchers inevitably bring human traits to the interaction (Ahern, 1999; Charmaz, 2006; Fontana & Frey, 2005; Holloway & Fulbrook, 2001). However, the researcher sought to minimise her influence by withholding her personal opinion and focusing questions to encourage participants to elaborate on their narratives and explore meaning in their worlds. The researcher adopted the pose of listener and endeavoured always to take a nonjudgmental approach. Strategies included using active listening techniques and participants' language, asking for illustrative examples and reflecting statements back to participants for clarification (Holloway & Fulbrook, 2001; Kvale, 1996; Rubin & Rubin, 2004).

Two participants described feeling distressed while being interviewed. One stated that she felt overwhelmed with emotion when describing her mother's

experience of chronic pain. This incident occurred during the first minute of the interview. The researcher offered to pause or terminate the interview but the participant wished to continue. The researcher did not pursue potentially distressing personal issues during the balance of the interview. Rather, topics included nursing knowledge, experience, and support needs when providing pain management in the acute hospital. The interview was completed without further incident. A second nurse reported feeling anxious approximately 20 minutes into her interview, which was subsequently terminated. The researcher offered the nurse access to hospital-based counselling support but this was declined. These incidents are discussed further with regard to ethical issues in a later section.

The use of semi-structured interviews gathered rich data from nurses who were caring for patients experiencing severe pain. Broad questions ensured that the interviews were sufficiently focused to capture pertinent information. Yet the inherent flexibility of this data collection method facilitated exploration of emergent ideas and themes that were particularly relevant to participants' social world. To obtain multiple perspectives and to clarify meaning, interview data were supplemented with participant and structured observations.

Participant observation.

Ninety-three hours of participant observation, which included 11 structured observations of nurses caring for patients who experienced severe pain, were conducted in the four acute care wards. Participant observation aims to "generate practical and theoretical truths about human life grounded in the realities of daily existence" (Jorgensen, 1989, p. 14). Furthermore, the researcher as a participant observer enters the setting and looks beyond what is obvious and taken for granted (Spradley, 1980). Through participant observation, the researcher can gain access to participants and activities in order to understand social situations (Spradley, 1980). Strengths of participant observation include flexibility, and the opportunity to gather rich data about what people actually do and to develop rapport and trust with participants (O'Leary, 2005). Challenges include the potential for the researcher's biases to intrude, the requirement to protect confidentiality, to build trust and to

minimise the effect of the researcher's presence in order to capture natural behaviour (O'Leary, 2005).

Participant observation is founded on the perspective that the social world is subjective, which is predicated upon meanings and experiences constructed by inhabitants (Burgess, 1984). The participant observer experiences the social situation as both an insider and outsider, in order to gain the insider's understanding of meaning and also the clarity of perception afforded to the outsider, for whom little is taken for granted (Spradley, 1980). As an insider, the researcher accesses participants' worlds through language and culture (Jorgensen, 1989). As an outsider, the observer can transcend aspects of culture that are so familiar as to be invisible to participants. The challenge is to maintain the social distance that is lost when one develops rapport to the point of identifying with participants (Hammersley & Atkinson, 1995). A further consideration is the effect of the researcher's presence on participants, although this diminishes over time (Polit & Beck, 2006). Moreover, in health care settings researchers must be sensitive to privacy issues and the potential for observation to be intrusive (Starks & Brown Trinidad, 2007).

In this study, participant observation facilitated immersion of the researcher into the acute hospital environment. Sufficient time in the field was important to gain an understanding of ward culture and to develop rapport with participants without identifying with them. Participant observation was conducted across four wards in the study hospital in four blocks. Each block of participant observation continued until no new information was emerging or until the researcher's familiarity with the ward and nurses eroded the social distance needed for an outsider perspective.

The first block of participant observation was conducted on the renal/hepatology ward. Data were collected over a five-month period with participant observation conducted on two days each week. On the intervening days, collected data were transcribed, coded and compared. Literature pertaining to grounded theory methodology and methods of interview and observation was also reviewed.

The researcher's reflection determined that fragmenting the observation block by attending the ward on only a few days per week was not sufficiently intensive to build the required trust and rapport with participants. It was decided that more frequent observation periods over a shorter time frame was preferable. Thereafter,

the researcher spent a maximum of five weeks immersed in each ward during which observations were conducted on four or five days per week. Field notes and interview transcripts were transcribed on intervening days. To facilitate data transcription, coding and comparison, data collection was paused between each block of participant observation.

Three further blocks of participant observation were conducted; one on each of the orthopaedics, eye/ear/plastics and respiratory wards. At the beginning of each block, the researcher went to the ward on consecutive mornings at around 8.30am when patient-related nursing activity was high. Later, as the researcher became more familiar with the ward routine the timing of observation periods was adjusted to facilitate more focused data collection to advance emergent categories (Glaser, 1992). Data were collected between April 2007 and December 2008.

An excerpt from the researcher's reflective journal written during observation on the respiratory ward demonstrates the flavour of participant observation:

11/11/2008

I am now on my fourth ward. I started yesterday after introducing myself at handover last week. My approach has varied as I have progressed as a qualitative researcher. The journey of a student, I suppose. My approach is now to spend time on the ward – short and sharp are the catchwords. I plan to spend four weeks here. Each morning I go to the ward at about 8.30am . . . As I am fairly shy I do not approach people “willy-nilly.” The Staff Development Nurses are very approachable in my experience. If there is someone I can observe I will find the nurse. However they are often busy and not visible from the desk or corridor. If they are busy with another patient I will not approach until they are free. Most often then I will go into the [patient] rooms and ask to be of help . . . the nurses can be daunting. When I introduce myself at handover I seem to be inevitably confronted with blank faces as I speak. However when I am out helping on the ward I get smiles and they have usually remembered who I am. They appreciate the help, especially when they are busy. (Reflective journal)

Each block of participant observation was conducted on one ward, and each consisted of five phases. These phases were designed by the researcher and involved (a) negotiating entry, (b) introducing, (c) building familiarity, (d) collecting data, and (e) exiting the field. The first two phases, negotiating entry and introducing, entailed preliminary meetings with ward management and nurses to obtain permission to conduct observations and disseminate information about the study. Initially the

researcher met with the relevant Nurse Manager and Clinical Nurse Specialist (CNS) responsible for day-to-day ward management to apprise them of the study, obtain permission to enter the clinical setting and negotiate suitable timing. A copy of hospital ethical approval (see Appendix I) was supplied. Having obtained this permission, the CNS introduced the researcher to nursing staff at each afternoon handover meeting over the next week. This served to establish the trust and cooperation between researcher and participants that was required to obtain dependable and rich data (Bogdewic, 1992).

After this introductory week, the researcher conducted participant observation in the ward environment, which included both building familiarity and collecting data. These periods of participant observation lasted for up to four hours each, depending on ward activity and the presence of patients experiencing severe pain. At the commencement of each participant observation, the researcher introduced herself to the senior nurse coordinating the shift and any nurses not encountered previously. Clear identification in the form of a name badge was always worn.

When building familiarity, the researcher maintained a frequent presence around the ward by talking to nurses and assisting with making beds, fetching, carrying and tidying. These interactions served to build trust and rapport, which facilitated participant recruitment, and allowed nurses to become familiar with the researcher in order to minimise her influence on observations (Polit & Beck, 2006). As a registered nurse, the researcher was sensitive to issues of privacy and drew on her personal understanding of the clinical setting to ensure the privacy of nurses and patients was protected.

The researcher acknowledged that her clinical nursing background potentially enhanced data collection. Familiarity with the language and culture of the acute hospital contributed to a capacity to assume insider status, and to build rapport with potential participants. Ward nurses became aware of the researcher's nursing identity as she made herself known, conversed informally and "worked" alongside them in the clinical setting. However, although also a nurse, the researcher was concurrently afforded outsider status, having never been employed by the study hospital. To consolidate this perception and negate any power imbalance inherent in the researcher-participant interaction, the researcher endeavoured to assume a naivety,

maintaining an openness to points, issues and opinions that would constitute a safe environment for participants to speak freely (Fontana & Frey, 2005; Kvale, 1996). Similarly, the researcher did not wear a nursing uniform during data collection, but rather preferred street attire of neutral colour.

Apart from meeting the objective of building familiarity, the researcher focused on the issue of nurses caring for patients experiencing severe pain. She was alert to the generalities and specifics of the ward environment, nurses' positions, activities and interactions, and their language, opinions, anecdotes, interests and problems (Charmaz, 2006). Each period of participant observation was documented in field notes, which constituted collecting data. The researcher found that immersion into the research setting over four weeks was sufficient to build familiarity and collect rich data. After this time, the researcher found it difficult to remain objective, as evidenced by the following excerpt from the field notes:

31/10/2008

I spoke to the CNS and informed her that I will not be helping out so much this week as I was concerned that I might be losing my research distance. I said that I hoped to conduct some observations and interviews if possible to finish up on [this ward]. I asked if I might address the nurses at handover on Friday to thank them and she agreed. (Field notes)

This was the final stage of participant observation, which constituted exiting the field. In the final week, the researcher provided nursing management with an overview of the research progress and the expected final date of attendance. Permission to address a ward meeting on or after this date was also requested. This provided the opportunity to thank nursing staff for generously sharing their experiences.

Structured observations.

Eleven structured observations of nurses caring for patients who were experiencing severe pain were conducted during participant observation. Ward nursing staff alerted the researcher to the presence of patients who were in severe pain and, therefore, potential participants. Each potential patient participant was approached and informed of the study. Those patients who expressed interest in

participating were assessed to determine whether they met the inclusion criteria. Nurses who were caring for eligible patients were located and also informed of the study. Nurses and patients who both met the inclusion criteria were then included in the study. Each observation commenced after the patient provided consent, either written (see Appendix A) or verbal (see Appendix B) if the patient was too distressed to write, and the nurse provided written consent (see Appendix E). The processes for obtaining participant consent are further discussed in regard to ethical issues in a later section.

Nurses were asked to provide information about their length of clinical experience and previous education (see Appendix G). Basic demographic information about the patient was also collected (see Appendix J) from the ward notes. Each structured observation continued until the patient's pain eased or for a period of no longer than four hours. This time frame was sufficient to capture a cycle of assessment, planning, implementation and reassessment of pain management strategies, and avoid observer fatigue (Manias & Williams, 2007; McCaffery & Pasero, 1999).

The researcher was positioned unobtrusively during each structured observation in order to observe the interaction between nurse and patient. When the patient was accommodated in a single room, the researcher sat quietly in the ward corridor out of sight and entered with the nurse to capture their exchanges. Interactions between the patient and other health professionals who had not consented to participate were not observed. When a patient participant was situated in a four-bed room, the researcher sat nearby in the corner. The activities and interactions of other patients and nurses who entered the room were disregarded. During one observation, the patient requested that the researcher sit next to her bed and an informal conversation ensued.

The first two structured observations were conducted as "warm-ups", although the data collected were included in the main analysis. These initial experiences sensitised the researcher to her effect on participants' behaviour and provided tacit understanding of what was being observed. This led the researcher to a more in-depth search of literature pertaining to observation methods and other researchers' published accounts of their experiences in similar settings. A checklist

(Charmaz, 2006, p. 24) was used to guide the early structured observations. The use of a checklist helped to render participants' actions visible and to ensure that salient details were recorded (Charmaz, 2006). However, this guide was dispensed with as the researcher became familiar with the role of observer.

Field notes.

Field notes were made after each period of participant observation and during each structured observation. These notes documented information about participants, their actions and interactions, and the settings in which these activities occurred. Field notes constituted a written record of what was observed in the field and helped the researcher to note impressions and ideas about data collection and analysis (Burns, 2000; Montgomery & Bailey, 2007). Field notes can be coded and the detailed descriptions they contain of people and settings lend themselves to line-by-line examination (Charmaz, 2006).

In this study, the researcher documented the data collected during each period of participant observation as a field note immediately after leaving the ward. Refraining from writing during the observation served to enhance the researcher's immersion into the ward and, as has been noted in previous research conducted in hospital wards, minimised intrusion into patient areas (Groenkjaer, 2002). However, notes made as soon as possible after concluding the observation maximised the researcher's recall of salient details.

In contrast, field notes of structured observations were made contemporaneously, albeit unobtrusively, to ensure interactions between nurse and patient were captured in detail. The researcher carried a small notepad, making entries quietly while seated. Wherever possible, note taking in front of patients was minimised. During nurse-patient interactions, the researcher accompanied the nurse to the bedside while holding the notepad by her side and refraining from writing. Interactions were recorded upon her return to the observation position. An excerpt from field notes made from Observation Nine follows:

27/10/2008

The patient was lying supine in bed with her right leg elevated on a pillow. She had slipped down the bed and was still wearing the gown that she had been in overnight. There had been some mention of the patient going to the shower. However, she was periodically displaying grimacing and exclamations that indicated that she was experiencing waves of severe pain. The nurse was at the medication cupboard obtaining tablets. She went over to the bedside and dispensed two Panadol tablets from their packet. She had the medication chart open and referred to it as she spoke to the patient. The nurse expressed concern for the patient in pain both verbally and in her facial expression . . . [She said] "I see you have been refusing your regular Panadol since yesterday morning." The patient replied that she didn't like to take tablets if she didn't have to. The nurse gave her the Panadol tablets and then said that she could give her a further dose of oxycodone in an hour and a half. As she returned the Panadol box to the medication cupboard, the nurse wondered aloud if she should take patient's dressing down. She mentioned talking to the doctors and left the bedside. (Observation 9)

At times, nurses initiated informal conversations with the researcher about what was happening during the observation. Records of these informal interviews were included in the field notes. Documentation provided not only an accurate record of nurses' actions and interactions but also information about the context and background of nurses' actions and decisions.

The reflective journal.

Prior to entering the field and throughout data collection and analysis, the researcher kept a reflective journal to develop her theoretical sensitivity and provide a framework to assess and manage any issues encountered. Initial entries served to render personal feelings, values and opinions visible to facilitate their recognition and acknowledgement. The following excerpt provides an example:

29/05/2007

I believe that nurses experience a degree of discomfort when they are at the bedside but are without the tools to make a difference for their patients. I am surprised that nurses do not articulate this viewpoint as I have felt it keenly when required to care for a patient in pain yet unable to access resources to help me. I believe that nurses are so busy that they prioritise pain down the scale. If patients can do what nurses need them to do, they can complete the required tasks on a shift, then effective pain control may not be a priority to

the nurse. I believe that my beliefs arise from my own experience that may not reflect those of other nurses. (Reflective journal)

Later entries helped to explicate the researcher's responses to the experience of being immersed in the research setting. The excerpt provided below was written after time spent with two nurses on the third ward:

1/10/2008

I asked how the evening [shift] had gone and both commented on it being difficult, busy and messy. The CN [Clinical Nurse] said it was one of the worst shifts that he has ever had – busy and messy with things that didn't need to be busy and messy. He then commented that he had gone home at the end of the shift not having been able to have given the care he wanted. I watched him rub his face as he said that, and I felt his [was it] frustration? Disappointment? Sadness? . . . I felt really affected by this conversation. Perhaps because I am so immersed in the data I was immediately alerted to the frustration and disappointment of these nurses . . . I feel really sad for these nurses and for nursing. They are stuck. I wish my study would help . . . they give it to me and I fear that I will let them down. No-one will listen even if I can tell our story – who cares? . . . I feel deflated and understand their difficulties. (Reflective journal)

The researcher acknowledged such perspectives and set them aside to minimise the influence of her own preconceptions on the emerging theory.

Literature as data.

Field notes of interviews and observations were supplemented with other documents pertaining to the area under study. These included technical and nontechnical literature (Charmaz, 2006). Nontechnical literature includes letters, diaries and newspapers, which can provide a source for comparison with concepts emerging in the data and to enhance sensitivity (Charmaz, 2006). In this study, media reports about nursing in Western Australia contributed to data about the workload issues in the acute hospital practice environment. The cartoon accompanying one of these reports is included in Chapter Four as Figure 7. Technical literature refers to documents such as published research findings and expert opinion (Charmaz, 2006). These sources of data were not accessed until the developing theory had stabilised. At this point, such documents became data to be compared with emergent concepts

to build upon properties and dimensions (Glaser, 1998; Strauss & Corbin, 1998). The use of technical literature is described separately in a later section.

Data analysis.

A feature of grounded theory is that data collection and analysis occur simultaneously. In this study, data analysis commenced from the first period of participant observation and continued concurrently with data collection. As has been described, data collection was paused between the researcher's immersions into each ward to facilitate data analysis. Data analysis entailed the use of constant comparison and coding to generate substantive categories, which were then integrated to generate coherent theory (Glaser & Strauss, 1967). Theoretical sampling directed data collection and, along with memo writing and sorting, ensured completeness of the generated theory (Glaser, 1978; Glaser & Strauss, 1967).

Throughout the research, a four-stage process was used to analyse the data. These stages involved: (a) comparing incidents in the data to generate categories and delineate their properties, (b) integrating categories and their properties, (c) defining the theory, and (d) writing the theory.

Constant comparison.

Adapted by Glaser and Strauss (1967) for the generation of theory, the constant comparison method of analysis is used in all versions of grounded theory to identify participants' main concern and explain how this is resolved (Artinian, 2009). Constant comparison involves the making of comparisons between data, codes and categories to evolve conceptual thinking (Charmaz, 2006). As data are collected and coding develops emergent categories, constant comparison prompts questioning to elicit how the data relate to theoretical categories (Charmaz, 2006). It is these constant comparisons that help the researcher to find meaning in categories and their properties (Glaser, 1998).

Data collection, analysis and memo writing are concurrent when using this method (Glaser, 1998). Incidents from new data are compared to incidents in previously collected data and emergent categories. Staggering the data collection facilitates coding and theoretical sampling, which directs further data collection.

Pausing to compare data facilitates saturation and completeness of theory (Charmaz, 2006; Glaser, 1998).

Coding.

In grounded theory, the starting point for theory generation is with substantive codes, which are the categories; their properties and dimensions emerging from the data through coding (Artinian, 2009). Glaser (1998) explains coding as the “generating of categories and their properties by constant comparison of incidents and categories” (p 137). Substantive codes relate to actions in the substantive area, which are described either in participants’ words or generated by the researcher (Glaser, 1998). The current study was guided by the method of coding outlined by Glaser and Strauss (1967). This approach entails three levels of coding: (a) open coding, (b) axial coding, and (c) selective coding.

Raw data in the form of audio-tapes of interviews and handwritten field notes were transformed to texts for coding through transcription. Firstly, the researcher listened to the interviews and read the field notes and then each was transcribed verbatim to create text documents. The transcripts were checked and printed ready for coding. These transcribed texts were then subjected to open, axial and selective coding to generate theory. A description of these procedures follows.

Transcription.

The transcripts of the audio-taped interviews were texts that became the “instruments for interpretation” (Flicke, 2009, p. 75). The transcripts documented nurses’ narratives and generated written data as the basis for further analysis and validation of findings (Flicke, 2009). Field notes of participant observation were also transcribed. The researcher performed all transcriptions herself as soon as possible after leaving the research field. This activity immersed the researcher into the data, enabling her to hear the voices of participants and sensitising her to nuances, ideas and themes not immediately obvious during interviews and observation (Artinian, 2009). Transcribing the data also provided the researcher with an opportunity to become thoroughly familiar with the data, which minimised the potential for error (Easton, McComish & Greenberg, 2000).

During transcription, pauses in the dialogue and nonverbal communications, such as “mmm” and “ah”, were noted. Short pauses were indicated as a series of three spaced dots, such as “. . .” and long pauses or laughter were described in words. The researcher listened to the audio-recording again after completing each transcription to check the typed text for accuracy. Transcripts were amended as necessary. Field notes of participant observations were written directly into a computer file immediately after leaving the clinical area. Hand-written field notes from structured observations were transcribed into a computer file after completing the observation.

Typed transcripts of interviews and observations were then printed in preparation for initial coding. Additionally, electronic copies of transcriptions were entered into the NVivo (Version 7) computer programme (QSR International, 2006) in preparation for later coding. This computer programme was developed to assist in the management of qualitative data and selected for the current study for its ability to manage multiple levels of coding and produce a coding tree.

Open coding.

After transcription, data were subjected to open coding, which entailed a line-by-line reading of the text. This was the initial step in conceptualising, in which the data are broken down to incidents and compared (Glaser, 1992; Strauss & Corbin, 1998). In open coding, data are coded in as many ways as possible, allowing the researcher to remain open to direction in the data before becoming focused on the emerging problem (Glaser, 1978). Categories are generated quickly, which the researcher can then develop through theoretical sampling (Strauss & Corbin, 1998).

In the current study, printed transcripts were examined. Words, phrases and sentences were searched for meaning, highlighted, and recorded in the document margin. This process fragmented the data so incidents could be compared, which led to the generation of categories and a search for pattern and themes (Glaser, 1992). Patterns emerged when similar incidents were labelled and identified as categories, while dissimilar incidents were labelled and became properties of categories (Glaser, 1992). As a result, many categories and subcategories emerged from the data, which were explored, merged, adjusted and deleted as coding continued.

At this stage, NVivo (Version 7) software was used to develop coding trees, which displayed categories and subcategories. For example, the category named *Nurses' Internal* emerged as the largest category and was described with the words, *encompasses all the internal thoughts described by nurses*. Seven subcategories were identified and labelled: *Feelings*, *Reacting to others*, *Being at the bedside*, *About patients*, *Experiences*, *Opinions*, and *What helped me*.

The largest of these subcategories was *Feelings*, which had positive and negative dimensions. Five further subcategories were identified. The first of these subcategories, labelled “Positive feelings”, was comprised of nineteen incidents in the data and included: *Feeling good*, *Feeling relieved* and *Feeling vindicated*. The other subcategory was labelled “negative feelings”, which despite consisting of eighty-nine incidents, had only two subcategories: *Feeling frustrated* and *Feeling helpless*. Figure 1 represents the coding tree and shows the pathways used to delineate these subcategories.

During open coding, incidents and categories were compared as they occurred in the data and conceptually, and memos were written to tease out and develop relationships and theoretical ideas (Walker & Myrick, 2006). This facilitated axial coding in which categories and their properties were related and the data, which were fractured in open coding, were reassembled (Strauss & Corbin, 1998).

Axial coding.

A category is said to be saturated when comparison of incidents yields no further properties and theoretical sampling directs the researcher to gather data about other categories and relationships (Glaser, 1998). At this stage, axial coding can begin to relate categories and their subcategories according to their properties and dimensions to explain the phenomena occurring in the data (Strauss & Corbin, 1998). The defining characteristic of axial coding is that categories are linked at a conceptual rather than descriptive level (Strauss & Corbin, 1998). For example, nurses spoke frequently of “being there” for patients who were distressed with severe pain. Data were identified that indicated this involved “having the nurse there” (N26), “holding their hand” (N27), and wanting to “sit down and have a chat” (N02) and to “sit and talk with him” (N24). Conceptually, the category labelled *Being there* related to

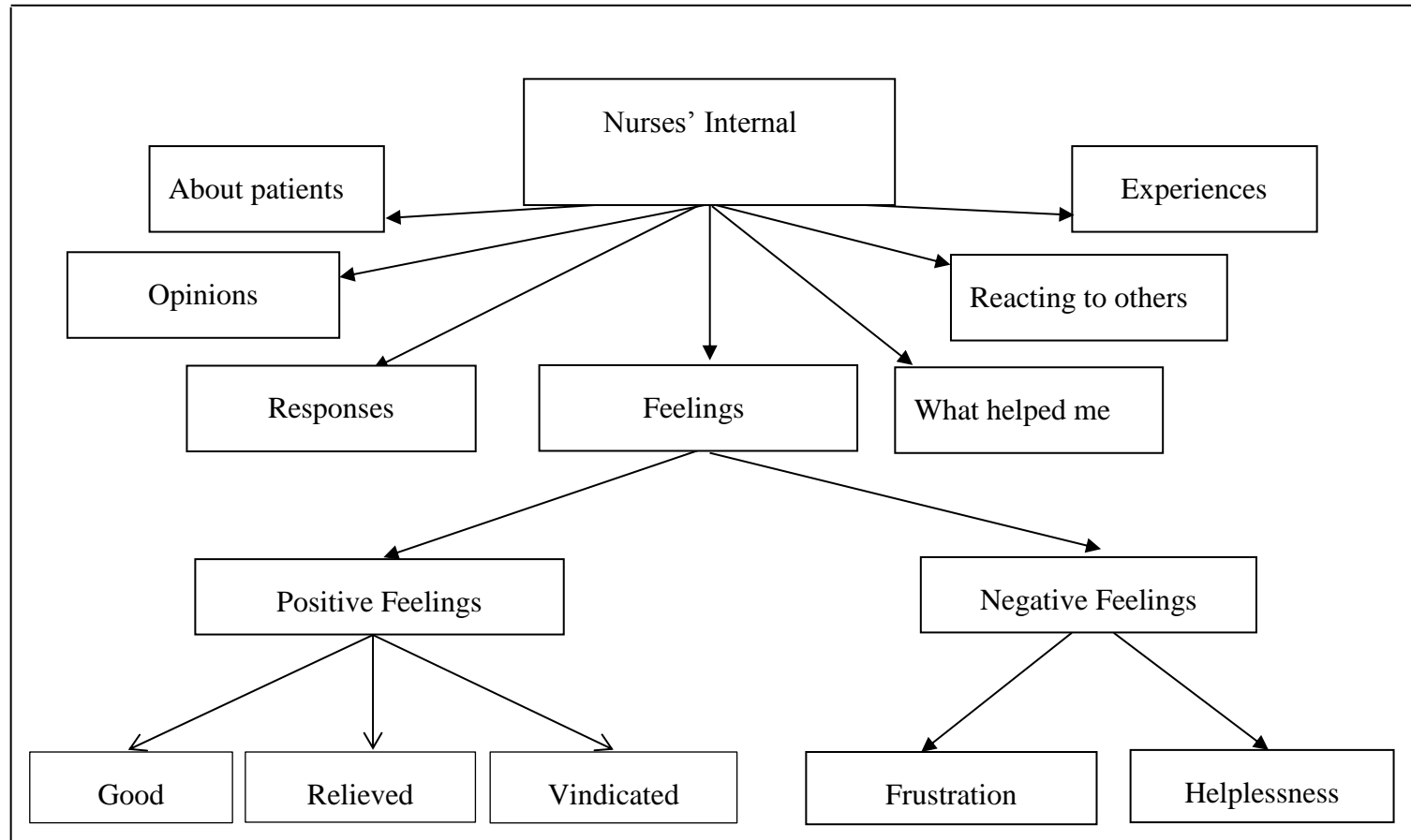


Figure 1. Coding tree – Pathway of “Feelings” subcategories

“physical presence”, “emotional presence”, “distraction”, “providing comfort” and “finding alternatives” to help explain the nurses’ responses to their patients’ suffering.

Relating categories and subcategories through axial coding locates the phenomenon under investigation in a structure to explain why and the process by which it happens (Strauss & Corbin, 1998). Contextual conditions, which are a conceptual understanding of the situations in which the phenomenon occurs, and participants’ responses are revealed (Strauss & Corbin, 1998). However, it is the analyst who decides whether the conceptual category is a condition or a strategy (Strauss & Corbin, 1998). Eventually, through coding and constant comparison, a central issue or core category is revealed (Glaser, 1978).

In the current study, coding, comparison and the emergence of patterns and categories with their properties and dimensions, revealed that the central issue for nurses concerned their feelings of disempowerment when caring for patients who experienced severe pain. This concept was tentatively designated as the core problem, which represented the participants’ main concern (Strauss & Corbin, 1998). Use of theoretical sampling, comparison and coding saturated the emergent categories, developed linkages and determined relationships between them. A search ensued for the basic social psychological process used by participants to resolve the core problem, and the variations in the data that constituted conditions, context, and consequences for nurses (Glaser, 1978).

Selective coding.

The final phase of coding is selective coding whereby categories are refined, related and integrated to allow for development of explanatory theory (Artinian, 2009; Charmaz, 2006; Strauss & Corbin, 1998; Walker & Myrick, 2006). With recognition, interpretation and some selectivity, the integration of categories develops theory (Glaser, 1992; Strauss & Corbin, 1998). Integration of the theory relies on the discovery of the core category, which can pull other categories together (Strauss & Corbin, 1998). The core category must be central and occur frequently in the data, able to explain variation in the data, and be named sufficiently abstractly that it could be used in other research (Strauss & Corbin, 1998). This category is

considered the story line, which is produced by constant comparison and which will account for most of the variation in the data (Glaser, 1992).

In this study, empowerment emerged as the integrating theme of the research and, as such, was revealed to be the core category. Understanding of the central theme of empowerment facilitated discovery of the core problem and the basic social psychological process through which participants avoided or resolved the core problem. The core problem in the current study was identified as *feelings of disempowerment*, which was experienced by the nurses when unable to provide comfort for patients who experienced severe pain. Intervening conditions, which influenced the level of empowerment that nurses experienced at a given time, were also emergent in the data. These conditions involved nurses': *levels of empathy; access to effective medication; collaboration with patients and colleagues; and time to care*. The basic social psychological process revolved around nurses *seeking empowerment to provide comfort* for their patients and thus protect their own well-being.

Selective coding commenced in this study with discovery of the integrating theme of empowerment and continued as the researcher reimmersed herself frequently into the data and finalised the writing of the final report. Other analytic procedures of theoretical sampling, theoretical memo writing and use of the literature were also used to develop the final substantive theory.

Theoretical sampling.

Once initial data collection and analysis had taken place, theoretical sampling directed both recruitment of interview participants and the selection of wards for participant observation. Theoretical sampling has been defined as “sampling on the basis of emerging concepts with the aim being to explore the dimensional range or varied conditions along which the properties of concepts vary” (Strauss & Corbin, 1998, p. 73). This sampling strategy guides data collection that will develop the theory as the analyst seeks to advance categories or their properties (Glaser, 1998). Pertinent data are sought to illuminate categories emerging from earlier comparisons, although theoretical sampling is also important when exploring new areas, while the

analyst builds on previous sampling until theoretical saturation is reached (Charmaz, 2006; Strauss & Corbin, 1998).

The researcher approached the first three participants after being notified by ward nursing staff that the patients being cared for by these nurses were experiencing severe pain. These three nurses and their patients were included in the study. The fourth participant was invited to participate after she revealed her recent experience of caring for a patient with severe pain to the researcher during participant observation. As data gathered in these early interviews were analysed, the emerging categories increasingly directed subsequent data collection. Examples of the use of theoretical sampling in the current study include the selection of the respiratory ward as a source of data to develop the emerging category of “pain in medical patients” and the inclusion of nurses with experience of caring for patients with a history of chronic pain as well as nurses with varying levels of clinical experience. The emerging category of “medication ineffectiveness” was developed with the inclusion of a structured observation of a nurse caring for a postoperative patient who was receiving analgesia via the epidural route.

When using theoretical sampling, selection and recruitment of participants evolves with the analytic process and the sample size cannot be determined prior to commencement of a grounded theory study (Glaser, 1998; Starks & Brown Trinidad, 2007). In the current study, data collection continued until theoretical saturation was reached. This occurred when no new codes emerged from the analysis and categories and their properties and dimensions were fully developed (Strauss & Corbin, 1998).

Memo writing and development of the final report.

The writing of memos is considered to be central to the development of theory because the researcher is compelled to interact with the data on a conceptual level (Strauss & Corbin, 1998). Memo writing facilitates the translation of substantive codes to theorising, which underpins theoretical sampling and enables the researcher to “capture and keep track of the emerging theory” (Glaser, 1998, p. 177). These memos comprise of the researcher’s written ideas that can take any form or content to document the researcher’s thinking about the emerging categories and help to turn description into theoretical accounts (Glaser, 1998; Montgomery & Bailey, 2007).

Memos can comprise of words or diagrams, which capture the analyst's thoughts as they arise during the research process (Glaser, 1978). As Glaser advises, whether coding, writing, reading, sorting or analysing, it is important to stop and memo in order to document ideas and create a "sortable" (p. 87) bank of ideas (Glaser, 1978). It is through this sorting of abstract ideas that explanatory theory is generated.

Memo writing in this study began with initial coding of the first interview and continued through to the writing of the final report to develop emerging concepts. The researcher preferred to write or draw in pencil into a theoretical memo journal in the spirit of free thinking and the tentative nature of ideas. These memos variously took the form of jottings, points, prose, lists and diagrams. The researcher found them vital to the analytical process. This writing filled three journals and facilitated the generation and fleshing out of categories, as well as the relating of concepts toward explanatory and coherent theorising.

Glaser (1998) emphasises that memo writing is a private process and that memos do not necessarily adhere to the mores of grammatical structure. However, some examples are included here for illustrative purposes. The following have been transcribed from pencil jottings entered into the first theoretical memo journal. The first excerpt was jotted during initial coding of the first 18 interviews:

08/02/2008

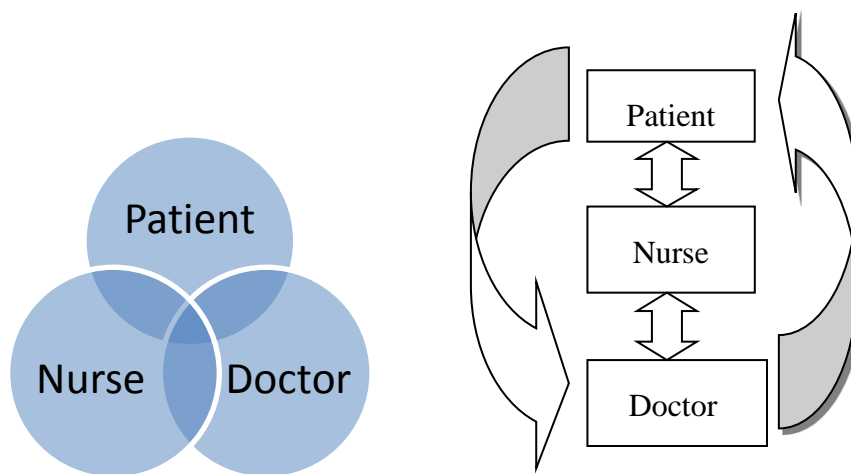
It seems that patients prioritise differently to nurses, and nurses prioritise differently to doctors. "Waiting" is stressful – a lot of nurses' stress seems to come from perceptions of time, having to wait: for [doctors'] review, to get back to patient, pain takes time.

(Theoretical Memo journal)

This second example includes diagrams made as an adjunct to the written jottings:

09/02/2008

Nurse Five talks of being the only one “in the room trying to comfort and reassure everyone.” Does this change the [nurse/patient/doctor] triangle because it suggests that the nurse is a more central player? She spoke of trying to appear calm but feeling “flustered inside” = inner disturbance despite outer calm. She wanted to make the patient feel better. Why? Is a common problem → resolving inner disturbance that arises from patient/family distress. Is medication seen as a quick fix in a busy day?



(Theoretical Memo journal)

As these jottings demonstrate, participants’ words were commonly included. These inclusions helped the researcher make sense of what nurses were saying about how and where they saw themselves in the ward when their patients were suffering from severe pain.

The following examples are taken from memos written much later in the analytical process. While the researcher still included nurses’ words, at this stage of the analysis questions focused on the relationships between categories in the data and how these fitted with the emerging core problem, conditions and basic social psychological process. The researcher tended not to diagram these thoughts and ideas, but rather used words to question and explore the data. The first excerpt from these later theoretical memos was written while the researcher listened again to an interview recording:

16/12/09

[She says] “I can’t deny that someone has pain.” My opinion is that I can hear a conflict here in this nurse’s voice. Is she disempowered from pursuing the care she thinks is appropriate? Why can’t she deny it? Because it is what she has been taught? [She] interprets no pain yet has to give [medication] = disempowerment – helplessness? Is this then related to the process as in – keep giving what is ordered = disempowerment + compromise, “then go into the back room and whinge about it”?

(Theoretical Memo journal)

Even later, the researcher was exploring the category of “empathy” as a theoretical concept before its properties and dimensions had been clarified. An example of her jottings at this time follows:

5/1/2010

Empathy [is related to] personal experience of pain (nurses, family member, surgical), seeing distress, nice patient. How is empathy empowering? What does empathy do? → triggers prioritising e.g. acute pain is prioritised because [nurses] see suffering. Triggers mirrored distress in nurses. What does empathy do?

- When related to personal experience of pain [nurses say] “I can empathise” or “they can empathise” → “I am more gentle, I listen” (N07), “I really listen . . . they’re a lot more attentive, a lot more thorough . . . go the extra mile” (N08).
- Surgical pain is easier to empathise with therefore is empowering.
- Compliant patient → “you do the same but you feel more compassionate” (N26).
- Seeing distress → triggers an inherently empathic response.

(Theoretical Memo journal)

Glaser (1998) considers the sorting of memos to be key to theory building. This essential step facilitates the integration of fractured data as memos are sorted to prepare for writing and an outline of theory emerges (Glaser, 1998).

In the current study, the sorting of memos were always done by hand and entered in pencil into the theoretical memo journals. Sorting helped to develop conceptual and theoretical ideas, linkages and relationships. When the theoretical

outline of the core problem, conditions and basic social psychological process emerged through sorting, the researcher immersed herself back into the data by listening again to all interview recordings and reexamining field note transcripts.

These actions facilitated further coding, memo writing and sorting, done both by hand and by using computer word processing. At this stage, computer word processing helped to manage the volume of data and organise categories into the emerging theoretical outline. Further sorting occurred when these computer-generated documents were printed. Categories could then be refined, manually sorted and placed into tentative chapters in preparation for report writing. Manually organised data were entered electronically and report writing proceeded, which facilitated integration of the emergent theory. Repositioning of data and categories continued until the theory was fully developed and presented clearly and logically.

Use of the literature.

The way in which literature is used in grounded theory research depends upon where the researcher is in the project (Giske & Artinian, 2009). This approach differs from other research methods because knowledge of existing literature can constrain theory development (Strauss & Corbin, 1998). In grounded theory, salient issues and concepts are not known until they emerge in the data. For this reason, Glaser (1998) cautions the analyst not to examine the literature prior to research commencing, in order to have the “freedom to discover” (p. 68). It is recognised, however, that perusal of existing literature is required during the planning phase of a study to identify gaps in knowledge for proposal development (Giske & Artinian, 2009). In addition, literature pertaining to grounded theory approaches can be accessed during data collection and analysis to guide procedures and to facilitate openness to the study (Giske & Artinian, 2009; Glaser, 1998).

In the current study, literature was reviewed during proposal development to gain an overview of the status of knowledge about nurses’ care of patients experiencing pain and to identify gaps. Computer databases Medline and CINAHL were used to locate literature pertaining to nursing care, nurse stress and coping, and the substantive area of nurses’ pain management practice. This literature was then set aside during data collection and coding to ensure that the emerging theory was not

derailed and that the focus remained on participants' experiences (Glaser, 1998, 1992). Books and journal articles explaining the use of qualitative research, grounded theory methodology, and interview and observation methods were also read and reviewed to advance data collection and analysis.

Once the developing theory was sufficiently stable to accommodate comparison with existing studies, theories and published perspectives, an additional search was undertaken to identify literature pertinent to the findings. This is the point at which the researcher can determine which literature is relevant and integrate it using constant comparison to define new theoretical properties in the emergent theory (Glaser, 1998). Moreover, locating the formulated theory in the literature clarifies its contribution to the substantive area, whilst corroborating, extending and integrating knowledge in the field (Glaser, 1998; Strauss & Corbin, 1998).

The findings of the current study directed the researcher to specific literature pertaining to empowerment, comfort, nurse caring, stress and coping, and the substantive area of nurses' pain management in acute hospitals. This literature was integrated into the developing theory for conceptual and theoretical completeness through comparison. Furthermore, placement of the developed substantive theory into the relevant literature elucidated the contribution of this research to the current state of knowledge. This aspect of the study will be described in Chapter Six.

Trustworthiness and rigour.

Issues surrounding reliability and validity can be problematic in qualitative research paradigms; however, Guba and Lincoln (2005) contend that questions of trustworthiness and rigour must be answered in some way. This is necessary because findings must be sufficiently faithful to the construction of the social world that their implications can be acted upon (Guba & Lincoln, 2005). It is acknowledged that the concept of reproducible research is not easily applied to qualitative approaches, which are subjective by nature, and in which knowledge is constructed and the researcher is the instrument of analysis (Bloor & Wood, 2006; Starks & Brown Trinidad, 2007). Glaser contends that reproducibility and replication are not relevant to grounded theory because conceptualisation means that the theory will only be modified or extended by new data (Glaser, 2001). In contrast, Strauss and Corbin

argue that with the same theoretical perspective, conditions, and procedures, another researcher should be able to come up with a similar theoretical explanation for a phenomenon under study (Strauss & Corbin, 1998).

Various measures have been proposed to enhance the trustworthiness of qualitative research findings. These include the use of memo writing, which contributes to an audit trail documenting how an understanding of the data emerged and to triangulation through which a variety of research approaches are used to investigate the same problem (Hesse-Biber & Leavy, 2006; Starks & Brown Trinidad, 2007). These methods are useful to increase confidence that the findings can be trusted to represent the data collected. Furthermore, detailed documentation of data collection and analysis procedures, along with direct quotes from the data, are included in the final report and allow the reader to determine how interpretations have been made (Bloor & Wood, 2006; Crotty, 1998).

A further issue concerns the extent to which a qualitative inquiry captures an authentic understanding of participants' social reality (Hesse-Biber & Leavy, 2006). Three criteria by which to judge this have been suggested by Kvale (1996). These criteria are: (a) craftsmanship, (b) communication, and (c) action in qualitative research (Kvale, 1996). Craftsmanship refers to the credibility of the research, which rests on the researcher's questioning of the data and theorising. Communication opens the interpretation of the data to challenge through dialogue. Finally, action allows consideration of the effect of the study on those studied as a means to evaluate the research (Kvale, 1996, 2007).

Another perspective is the consideration of qualitative research in terms of methodological and interpretive rigour (Guba & Lincoln, 2005). Methodological rigour refers to "prolonged engagement and persistent observation" (p. 205), while interpretive rigour relates back to trustworthiness and the ability of the research to capture the human experience (Guba & Lincoln, 2005). Despite the acknowledged difficulty of knowing when social inquiry can be trusted to be faithful to social reality, concepts such as fairness and authenticity are suggested as criteria by which to judge qualitative research (Guba & Lincoln, 2005).

In grounded theory, the merit of substantive theory is said to depend upon the extent to which it "speaks specifically to the populations from which it was derived"

(Strauss & Corbin, 1998, p. 266). Theoretical sampling, which brings variation to the data, enhances the research (Strauss & Corbin, 1998). When categories emerge from the data through constant comparison the resultant theory that fits, works, and is relevant and modifiable will therefore be credible (Artinian, 2009; Glaser, 2001). Furthermore, when integration of the core category produces theory that accounts for variation in behaviour and explains resolution of participants' main concern, the generated theory can be trusted (Glaser, 1998).

A number of strategies were incorporated into the current study to enhance the credibility by ensuring that participants' voices were heard and that the developed theory was firmly grounded in collected data. Firstly, literature relating to the substantive area was avoided until the emergent theory had stabilised and been placed tentatively into a draft of the final report (Glaser, 1978; Strauss & Corbin, 1998). As described earlier, a reflective journal was maintained during the research process. In addition to enhancing the researcher's theoretical sensitivity, journaling served to keep the researcher's intellectual and emotional responses in perspective and raise awareness of their influence on the research procedures. This is referred to as reflexivity, which recognises the researcher's effect on data collection and participants, and contributes to the credibility of findings (Mays & Pope, 2000).

Triangulation was also used to lessen the possibility of misinterpretations during data collection and analysis, and thus enhance the credibility of the findings of this research (Stake, 2008). Multiple perspectives of nurses caring for patients who experienced severe pain were captured by collecting data from four different wards using different methods, including interviews, participant observation and structured observation. It is acknowledged that no qualitative interpretation will be entirely reproducible, however the strategy of using multiple data collection methods assumes that weakness in one approach will be compensated by the strength of another (Mays & Pope, 2000). Furthermore viewing a phenomenon from a variety of vantage points tends to clarify the researcher's observations, perceptions and interpretation (Stake, 2008).

In the current study, participant observation conducted in four wards immersed the researcher in the field over a prolonged time. By collecting the data herself over this extended time, the researcher had ample opportunity to become

thoroughly absorbed in the data to facilitate “within-case and across-case analysis” (Polit & Beck, 2010). Such prolonged engagement facilitated familiarity and rapport with participants, increasing the likelihood that experiences and perspectives were shared candidly.

A further strategy included the researcher personally transcribing the interviews and field notes to increase her immersion into data and to minimise error. All memo jottings and diagrams were referenced extensively with the data, using participants’ words and linking exemplars from transcribed texts to emerging theoretical concepts to ensure the emerging theory was grounded in the data (Strauss & Corbin, 1998). Similarly, segments of data have been included in the final report to demonstrate fit and facilitate the reader’s evaluation of conceptual interpretations (Glaser, 1978).

Member checking, which involved sharing tentative findings with two participants and two expert clinicians in the acute hospital, was used to determine the extent to which emergent concepts made sense and remained true to participants’ experiences (Stake, 2008). Additionally, the tentative theory was presented at two international conferences, a symposium, a scientific meeting, two university postgraduate seminars and three hospital meetings involving clinical staff. The details of these presentations are included in Appendix K. Sharing the tentative findings with meetings of ward nurses, as well as nursing, medical and allied health professionals working in hospital-based, pain-related disciplines helped the researcher to gauge the relevance of the substantive theory. Feedback and issues raised in several post presentation discussions informed some elements of the discussion and recommendations, and helped to facilitate the final presentation of the substantive theory. Finally, the substantive theory of seeking empowerment to provide comfort was compared with existing literature.

Regular peer debriefing with fellow grounded theory students provided the researcher with a nonthreatening environment in which to explore research experiences and analytic ideas (Polit & Beck, 2012; Schneider, Whitehead, Elliott, Lobiondo-Wood & Haber, 2007; Spall, 1998). In addition, regular meetings with experienced supervisors, who acted as mentors, contributed to the researcher’s capacity for conceptual interpretations and presentation of the final emergent theory.

Using a combination of approaches, the researcher has attempted to ensure that the research findings presented in the final report are consistent with the empirical data that was collected. Moreover, this will accurately represent the participants' perceptions of the world in which they live and work as well as the phenomenon of caring for patients who experience severe pain in the acute hospital.

Ethical considerations.

Four moral principles of professional ethics outlined by Beauchamp and Childress (2001) guided the conduct of this study. These principles include respect for autonomy, nonmaleficence (avoiding harm), beneficence (providing benefit) and justice (Beauchamp & Childress, 2001). Application of these principles was directed by compliance with the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007).

Produced by the National Health and Medical Research Council and issued by the Commonwealth Government of Australia, this statement contains guidelines that provide for the protection of participants' welfare and rights when designing and conducting research. The statement was last updated in 2007. The research proposal was approved by the Human Research Ethics Committee at the hospital in which the study was conducted and the Human Research and Ethics Committee at Curtin University (see Appendices I and L for copies of approval letters).

Informed consent.

The National Statement on Ethical Conduct in Human Research requires that all participants provide informed consent before being included in a research study (National Health and Medical Research Council, 2007). There is a legal and ethical requirement for potential participants to be given sufficient information upon which to base their decision-making. Such information includes the purpose, methods, risks and benefits of the study to ensure the participant can voluntarily choose to participate or not.

In accordance with the National Statement on Ethical Conduct in Human Research, potential participants may refuse to participate in a research study without reason or withdraw at any time and without reason (National Health and Medical

Research Council, 2007). In general, concealment for the purposes of a study or covert observation is considered unethical because it conflicts with the ethical principle of respect, and negates the provision of informed consent.

In the current study, all participants were informed verbally and through written information, provided with the invitation to participate, that participation was voluntary. Nurse participants were assured that their decisions to accept or refuse the invitation to participate would not be divulged to hospital staff or affect their employment. Patient participants were told that their involvement would not affect their care in any way. Information Sheets providing detailed information about the conduct of the study provided to all nurse and patient participants are included in Appendices M, N and O. Potential participants were given the opportunity to ask questions about the study prior to making their decisions. They were also advised that participation was voluntary and they could withdraw from the study at any time without reason and without penalty. All participants who provided written informed consent to participate were offered a copy of their signed Consent Form (see Appendices A, E and F) for their personal records.

A particular ethical concern for this study was the protection of vulnerable participants. Patient participants were considered to be vulnerable because they were hospitalised and because there was potential for the experience of severe pain to impinge on the cognitive capacity to provide informed consent. The National Statement for Ethical Conduct for Human Research (National Health and Medical Research Council, 2007) recognises that people who are highly dependent on medical care may have a limited capacity to give informed consent by way of their medical condition, or fear that refusal to participate may affect the provision of care.

In the current study, it was also acknowledged that the experience of severe pain may render patients who wished to be involved unable to provide written consent. Therefore, all patient participants were provided with the option to sign a Consent Form (Appendix A), although verbal consent was also accepted in the first instance. A record of the time, date and place at which verbal consent was obtained was made (Appendix B), witnessed by a family member or nurse, and kept with study records. Continuing assent was obtained from these patient participants throughout the observation. Verbal consent was then followed up with a signed,

dated and witnessed Consent Form when the pain settled. However, it was recognised that verbal consent was still valid consent should the patient participant decline to provide this (Personal communication, Millett, 2006). Four patients provided initial verbal consent. Of these, two exercised their option to forego written consent but still participated in the study.

Privacy and confidentiality.

Privacy and confidentiality of all participants in this study was protected in accordance with the National Statement on Ethical Conduct for Human Research (National Health and Medical Research Council, 2007). Privacy refers to restricting access to personal information in order to protect a person's interest, while confidentiality requires that information gathered about another person is not used for purposes other than that for which it was given.

In the current study, all collected data was de-identified to protect participants' privacy and confidentiality. The researcher constructed a master list, which assigned a numerical code to each participant. This master list was stored securely in a locked filing cabinet, accessible only to the researcher. The data and completed consent forms were kept separately so that numerical codes could not be matched to participants' personal information. Interview transcripts and field notes were identified only this numerical code. Any audible names or identifying information included in the interviews were removed during transcription.

Only interviews and structured observations involving nurses and patients who had given informed consent to participate in the study were included as data. All other information gathered inadvertently about other nurses, patients or health professionals was disregarded. To protect patient privacy, medical records were not accessed in the course of patient recruitment. Rather, the clinical judgment of ward nursing staff was used to determine which patients met the inclusion criteria. With the advice of the senior nurse in charge of each ward, an initial cohort was set up and personal contact made with potential patient and nurse participants.

Data storage, access and disposal.

Cassette audio-tapes and devices containing digital recordings of interviews were stored in a separate locked cabinet. All electronic data were password protected and only accessible to the researcher. Study documents and audio-recordings will remain in secure storage for a period of five years from the date of last publication of this research, after which time recordings will be erased and paper documents shredded.

Minimising risk.

The researcher's presence was always made clear during participant and structured observation. The researcher wore "civilian" clothing, and clearly identified herself as a researcher verbally and with a name badge when interacting with nurses and patients in the study wards. As a registered nurse, the researcher was aware of the need for sensitivity in the clinical setting and conducted all observation as an unobtrusive and respectful visitor (Miller & Crabtree, 2005; Patton, 2002). The potential for the researcher to become privy to unethical or harmful clinical practice to patients in the course of participant observation was acknowledged. Upon consultation with the study supervisors, it was decided that, should this eventuate, the researcher would use her clinical judgment to determine the need for intervention to prevent or minimise harm.

The risk that nurse participants may become distressed during interviews was also anticipated. This risk eventuated in two interviews. One participant requested to continue with the interview; however the other participant elected to terminate the interview. This participant was given immediate emotional support and offered access to hospital-based counselling services. All interviews were followed with a period of informal conversation that was not audio recorded. These interactions provided the opportunity for the researcher to thank participants, offer feedback about the research and ensure that the participant disengaged comfortably from the research process. Interaction between researcher and participant ended when the participant indicated a readiness to leave.

Summary of Chapter Two

This chapter has described the rationale for selecting a qualitative approach and using grounded theory method to investigate, from the perspectives of nurses, the effect of caring for patients experiencing severe pain in an acute hospital. This chapter has outlined the characteristics, historical background and current perspectives of grounded theory method. The practical application of grounded theory method to this current study was also presented. The use of semi-structured interviews and participant observation to collect data was discussed. The constant comparative data method of data analysis was described, along with the use of literature, theoretical sensitivity and theoretical sampling. Issues of trustworthiness and rigour, and the ethical considerations of conducting this study were also explored.

The research findings from this study are presented in Chapters Three, Four and Five. The following chapter describes the context of nurses' regard for well-being, which shaped their actions and interactions when caring for patients experiencing severe pain. The concept of well-being is defined and the effect of patients' severe pain on nurses' well-being is outlined. The pleasurable, relaxing and satisfying feelings of nurse empowerment, experienced when nurses were able to alleviate patients' suffering, are discussed. A link between empowerment and nurse wellness is proposed. Nurses' regard for patient well-being, which prompted them to help patients by providing comfort with comprehensive assessment and a holistic approach, is also explored.

Exemplar quotations from nurses' interviews and the field notes made of participant observations will be included in presentation of data to demonstrate fit and relate emergent concepts to the developing theory.

CHAPTER THREE

Findings: The Context of Regard for Well-being

Introduction

This study explored and described the effect of caring for patients experiencing severe pain on nurses working in medical and surgical wards of an acute hospital in Australia. A central context entitled “regard for well-being” was identified, which explained how nurses understood their role of caring for patients who experienced severe pain and then interpreted their fulfilment of that role. Context refers to the social world inhabited by individuals, within which they engage with the phenomenon being investigated (Chenitz, 1986). As Chenitz explains, in grounded theory context “accounts for the setting as well as the events impinging on a particular setting” (Chenitz, 1986, p. 42). These events may be real or more abstract, relating to the meaning of an event to those involved.

In the current study, nurses saw their patients’ experiences of comfort and severe pain through a prism of well-being. The findings indicate that they shared an understanding that comfort was relaxing, conducive to healing and, therefore, beneficial to well-being. In contrast, severe pain was seen as distressing, incapacitating and a threat to well-being. Additionally, nurses saw the perceived threat of severe pain as an imperative for them to provide comfort to protect and promote the well-being of their patients. In turn, nurses’ own well-being was at stake as they evaluated their effectiveness in providing comfort to alleviate their patients’ suffering and promote recovery. Nurses’ regard for their own well-being, as well as that of their patients, was found to shape their actions and interactions as they strove to effectively provide comfort for patients experiencing severe pain.

In addition to providing the impetus for comfort provision, nurses’ regard for their patients’ well-being influenced the type of care they provided. While it was

paramount to address severe physical pain, a focus on the wellness of the whole person prompted nurses to attend to the associated emotional discomfort. A shared understanding that patients had multidimensional needs ensured that nurses saw effective comfort provision as involving comprehensive assessment and holistic care.

The data from this research revealed that nurses aimed to provide comfort in this way to most effectively promote patients' recovery. When they felt able to do so, nurses experienced a sense of empowerment. This sense of empowerment was pleasurable, relaxing, satisfying, sustaining and beneficial to nurses' own well-being. In contrast, nurses who felt unable to provide comfort experienced disempowerment, which was distressing, frustrating, unsatisfying, exhausting and damaging to their well-being. This negative experience constituted the core problem encountered by all nurse participants in this study and is described in Chapter Four. Although they were largely unaware of it, nurses' regard for their own well-being influenced their perceptions of empowerment and drove efforts to avoid or resolve the core problem of *feelings of disempowerment* identified in this study.

This chapter introduces and defines the context of regard for well-being in terms of (a) nurse empowerment, and (b) patient comfort. Firstly, the concept of well-being will be defined. Following this, nurses' regard for their own well-being and the experience of nurse empowerment will be described. Finally, nurses' regard for patient well-being, which shaped their shared understanding of comfort and comfort provision, will be explored.

The Definition of Well-being

In the current study, well-being is defined as a subjective state of physical, mental, and emotional wellness derived from individuals' evaluations of themselves and their situations. This conceptualisation emerged in nurses' descriptions of their patients' experiences, needs and preferences, and their own feelings, thoughts and responses.

The dictionary describes well-being as "the state of being comfortable, healthy or happy" ("Oxford Dictionary of English," 2007, p. 1999). In 1947, the World Health Organisation (WHO) established a focus on wellness when it defined

health as “complete physical, mental and social well-being and not merely the absence of disease or infirmity” in its constitutional Preamble (Grad, 2002). This understanding of health as a positive and multidimensional state of well-being was reaffirmed in 2006 (World Health Organisation, 2006). In the psychological literature, well-being concerns peoples’ subjective appraisals and sense of satisfaction encompassing all facets of life (Hattie, Myers & Sweeney, 2004).

Nurses in the current study spoke of well-being only in terms of their patients. In doing so, they demonstrated a shared understanding that well-being was multifaceted, meaning: “physical as well as mental, emotional” (N19). In addition, well-being was thought to depend on how each individual experienced his or her own world. As this nurse explained:

Well-being looks at . . . everything to the patient the clinical side . . . socially, the home life . . . mobility, the diet, everything. Everything we look at in hospital is . . . their well-being . . . how they think and how they feel about . . . their condition, their treatment, them getting better, and their psychological [state] as well. (N22)

Through these descriptions, nurses revealed that they thought about patients in terms of the whole person and with a focus on helping patients towards wellness. These perspectives were congruent with current usage of well-being. Therefore, it was concluded that nurses’ understanding of and concern for well-being determined how they assessed and met patients’ needs.

The data also demonstrated that nurses had a regard for their own well-being as they cared for patients who were distressed and incapacitated with severe pain, although they were seemingly unaware of this concern. It emerged that nurses experienced detrimental emotional and then physical effects of witnessing patients’ suffering, and feeling ineffective and unable to help. These findings of a multidimensional impact on nurses, largely contingent upon their subjective evaluations of themselves, led to the conclusion that caring for patients experiencing severe pain affected nurses’ well-being.

In this study, well-being was a multidimensional and subjective concept relating to the wellness of individuals, which underpinned the social world of nurses caring for patients in the acute hospital. Regard for well-being, their own and their patients, was the context for nurses’ actions and interactions. Firstly, regard for their

own well-being shaped nurses' responses to feeling disempowered from providing comfort for patients, which constituted the core problem and subsequent basic social psychological process identified in the data. Secondly, nurses' regard for their patients' well-being shaped their understanding of patient comfort, severe pain and comfort provision. The following section will describe nurses' regard for well-being in terms of (a) nurse empowerment and (b) patient comfort.

Nurse Empowerment

In this study, the concept of empowerment related to individuals having control and the ability to achieve positive change. Specifically, nurses who felt able to provide comfort for patients experiencing severe pain experienced a sense of empowerment, which was pleasurable, satisfying and relaxing. They enjoyed seeing the easing of patients' pain and distress, and relaxed as the perceived threat to patient well-being diminished. Furthermore, they saw patients' comfort as evidence of their own effectiveness and subsequently felt satisfied as they improved outcomes for those in their care. Hence, it was found that empowerment was a positive experience drawn from the nurses' subjective evaluations of their own success, which facilitated the wellness at the heart of well-being. Figure 2 represents the relationship between concepts of empowerment, comfort and the well-being of both nurses and their patients.

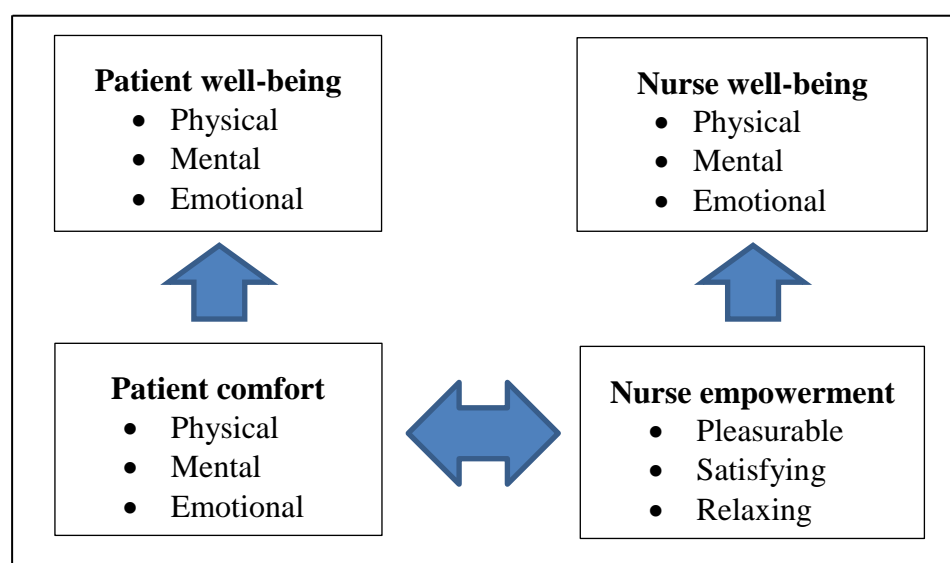


Figure 2. The relationship between nurse empowerment, patient comfort and the well-being of nurses and patients.

The data indicated that nurses' experiences of empowerment related to their perceived nursing role to protect the well-being of patients. As one nurse stated: "ultimately you always want the best outcome for the patient" (N31). The nurses described wanting to "make it better" (N05), which was suggested to be a human response to suffering. Another nurse explained: "you just want to do your best for someone and make them feel better . . . I just think that's natural isn't it" (N19). Consequently, nurses derived enjoyment from having alleviated the severe pain of their patients as evidenced by one who commented: "if you think you are relieving it, it gives you a lot of pleasure thinking that you are making that person feel better and making that day a bit more tolerable" (N05). Other nurses described feeling "reasonable because the patient was at the time pretty well pain free" (N28), and "it feels really good 'cause it was resolved" (N02).

Nurses elsewhere have reported similarly positive effects when they felt able to alleviate their patients' pain. For example, a study conducted in the USA used a phenomenological approach to explore in-depth how three nurses who had worked for more than five years in a surgical hospital unit experienced caring for patients with postoperative pain. The findings emphasised the commitment and pride these nurses felt in their ability to "make a difference" (p. 23) for their patients (Richards & Hubbert, 2007). All three nurses valued their capacity to improve patient outcomes. Similarly, in a more recent phenomenological study conducted in Iceland, feelings of enjoyment and satisfaction were found to underpin the "mutual contentment" (p. 2092) described by nurses when their patients were comfortable (Blondal & Halldorsdottir, 2009).

In the current study, nurses demonstrated that pleasure derived from providing comfort stemmed directly from seeing their patients improve. Comments made by nurses who took part in the study illustrate this. For example: "it was so good [laughs], because he was pain free . . . good really. I feel good when I see my patient [is] pain free" (N09), "you see patients with no pain and you . . . [feel] really . . . great" (N17), and "if they always answer that they are comfortable with the pain that they have then . . . I'm happy" (N21). As patients' pain eased, so did the perceived threat to patient well-being and nurses tended to stop worrying, allowing them a measure of relaxation. This was demonstrated when nurses stated: "I feel good now

because she's having a much better day" (N04), and "[I felt] relieved that she was comfortable . . . it was a relief. I mean I don't want to see her in pain" (N18).

It was also evident that a sense of having control was important. For example, nurses commented: "you see patients with no pain and you're really like 'great' . . . [because] that's when things can be managed and can be controlled" (N17), "it was better because . . . the pain was under control" (N23), and, "[when pain is] under control is getting better, is good" (N25). The data clearly showed this enjoyment and lessening of concern stemmed from feelings of having ability, of achieving positive change, and of being in control. Identifying these elements of the nurses' experience led to the conclusion that nurses experienced empowerment in this circumstance, a supposition supported by the literature.

Empowerment has been described as an outcome and a process concerned with having the power to gain control and effect change (Rodwell, 1996; Ryles, 1999). First appearing in the 1960s within the discipline of religion, the concept of empowerment has been developed and adapted into many areas within the social sciences (Bartunek & Spreitzer, 2006). The term has been used in three broad ways; firstly, as sharing real power, in terms of strengthening the underprivileged and control over destiny; secondly, as fostering human welfare through culture, self-worth, knowledge, dignity and respect; and, lastly, as fostering productivity (Bartunek & Spreitzer, 2006). This third definition of fostering productivity emerged in the 1980s and 90s in management literature and referred to empowerment as a way of getting work done through participation, responsibility, ownership and enabling others (Bartunek & Spreitzer, 2006). In 2000, a review of the nursing literature found empowerment in this context to be positive, dynamic, orientated toward solutions and shared power, and associated with growth and development (Kuokkanen & Leino-Kilpi, 2000).

Notions of having power and creating positive change are central within the body of work exploring empowerment. As an outcome, empowerment has been described as a positive psychological state achieved when individuals feel they have meaning, competence, self-determination and impact in the work environment (Spreitzer, 1995). In that usage, competence and self-determination relate to having ability and power, whilst the idea of having an impact suggests positive change. On

the other hand, empowerment as a process has been related to using formal and informal power, which imbues individuals with the ability and resources to be productive (Kanter, 1977; Laschinger, Gilbert, Smith & Leslie, 2010).

In the current study, empowerment occurred in the data as both an outcome and a process. Empowerment was the positive outcome enjoyed by nurses when they felt the pleasure and satisfaction of being able to alleviate distress and promote the recovery of patients who suffered with severe pain. In addition, empowerment was a process used by nurses in their pursuit of this positive outcome. Nurses' efforts to empower themselves are described in Chapter Five, which discusses the basic social psychological process identified in this study. Meanwhile, this chapter has described the outcome of nurse empowerment, which rested upon nurses' judgements of whether they effectively provided comfort for patients who experienced severe pain. To understand nurse empowerment, therefore, it was necessary to understand the meaning of patient comfort on which the experience was predicated.

Patient Comfort

The findings of this research indicated that nurses conceptualised patient comfort to be an experience characterised by minimal physical pain. As one nurse surmised: "she's fast asleep so she can't be in too much pain. She must be pretty comfortable in bed" (N10). Without the stress of severe pain, patients could relax, as one nurse observed: "they're pain free again and then they can relax properly" (N33). However, nurses tended to see patient comfort more as a state of ease than the complete absence of pain. Some suggested that patients could still be comfortable with mild pain, as long as the discomfort was not severe enough to limit the ability to function. For example, two nurses commented: "minimal pain . . . so she can move around" (N32), and "she can manage it [the pain] and she could continue to do what she needed to do even though she's in pain" (N02).

It was also apparent that nurses associated patient comfort with health. For example, when questioned about the meaning of patient well-being one nurse remarked: "comfort and . . . seeing an improvement" (N24). Others suggested comfortable patients were able to comply with treatment, which was conducive to healing. As one nurse recalled: "he didn't mention about a lot of pain . . . did

cooperate with us . . . pain control is [*sic*] pretty good” (N14). These findings indicated that nurses saw patient comfort as a therapeutic experience that facilitated wellness, a perspective supported in other literature.

In particular, the concept of patient comfort that emerged in this study reflects the three senses of comfort in nursing proposed by Kolcaba and Kolcaba (Kolcaba & Kolcaba, 1991). They described firstly the “state” of comfort, which was an enduring state of ease rather than a total absence of discomfort, and, secondly, comfort as “relief,” meaning relief of the discomfort of adverse stimuli or thoughts. Thirdly, comfort was “renewal,” referring to comfort measures that prepared a person to meet challenges, which could be experienced even when a degree of discomfort remained (Kolcaba & Kolcaba, 1991). The development of Kolcaba’s theory of comfort is further described in Chapter Six, where the substantive theory developed in the current study is discussed in light of current literature.

Further understanding of comfort as experienced by hospitalised patients was provided in a study of patients (n=40) and nurses (n=32) conducted in Western Australia (Williams & Irurita, 2006). The grounded theory method was used to explore the perceived therapeutic effects of patients’ interactions with nurses in a variety of settings. The findings indicated that patients experienced a therapeutic state of emotional comfort, which was underpinned by their feelings of personal control in the hospital environment. In that study, patients’ emotional comfort was characterised by pleasant positive feelings and relaxation that increased physical comfort and promoted healing (Williams & Irurita, 2006).

In the current study, comfort was characterised by minimal physical pain that allowed patients to relax and to function. It was also considered a therapeutic experience, which protected patients from distress, promoted healing, and aligned with nurses’ focus on wellness of the whole person. Accordingly, providing comfort was the goal of nurses’ care to protect and promote the well-being of patients who suffered with severe pain.

Nurses' Comfort Provision

The chapter to this point has explained nurses' shared regard for well-being and understanding that the experience of comfort facilitated patients' wellness. It was not surprising, therefore, that the provision of comfort emerged as nurses' principle aim when caring for patients who experienced severe pain. For example, one nurse stated: "it's your role to bring comfort to people and to make them feel better" (N24). Another explained: "you just want them to be comfortable and you just worry about 'how can I achieve the goal of comfortable'" (N25). Accordingly, promoting patients' recovery meant ensuring they were comfortable and, therefore, able to mobilise and cooperate with treatment. For example:

A major role in getting someone recovered [is] to give them the ability to be able to get out of bed and start moving . . . they need that pain coverage. It's a huge area of nursing care that helps them to be able to do better in all other aspects . . . good pain coverage and pain management is a huge thing to getting them rehabilitated and ready to go home. (N10)

One nurse linked comfort provision directly to patients' wellness when she described the meaning of well-being as: "they're safe . . . they're comfortable and . . . being well cared for" (N23). To emphasise further, she added that being well cared for meant: "showered, they're fresh . . . comfortable . . . not in pain . . . eating well . . . [and] they have company 'cause it gets really lonely" (N23). This finding is supported in the literature where comfort, described as a holistic state of positive human experience, has long been seen as integral to nursing care (Clements & Cummings, 1991; Dowd, 2002; Duffield, Gardner & Catling-Paull, 2008; Kolcaba & Steiner, 2000).

In the current study, nurses showed that witnessing patients in severe pain affected them and moved them to help. The following comments illustrate this: "it's not nice to see someone in pain" (N06), "I just feel so bad because this patient is in a lot of pain and I need to do something to stop this pain . . . I try to find a solution to it" (N09), and "I feel bad if I see someone in pain. I feel like I have a responsibility to make that go away" (N18). Descriptions of feeling "bad" suggest that nurses reacted emotionally when they perceived that patients were suffering with pain.

The findings indicated that such emotional responses engaged nurses with their patients' pain problems, prompting them to assume responsibility for resolution. Nurses demonstrated that they responded to the immediacy of patients' distress. For example, one nurse recalled caring for a young patient with intractable severe headache which involved:

Trying to see if I could get her feeling better, with her pain . . . I don't like to see the patient in pain . . . you just want to try and you want to stop it. You want to make them more comfortable. (N05)

Another nurse demonstrated the significance of the imperative to provide comfort when she implied that this outweighed the perceived risk associated with using analgesic medication:

If it is a cancer patient . . . you have to manage it [the pain] and if that will make them a bit addicted [to analgesic medication] for a while . . . get it all done and then get that treated . . . you still have to keep them . . . pain free. (N02)

The findings further indicated that nurses' focus on comfort as a therapeutic state of relaxation meant that they saw comfort provision not as elimination of pain but, rather, as the relief of enough discomfort to ease patients' anguish. For example, one nurse recalled: "the pain won't just go away . . . but at least . . . after the . . . [analgesic] dose . . . he [can] sleep. He [can] relax and have a snooze" (N25). This perception accords with Kolcaba and Kolcaba's (Kolcaba & Kolcaba, 1991) conceptualisation of the state of comfort as an enduring state of ease rather than a total absence of discomfort.

Nurses in the current study commonly spoke of getting and keeping pain under control. These descriptions were typical as nurses recalled trying to "get his pain under control . . . so that he would feel that he would be able to go home" (N30), "do everything I can to try and get on top of the pain . . . everything to get his pain under control" (N29), and "pain . . . I made sure I kept on top of it" (N12). With pain under control, patients could resume therapeutic activities: "getting the pain under control he was able to stand himself . . . he's doing pretty well . . . standing up and sitting on the chair to the shower" (N14). Another nurse similarly

commented: “we’re staying on top of the pain and looking after him holistically so much so that we’re looking at discharging him” (N22).

Apart from keeping patients’ pain at low levels to promote healing, mild pain was considered eminently treatable. Therefore, controlling pain involved nurses intervening early. As these nurses observed: “if pain is allowed to increase it’s a lot harder to bring it back down again in comparison to keeping it under control” (N20), and “[if we] get onto the pain before it develops . . . we can prevent it before it gets worse” (N08). In this way, nurses indicated that comfort provision entailed a proactive approach that avoided the stress of severe pain and optimised treatment.

While the physical pain experience was central, nurses’ focus on the wellness of the whole person prompted a multidimensional approach to providing comfort. Consequently, effective comfort provision was characterised by comprehensive assessment and holistic care. These characteristics are outlined in the following section.

Comprehensive assessment.

Nurses indicated that the first step toward addressing the pain problem was an assessment of patients’ experiences. Pain was recognised as subjective and unique to each individual. This meant that nurses could not refer to their own experiences to quantify or qualify the pain their patients were feeling. One nurse explained:

You better ask them because it is their body. They can feel the pain. They can feel no pain . . . for a nurse, we just observe . . . but they feel it . . . deep down in their body, how do they feel the pain? . . . a burning pain? . . . a stabbing? . . . you look at the patient, you can’t tell . . . is it a burning pain or a stabbing pain or is it a throbbing pain? You don’t know, not until they tell you. (N25)

Another nurse similarly surmised: “when you [ask] . . . ‘what is your pain level?’ some people say ‘two [out of 10]’, some people say ‘four [out of 10]’ so everyone is different . . . each patient is different” (N09). This finding accords with a study of Australian renal nurses (n=62), who were surveyed to determine their perceptions of pain assessment and treatment knowledge (Williams & Manias, 2007a). Almost all participants in that study believed that patients’ self-reports were the best indicator of pain.

The perception that patients are best placed to describe the subjective pain experience also accords with McCaffery and Pasero's definition of pain as "whatever the experiencing person says it is, existing whenever he says it does" (McCaffery & Pasero, 1999, p. 17). In the current study, one senior nurse counselled her junior colleagues to "think of the patient; what works for them because everyone is different" (N08). These nurses knew that they needed to understand patients' pain to be able to address it effectively. As one nurse observed: "you've always got to assess the individual and make sure that you're giving that person what they need, not just what you'd give patients across the board" (N20).

Accordingly, nurses demonstrated that pain assessment was the starting point for clinical decision-making. For example, when asked to describe her role when caring for a patient with severe pain one nurse answered: "to assess their pain and assist them with appropriate treatment to alleviate the pain" (N01). Others declared: "you analyse it first . . . where it is and what kind of pain" (N02), and "decisions to be made? Of course I had to assess" (N12). In brief, these findings indicated that comprehensive pain assessment equipped nurses to handle the subjectivity of pain and provide pain relief tailored to patients' needs.

These findings reflect recent direction that individualised care requires that the subjectivity of patients' pain experiences be acknowledged and accommodated (Samuels & Fetzer, 2009). Recommendations for practice include assessment based on patients' reports of their experiences to address the inherent subjectivity of pain (Macintyre et al., 2010; McCaffery & Pasero, 1999). Nurses in the current study described interacting with patients to garner information about their pain. These interactions focused on communication, both verbal and nonverbal, through which they generated a composite picture of their patients' experiences.

Firstly, nurses described listening to patients' verbal communication, as the following recollections demonstrated: "he tells me . . . keeps saying 'I'm in pain, I'm in pain'" (N09), and "she was saying to me 'I am in quite a bit of pain'" (N04). These self-reports alerted nurses to patients' increasing or ongoing pain. Further probing could then elicit a more in-depth understanding of what patients were feeling.

Numerical pain scoring was indicated to be a useful tool to facilitate communication about pain. This tool involved patients expressing pain intensity as a numerical value relative to a defined 10 point scale. The findings indicated that this systematic approach gave nurses and patients a common language with which to describe pain:

Ask them . . . what is the pain score they have . . . from zero to 10. Zero is no pain, 10 is the worst pain . . . experienced . . . on the continuum. So I just ask them to rate what is the pain that they feel at the time that I ask them. (N14)

Assigning a numerical value to pain intensity translated the subjective experience of pain to an objective concept that could be communicated. With a shared understanding of the pain experience, nurses and patients could then agree on goals and strategies for pain relief. For example, one nurse stated: “in regards to pain, I always ask them . . . I find out their pain score and I’ll say ‘that’s high, do you want some medication? . . . Are you comfortable with your pain?’” (N21).

This finding supports other literature recognising numerical pain scoring as an effective means of quantifying and communicating pain experiences (Bell & Duffy, 2009; Passik, Byers & Kirsh, 2007; Walid, Donahue, Darmohray, Hyer & Robinson, 2008). This is despite the perception that some patients, particularly those with comorbidities, can have difficulty interpreting pain as a numerical score when a single number fails to capture its complexity (Blondal & Halldorsdottir, 2009; Layman Young, Horton & Davidhizar, 2006; Manias, 2003b; Manias et al., 2004).

Nevertheless, unlike all nine nurses included in a Norwegian study who did not use pain rating scales (Dihle et al., 2006), the nurses in the current study valued numerical pain scoring as a part of their pain assessments. Representing pain as a number facilitated documentation. Additionally, standardised scores could be compared over time to evaluate treatment. For example, one nurse recalled:

I just went and got the injection . . . gave it to her and assessed her pain later and it went down to five out of 10 . . . she was better . . . wasn’t so much displaying her pain. (N21)

Another nurse demonstrated how pain scoring facilitated ongoing reassessment when she stated:

I actually asked him each time ‘so what is it now and originally what do you think it was?’ . . . [to determine] whether it’s [the pain] . . . totally out of control . . . whether it’s just a bit of a niggle. (N01)

These data indicated that nurses regarded pain scoring as a useful tool, which enabled them to communicate about a subjective experience.

In addition to verbal communication, either as descriptors or numerals, nurses were found to attend to patients’ nonverbal communication about pain. Patients’ self-reports of pain were supplemented with nurses’ observations of behavioural cues. As one nurse explained: “if someone’s in pain I . . . ask them and . . . visual assessment as well . . . their body language, positioning and their facial gestures . . . tone of voice” (N21). These data indicated that nurses integrated subjective evidence from patients’ verbal descriptions with their own objectively observed behaviours. Other research has similarly demonstrated how nurses combine verbal and nonverbal cues in this way (Dihle et al., 2006; Kim et al., 2005; Richards & Hubbert, 2007).

In the current study, nurses suggested that integrating subjective and objective pain cues enabled them to formulate an understanding of patients’ pain that could inform clinical decision-making. The following comment was evidence of this:

Sometimes their behaviour doesn’t . . . [indicate] a lot of pain even though . . . they will verbalise, say[ing] “I’ve got pain nine out of 10” but they look quite comfortable . . . don’t groan or moan . . . I observe objectively . . . their behaviour, their attitude, their signs of discomfort . . . subjectively I . . . say, “ok, what sort of pain score that you experience”, combine both and just find out how much pain they’ve got. (N14)

Moreover, nurses incorporated information about patients’ emotional status, which included: “assess[ing] their mental state if they are actually coping . . . if they are mentally coping with it as well” (N20).

These data demonstrated that nurses interacted with their patients to collect verbal and nonverbal information about their physical, emotional, and mental condition. Where possible numerical pain scores assisted nurses to communicate about pain, monitor pain levels and evaluate the effectiveness of pain relief. As they

integrated this information, nurses were able to build a comprehensive picture of their patients' experiences:

We'd be looking at the patient's situation, the history, what they've been having currently, what's worked what hasn't worked. So we would have a look at the whole spectrum of the pain management that's gone on for that patient and then come up with strategies on how we can deal with it. (N08)

With this understanding, nurses were able to determine patients' needs and develop strategies to address them. One nurse articulated this approach:

You will identify the problem and you say "ok, he is in pain and his pain is because of the hand injury" . . . so you identify the problem . . . in your brain you will . . . number one . . . problem-solving skills . . . you are using that all the time. (N25)

In brief, nurses' regard for patient well-being prompted them to assume responsibility for resolving their patients' pain problems. Comprehensive assessments quantified and qualified these problems and informed nurses' problem-solving. Nurses' regard for well-being underpinned a consequent holistic approach to comfort provision, which is now described.

Holistic care.

Nurses' understanding of patients' well-being as a state of physical, emotional and mental wellness meant that they attended not only to physical pain but also to the associated emotional suffering. Severe pain is defined in this study as a distressing and incapacitating experience, which damages patients and jeopardises healing. This conceptualisation emerged from data in which nurses described the meaning of severe pain and the negative implications they saw for patients and their recovery.

When asked to describe severe pain, nurses consistently answered not in terms of an objective rating but rather as how people were physically, mentally and emotionally affected. Many evoked their patients' obvious distress. The following observation was typical: "they're often tearful and restless, they can't settle . . . calling, crying out" (N18). Nurses further understood that there were emotional implications of such an intense experience. For example, two stated: "I think pain is just generally very anxiety provoking . . . and the higher their anxiety levels go, I

think the more pain they tend to feel” (N15), and “I think it is a combination . . . the physical pain is there because . . . the body, the nerve sends the pain . . . and the anxiety, the worries, emotionally, make it worse” (N25). This nurse also suggested that the meaning patients ascribe to severe pain could intensify their distress. As she explained:

It’s not only the physical pain. It’s the . . . anxiety of the injury. Anxiety . . . [about] work and whether they can get better . . . and how can they function . . . so job wise, financial wise . . . all these add up together. (N25)

Nurses felt that the distress associated with severe pain could overwhelm people. There was a perception that the intensity of the experience narrowed patients’ mental focus and profoundly restricted physical mobility leaving them unable to function. The following were typical of many nurses’ observations: “severe pain is pain where you can’t carry out what you need to do for the day . . . very uncomfortable and it’s all they can focus on” (N04), and “severe pain just means ‘can’t think straight, nothing seems normal until that goes. It becomes all consuming . . . rational thought just goes out the door” (N08). Without the ability to think and move, patients in severe pain were thought to lose a degree of control. One nurse described it as:

An overwhelming amount of pain that you can’t even think . . . can’t even move . . . affecting you physiologically . . . breathing faster and you’re all tight and clenched up . . . it’s not manageable at all . . . and you can’t get your mind off it. (N06)

There was a sense that nurses saw severe pain as an experience which put people’s lives on hold. One captured this when she recalled:

It stops patients from being able to do anything else. She was in severe pain and it did stop her from leaving the bed . . . did stop her from being able to reason or do anything else. So maybe that’s severe pain when it actually the pain gets up to that level that it stops them from putting it aside, doing other things, living some kind of everyday life. (N02)

Apart from the immediacy of patients’ suffering, a further concern was that the inability to function could precipitate other clinical problems:

Firstly, you’ve got the pain . . . following that you’ve got inadequate diet intake because . . . [without] adequate analgesia at the right time he wasn’t

able to eat dinner which means his intake wasn't going to be adequate, which also means that . . . his output isn't going to be . . . effective . . . mobility, because if he got up and walked around . . . you know, cardiovascular, blood pumping, oozing, bleeding, hurting. (N22)

These data revealed nurses' understanding of severe pain as a nontherapeutic experience that caused their patients a range of problems. Accordingly, effective comfort provision was found to involve a holistic approach that addressed physical pain and the associated stress and anxiety to ease suffering and restore function.

Holistic care has been defined as "characterised by the treatment of the whole person taking into account mental and social factors not just the symptoms of the disease" ("Oxford Dictionary of English," 2007, p. 828). In the current study, one nurse described it as "mentally . . . psychologically . . . both mind and body . . . we're looking after everything and making sure that every aspect is being looked after, rather than just . . . physically" (N27). Another showed that this meant "looking at what analgesia is available . . . and also the reassurance, the emotional support side of things and looking at other strategies that might be nonpharmacological" (N08).

Within this holistic approach, nurses tended to first target physical pain, not only to alleviate immediate distress but also to avert a cascade of other problems. One nurse clearly stated: "the priority is . . . physical pain control" (N25). Another recalled caring for a patient with a traumatic eye injury and stated: "my first priority was [that] . . . his pain was effectively managed . . . analgesia before his dinner, he ate properly. Because he ate properly, his output is [*sic*] satisfactory" (N22). Later he added:

The pain and the eating and then the bowels and the output . . . treat the first problem effectively, all the secondaries will kind of fall in line . . . treat the primary problem . . . the primary problem would be the pain. (N22)

Analgesic medication was considered most effective to relieve physical pain, and nurses described turning to pain relieving medicines as a first response. This finding was in contrast to nurses (n=3) who had worked for more than five years in a hospital surgical unit in the USA and stated that they sought nonpharmacological approaches before resorting to painkillers to provide comfort (Richards & Hubbert, 2007). While that phenomenological study included only nurses who were considered expert in pain management, the findings were limited by a small sample size.

In the current study, nurses knew they needed to supplement analgesics with emotional and social comfort measures because, as one commented: “if you’re in pain and you get more stressed then your pain . . . elevates” (N27). Therefore, the findings indicated that holistic care for these nurses included pharmacological strategies to address physical discomfort augmented by emotional support, such as nurses’ presence, reassurance and the inclusion of family.

The findings indicated that while nurses relied on analgesic medication to address severe physical pain, they knew patients who were suffering also needed a comforting human presence. As one nurse explained:

When . . . someone’s in pain and you walk in and . . . [say] “you’re in pain and I’ll go and give your medications” and you leave . . . they’re kind of left alone. Whereas . . . if you sit with patients and you’re holding their hand or . . . talking to the patient . . . emotionally I think they’re feeling a bit nurtured, like we’re not just leaving them to deal with it . . . sitting with them and just making them feel that . . . like, you’ve got your Mum giving you a big hug . . . there’s someone going “it’s ok. You’re going to be ok. We’re going get you through this” rather than just going “here are your pain tablets.” (N27)

These nurses understood that hospitalisation, when patients were unwell and in unfamiliar surroundings, compounded the stress of a severe pain experience.

Therefore, they described the importance of human connection to soothe anxiety and alleviate distress. This connection was enacted through nurses being present for patients both physically and emotionally with a focus on eye contact and touch:

People are already vulnerable when they are in hospital. They are already frightened, tense, anxious . . . for somebody to actually give them the time, and look them in the eye, and not just rush in and throw a pill at them, and walk out again . . . not clinical. It’s like human touch and it’s like hugging somebody . . . you can see what comfort it brings people . . . if a child falls over you pick them up and you cuddle them because they’re sore and hurting. (N24)

Nurses also described supplementing their own presence by encouraging patients’ family to attend the bedside to provide social support and reassurance. As one nurse commented: “in the hospital [it] is all strangers . . . never met them before . . . but if someone that you know like family [is there] at least they feel more supported in a way” (N25). These data emphasised that effective comfort provision entailed strategies to address physical pain and emotional care communicated

through human presence, eye contact, and touch. While comprehensive assessment sought an understanding of the multidimensional effects of severe pain, nurses' holistic care addressed physical, emotional and social needs as they strove to protect and promote patient well-being.

Summary of Chapter Three

This chapter has described how nurses' shared regard for well-being influenced their actions and interactions when caring for patients who experienced severe pain. The finding that nurses' regard for patient well-being prompted their comfort provision to alleviate distress and promote recovery was described. Furthermore, it was shown that nurses' regard for patient well-being shaped this comfort provision to include physical and emotional support. In turn, regard for their own well-being, of which nurses were largely unaware, determined how they interpreted their ability to provide comfort for these patients. In this study, well-being was defined as a subjective state of physical, mental, and emotional wellness, which derived from each individual's evaluations of themselves and their situation.

The finding that nurses' well-being was affected by caring for patients experiencing severe pain was outlined. The experience of nurse empowerment, which was enjoyable, relaxing, satisfying and beneficial to well-being, was presented. Furthermore, it was argued that this positive experience of empowerment was derived from nurses' perceived ability to produce positive change for their patients. Nurses' experiences of empowerment were found to relate directly to their subjective evaluations of being effective when providing comfort for patients who experienced severe pain. Nurses perceived patient comfort as a relaxing and therapeutic experience, which enhanced patient well-being. Nurses saw their role as that of providing comfort, which meant controlling sufficient pain to relieve patients' distress and restore function.

This chapter provided descriptions of nurses' shared understanding that wellness concerned the whole person and that severe pain was a distressing, incapacitating and nontherapeutic experience which damages patients' well-being. Nurses' effective comfort provision, which involved comprehensive assessment and

holistic care to understand and address the multidimensional effects of severe pain, was also presented.

In Chapter Four, the core problem of feelings of disempowerment, which related to nurses' perceived inability to provide comfort for patients who experienced severe pain, is described. The intervening conditions found to cause and influence nurses' experience of the core problem are also discussed.

CHAPTER FOUR

Findings

The Core Problem: Feelings of Disempowerment

Introduction

Grounded theory seeks to discover the main concern shared by all participants, which crystallises what is happening in the data (Glaser, 1978). Using constant comparison, the grounded theorist searches for an emergent category in the data that is central, occurs frequently and has explanatory power (Glaser, 1978; Strauss & Corbin, 1998). The goal is to discover this shared concern and determine how it is resolved (Artinian, 2009). Conditions under which the phenomenon occurs that influence participants' actions, interactions and experience of the core problem are also discovered. These intervening conditions are described as "events or happenings that create the situation, issues, and problems and, to a certain extent, explain how and why persons or groups respond in certain ways" (Strauss & Corbin, 1998, p. 130).

This chapter describes the core problem of *feelings of disempowerment*, which related to nurses' inability to provide comfort. The conditions found to cause and influence nurses' feelings of disempowerment, which involved nurses' *levels of empathy, access to effective medication, collaboration with patients and colleagues, and time to care*, will also be discussed. Figure 3 provides a flow chart to explain the core problem, its descriptions and the influence of the four intervening conditions.

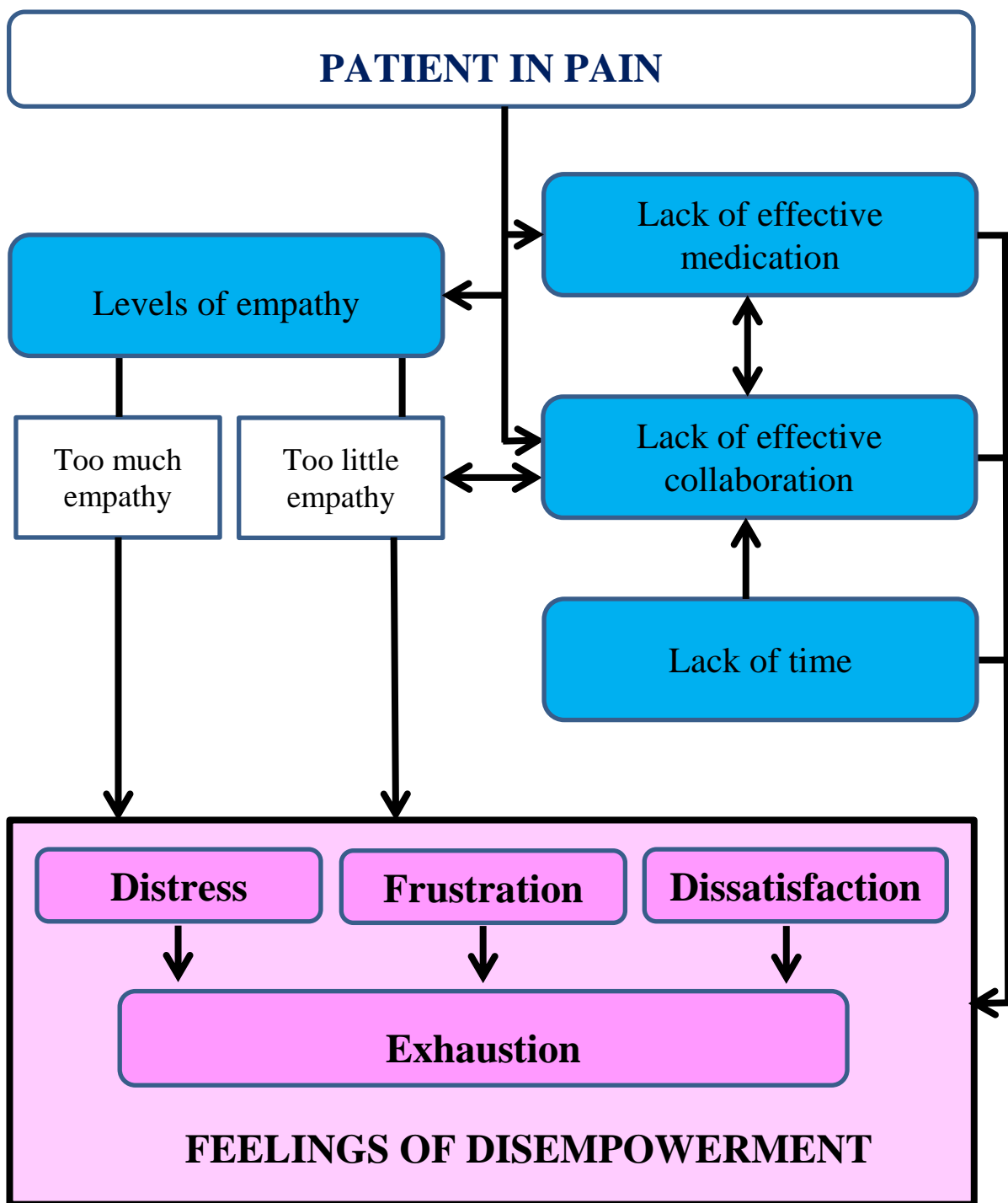


Figure 3. Flow chart explaining the core problem, Feelings of Disempowerment, its descriptions and the four intervening conditions

Feelings of Disempowerment

Regardless of the ward setting or level of seniority, all nurse participants in this study experienced, to varying degrees, a core problem which was entitled feelings of disempowerment. Disempowerment referred to nurses' perceived inability to facilitate positive outcomes and enhance the wellness of patients who experienced severe pain. Nurses who felt unable to provide comfort for these patients described feeling distressed, frustrated, dissatisfied and, ultimately, exhausted. At the heart of these experiences was a sense of ineffectiveness to produce positive change and mitigate risks to patients' well-being.

Findings from this study indicated that nurses' feelings of disempowerment tended to manifest in one of two ways. Firstly, and most commonly, nurses felt unable to protect patients from the distress and incapacitation of severe pain. Secondly, they felt unable to protect patients who they felt made baseless demands for analgesics from medication harm.

Nurses frequently described feeling helpless to assist patients who were suffering with severe pain. One said of her patient: "she had a lot of pain. She was in tears and . . . she couldn't lie still . . . there was nothing really that we could do that made it better" (N02). Their descriptions commonly depicted experiences of watching anguished patients while feeling unable to intervene, which tended to have significant emotional consequences for nurses. As this account conveyed:

She [the patient] was just in what she described as agony, 10 out of 10 [pain score] . . . wriggling around, restless . . . it was a very difficult situation 'cause I felt like I couldn't really do anything to help her. It was upsetting to see her. (N18)

Words such as "helpless" and "hopeless" often appeared in nurses' accounts of caring for patients whose severe pain persisted. Some typical recollections were: "I couldn't understand anyone being in pain when they could have analgesia . . . why I couldn't be giving it to her . . . a hopeless situation" (N04), and:

I felt very . . . helpless . . . to help him . . . as a nurse you feel inadequate . . . it's your role to bring comfort to people and to make them feel better, not to make them feel worse. (N24)

In using these terms, nurses evoked a sense of impotence in the face of patients' suffering. Two comments also suggested these feelings of disempowerment crystallised when nurses' expectations of having ample resources in the acute hospital had not eventuated. One nurse remembered feeling: "really bad . . . there's so many things that we can use to manage pain" (N18), while another explained: "you know . . . the channels to take and the people to call . . . to assist with pain . . . when that, even that doesn't work then you do feel quite helpless" (N24).

These descriptions of helplessness and hopelessness reflect those recognised in nurses working in a hospital in the USA, within an orthopaedic unit, 20 years ago (Clements & Cummings, 1991). A senior nurse clinician and a manager in the area of education and research were aware staff encountered difficulty when unable to meet their own and patients' expectations of providing pain relief. A process of change began, which culminated in new multidisciplinary pain protocols. Exploratory discussions with nurses in the early stages of the project revealed the extent of nurses' feelings of powerlessness, particularly when caring for patients whose pain persisted and for whom pain relief was previously ineffective.

At around the same time, community nurses caring for elderly patients reported feeling similarly helpless when they felt medical treatments failed to alleviate their patients' pain (Walker, 1994). Later research has continued to report nurses' powerlessness and frustration when the caring relationship crystallises patients' continued suffering and their own inability to provide pain relief (Blomberg et al., 2008; Blomqvist, 2003; de Schepper et al., 1997; Söderhamm & Idvall, 2003). Most recently, Icelandic nurses (n=10) working in acute medical and surgical hospital wards expressed the "powerlessness" and "hopelessness" (p. 2902) they felt when their patients' severe pain continued (Blondal & Halldorsdottir, 2009). That phenomenological study captured nurses' perceived inability to help as well as the emotional legacy when pain relief was refused or ineffective.

In the current study, nurses' feelings of disempowerment most commonly manifested as helplessness when they seemed unable to alleviate patients' ongoing suffering. Some, however, described feelings of disempowerment experienced as manipulation when they felt powerless to protect patients who seemed pain free but

kept asking for analgesics. Most often, nurses described feeling manipulated when caring for people with a history of chronic pain or substance abuse.

Nurses included in the current study suggested that patients who had lived with pain and used opioids over time, tended to tolerate both discomfort and analgesics:

[The] chronic pain patient . . . lives with pain . . . probably built up a tolerance . . . they would've given him lots of drugs before . . . didn't really work for him so he definitely would have lived with pain for a while. (N26)

This tolerance meant such patients could function normally despite their discomfort and often seemed pain free to the outside observer. As one nurse explained:

They've had this pain for so long and we can't see it . . . when they say they've got eight out of 10 pain we don't perceive it in the same way . . . because we can't see anything. They don't have a wound. They haven't had an accident. They haven't had an operation. Their back's been hurting them for the last eight years. Their pain's real but . . . it's not as obvious to us . . . we just don't see it in the same way. (N26)

Some nurses were able to understand why opioid-tolerant patients appeared comfortable. However, others demonstrated that they needed to see patients' distress and incapacitation to accept their reports of severe pain. For example, one nurse on the orthopaedic ward recalled her female patient who had bilateral ankle fractures and a coincidental six year history of back pain. The patient's ability to sleep and mount a coherent argument led the nurse to conclude:

She was actually snoring away . . . probably the pain woke her up but then again when she was reasoning with me about the times, the hours and how much [analgesia] she should get, just really tells me . . . I don't think she's really in pain. (N17)

This nurse's consequent feeling of powerlessness was palpable when, unable withhold analgesia, she recalled feeling: "just really helpless because she is ordered [analgesia] . . . I was just feeling ridiculous but . . . it's written up. [I had to] give it to her . . . I really couldn't argue with her" (N17).

These findings indicated that nurses often felt uncomfortable administering analgesics to patients who they believed were neither distressed nor incapacitated by pain. As was described in Chapter Three, these nurses viewed the nursing role as

protecting patient well-being. However, in this case nurses perceived that risk to patient well-being stemmed not from severe pain but rather from excessive medication. As the last quotation indicates, some nurses saw analgesics as inappropriate and the provision of analgesia as capitulation in this situation. Powerless to refuse patients' unwarranted demands for analgesics, such perceptions often led to nurses' feelings of disempowerment when manipulative patients seemed to thwart efforts to protect them from medication harm. One nurse captured this sense of powerlessness when she confessed:

It feels like crap . . . knowing the fact that I have a patient who is just simply taking advantage of our system . . . [to obtain] medication and walking away not being able to do anything . . . just doesn't make me feel any good. (N17)

Whether nurses experienced feelings of disempowerment as helplessness or manipulation, they described considerable distress, frustration and dissatisfaction. Watching another person's agony was distressing. Feeling unable to protect patients from this suffering was frustrating and dissatisfying. Eventually these feelings drained and exhausted nurses. The following section details data indicating that nurses became distressed, frustrated, dissatisfied and exhausted by the experience of disempowerment.

Nurses' distress.

A finding from this study was that witnessing patients' distress with pain elicited similar distress in nurses. One recounted: "I was . . . stressed . . . I didn't like to see him being in that much pain" (N23). Another remarked:

It's distressing . . . I get distressed . . . I can see she's in a lot of pain and you want to make it better and you know that it's not going to be better in the short period of time and you just feel for them lying in bed. (N05)

A senior nurse suggested this distress could be deeply felt from a long term perspective when she recalled: "patients that you think about from years ago . . . you never really let that go" (N24). These experiences reflect those of Icelandic hospital nurses (n=10), who were found to have felt "profound distress and frustration" (p. 2092) while watching patients suffer with unrelieved pain (Blondal & Halldorsdottir, 2009). That phenomenological study explored nurses' experience of caring for

patients in acute medical and surgical wards and captured the significant upset they felt at not being able to help those in extreme pain.

The findings from the current study indicated that nurses' distress at their inability to soothe patients' pain and anguish was a human response to suffering. As was shown in Chapter Three, comfort provision was found to be underpinned by nurses' natural desire to make it better for those in severe pain. Nurses' responses to patients' anguish, which moved them to assist, have been explained. This further evidence that nurses became increasingly upset when patients' pain persisted builds upon these earlier data. When nurses felt unable to improve outcomes for patients, escalating worry also contributed to their distress:

Because the pain was not under good [*sic*] control, you are so worried saying "what is going to happen" You are worrying about him. You are worrying . . . when they are in pain . . . crying . . . not happy and you know that and you just want them to be comfortable [if the pain is] under control, is getting better, is good. If not under control [the pain is] is getting worse . . . you need to get help. (N25)

As these examples indicate, patients' suffering with severe pain caused nurses considerable emotional turmoil. Apart from witnessing human distress, nurses saw patients' unrelieved pain as evidence of their own ineffectiveness. Consequently, many described significant frustration when their efforts to improve patient outcomes went unrewarded.

Nurses' frustration.

The data proposed that nurses interpreted patients' ongoing severe pain through their own incapacity to produce positive change. These perceptions elicited significant frustration conveyed by comments such as: "when you can't solve that problem it makes you feel . . . frustrated . . . when they're in pain and you can't resolve it" (N02). Having assumed responsibility to resolve patients' pain problems, nurses demonstrated that they became increasingly exasperated when powerless to do so. For example, one nurse remarked:

[You feel] really bad . . . really frustrated, because you see the problem there. You want to find a way that can solve the problem but at the end you cannot.

You cannot achieve it and you see the patient moaning and groaning all the time, very uncomfortable for her as well as for us. (N14)

Another nurse described the consequences when her tireless effort towards comfort provision proved fruitless:

Frustration. I'll just say frustration . . . you can't help but be frustrated when you've done everything you can for someone and it hasn't helped . . . don't feel good . . . when I came on they had eight out of 10 pain. I gave them heaps of analgesia and I went home and they've got eight out of 10 pain . . . you just think "well that was a waste of time and resources . . . what a bad shift . . . I'll probably have them tomorrow, it's going to be the same." (N26)

The example above describes a sense of futility. As was outlined in Chapter Three, nurses' shared regard for well-being provided an imperative to provide comfort. This quotation suggests that nurses' perceptions of being unable to do so underpinned, not only frustration, but also dissatisfaction at a job not done and a role not fulfilled.

Nurses' dissatisfaction.

Nurses' perceived role of protecting patient well-being was outlined in Chapter Three. These data suggest that when patients' pain went unrelieved, nurses' inadequacy in that role was crystallised. Their consequent disappointment and dissatisfaction were captured in comments such as: "you worry that you are not doing your job because you're not making it better" (N24), and "there's nothing worse than feeling like you're leaving the patient in pain . . . we're not meant to do harm, we're meant to do good" (N29). In a similar vein, one senior nurse remembered feeling:

Horrible, absolutely horrible . . . it would be my fault . . . you do go away and you feel dissatisfied that you've [not] done a good job . . . because . . . you haven't made them feel better by the end of the day. (N19)

Nurses demonstrated that they felt answerable for their patients' unrelieved pain and distress. Comments made by two junior nurses were testament to this. One nurse described feeling "pretty rotten . . . when you neglect your patients for whatever reason . . . you always feel disappointed" (N29), while the other felt "really bad . . . even though it wasn't my fault and I was trying to do everything that I could" (N12). Such comments revealed nurses' dissatisfaction and how this experience contributed

to their distress at watching suffering, and frustration at not being able to intervene. It was also evident that the stress engendered by these feelings wore nurses down and, eventually, exhausted them.

Nurses' exhaustion.

The findings indicated that ongoing distress, frustration and dissatisfaction sapped nurses' vitality. They described feeling drained when confronted with patients' unrelenting agony and their own inability to help. One nurse recalled how her constant concern for a patient in pain left her feeling "stressed out, tired . . . relieved that the shift was over" (N26). Another captured the emotional toll when she confessed:

Sometimes towards the end of the shift you get drained out . . . you come to a certain level when you can't take it . . . [to] look at that patient's suffering . . . your energy just wears off. (N07)

This evidence builds on findings from an earlier study observing nurses' care of patients with chronic kidney disease (Manias & Williams, 2007). While those nurses were caring for a defined patient group with complex and long-standing pain problems, they reported similar feelings of helplessness when unable to find medication to address a patient's discomfort. The authors noted how this experience emotionally drained nurses.

In the current study, there was evidence that nurses' concern kept them focused on the distress of patients with unrelenting pain. With little respite from worry and stress, one nurse recalled: "I was in there every twenty minutes but it gets really tiring . . . I can't keep going into her room" (N17). Another nurse revealed that this worry could linger beyond the end of a shift. She took up the story caring for a patient who had blood in her urine and severe abdominal pain during the previous evening and recalled:

[It was] about seven o'clock She was pale and [saying] "it's [the pain is] about an eight, nine out of 10 [pain score]" and that's when I rang [the duty doctor] and got her charted for codeine . . . she seemed to settle and said that the pain was getting better and then she had the vomit about an hour after that I went homethinking . . . I hope . . . what I'd given her was

going to get her through the night . . . ‘cause I knew that she had been in so much pain. (N32)

The implication of this ongoing worry for nurses was decreased opportunity to refresh and revitalise:

[You] take it home with you and you don't sleep properly and you wake up in the middle of the night thinking about them and you start thinking "I've got to go to work soon. I'm going to have to deal with this." (N24)

In brief, nurses indicated that they all faced feelings of disempowerment when unable to provide comfort effectively for patients who experienced severe pain. Moreover, the intrinsic distress, frustration and dissatisfaction of disempowerment could be pronounced when nurses watched this unrelenting suffering and felt unable to assist. The degree to which nurses experienced and managed feelings of disempowerment was found to relate to four conditions in the acute hospital, which determined their ability to produce positive patient outcomes. These involved nurses' (a) levels of empathy, (b) access to effective medication, (c) collaboration with patients and colleagues, and (d) time to care.

Conditions Causing and Influencing Feelings of Disempowerment

In grounded theory, theoretical analysis reveals the conditions influencing the actions and interactions of participants (Strauss & Corbin, 1998). Identification of these intervening conditions allows the grounded theory researcher to capture variation in the phenomenon under investigation and place it in participants' social world (Chenitz, 1986). The findings of the current study indicated that nurses felt able to provide comfort with comprehensive assessment and holistic care. When doing so, they experienced the pleasure, relaxation and satisfaction of nurse empowerment. In contrast, nurses felt unable to alleviate severe pain when they did not understand patients' experiences and felt unable to address physical pain and associated emotional distress. In these circumstances nurses tended to encounter the core problem of feelings of disempowerment and the associated distress, frustration, dissatisfaction and exhaustion.

Characteristics of nurses, patients and the acute hospital were found to influence nurses' ability to understand patients' pain, participate in decision-making, and secure tools for pain relief. These elements combined to produce four conditions, which determined the amount of empowerment or disempowerment nurses experienced at any given time. The intervening conditions involved nurses':

- 1) Levels of empathy.
- 2) Access to effective medication.
- 3) Collaboration with patients and colleagues.
- 4) Time to care.

Nurses' feelings of disempowerment were found to depend upon how much they engaged empathically with patients, could administer timely and sufficient analgesics, collaborated with those around them to implement comfort measures and had time to provide a human presence for patients experiencing severe pain.

Firstly, nurses' *levels of empathy* towards patients in pain determined whether they felt (a) enough concern to provide comprehensive assessment and holistic care, (b) so much concern that they felt distressed at patients' suffering, or (c) so little concern that they felt manipulated when giving analgesia. Secondly, the ease with which nurses could *access effective medication* governed their ability to provide timely and sufficient pain relief. Thirdly, *collaboration with patients and colleagues* influenced how much nurses participated in planning and decision-making. This was important because evidence-based pain management requires complex decision-making, adequate communication with patients, planning, and evaluation in a demanding environment (Samuels & Fetzer, 2009). Finally, the amount of *time to care* available to nurses determined their ability to be physically and emotionally present for patients, explore pain problems and use nonpharmacological strategies. Each of these intervening conditions will now be detailed with supporting examples from the data.

Levels of empathy.

While nurses in this study did not explicate feelings of empathy, their emotional reactions to patients' distress and consequent undertakings to provide

comfort support recent findings about the role of empathic responses in human helping behaviours. Empathy has been described as an ability to share the feelings of another person, in which imagination or observation of another's affective state prompts the same affective state in the observer (Campbell-Yeo, Latimer & Johnston, 2008; de Vignemont & Singer, 2006; Gu & Han, 2007; Jackson, Meltzoff & Decety, 2005). An early concept analysis (Wiseman, 1996) noted debate in the nursing literature about whether empathy should be considered a personality trait, dynamic state or learned skill. Despite the confusion, a defining characteristic of empathy was described as the ability "to see the world as others see it" (Wiseman, 1996, p. 1165). Other attributes were also identified, including that an empathic person is nonjudgmental, able to understand others' feelings and able to communicate this understanding.

Over the past decade, accumulating research in humans using functional Magnetic Resonance Imaging has established that empathy for another person in pain is mediated by the same neural networks that process painful stimuli to the self (Botvinick et al., 2005; de Vignemont & Singer, 2006; Gu & Han, 2007; Jackson, Brunet, Meltzoff & Decety, 2006; Jackson et al., 2005). The same areas of the brain implicated in the physical and emotional distress of one's own pain experience have been found to activate when observing pain cues, such as facial grimacing, in another (Botvinick et al., 2005; Ochsner et al., 2008).

This evidence may explain why nurses in the current study made comments such as: "I don't like to see people being in pain. I don't like to be in pain either" (N23), and "I am in pain when the patient is in pain" (N09). These data suggest that when nurses saw patients' distress with severe pain they were inclined to put themselves in the same situation. A seeming unawareness implied this was a natural response to suffering, which engaged nurses with patients' pain problems. As nurses identified with patients' pain experiences, they were moved to help:

I knew he was dehydrated that . . . wasn't my primary concern, getting his pain under control is always my priority . . . the pain was the priority 'cause that's directly affecting him and impacting on him. (N23)

Such comments suggested that nurses' empathic responses sensitised them to patients' suffering with severe pain and prompted comfort provision. However,

variations were also found in the levels of empathy nurses described towards patients who reported pain, which influenced their interactions and consequent feelings of disempowerment.

The findings indicated that while nurses required enough empathy to prompt comfort provision, their increasing feelings of empathy for patients in ongoing pain could cause them personal distress. Nurses described distress, frustration and dissatisfaction at the perceived plight of anguished patients who they had tried unsuccessfully to protect. The consequent finding was that these high levels of empathy led nurses to experience the helplessness associated with feelings of disempowerment as they intensified their emotional engagement with suffering patients.

Low levels of empathy in nurses towards patients in pain were also associated with feelings of disempowerment in nurses. However, in this situation, nurses tended to experience helplessness as a sense of manipulation. In particular, nurses' feelings of empathy seemed to falter when patients who appeared comfortable repeatedly requested analgesia. Their descriptions suggested that nurses were unable to engage with patients' pain experiences when these were not evident. With too little empathy nurses experienced powerlessness, frustration and dissatisfaction when they felt compelled to give seemingly unnecessary medication. In brief, while having enough empathy prompted nurses to initiate comfort provision, too much empathy could elicit the distress and the helplessness of disempowerment. Meanwhile, too little empathy could lead to disempowerment which was experienced as manipulation. Figure 4 represents the relationship between nurses' levels of empathy and their feelings of disempowerment.

Characteristics of nurses and patients were identified which influenced nurses' levels of empathy and their consequent empowerment or disempowerment, experienced as either helplessness or manipulation. Firstly, nurses' personal experience of pain sensitised them to the impact of severe pain on their patients. Secondly, patient behaviours communicating emotional distress and a cooperative demeanour, as well as visible indicators of pain, facilitated nurses' empathic engagement with the pain experience. These attributes helped nurses share the

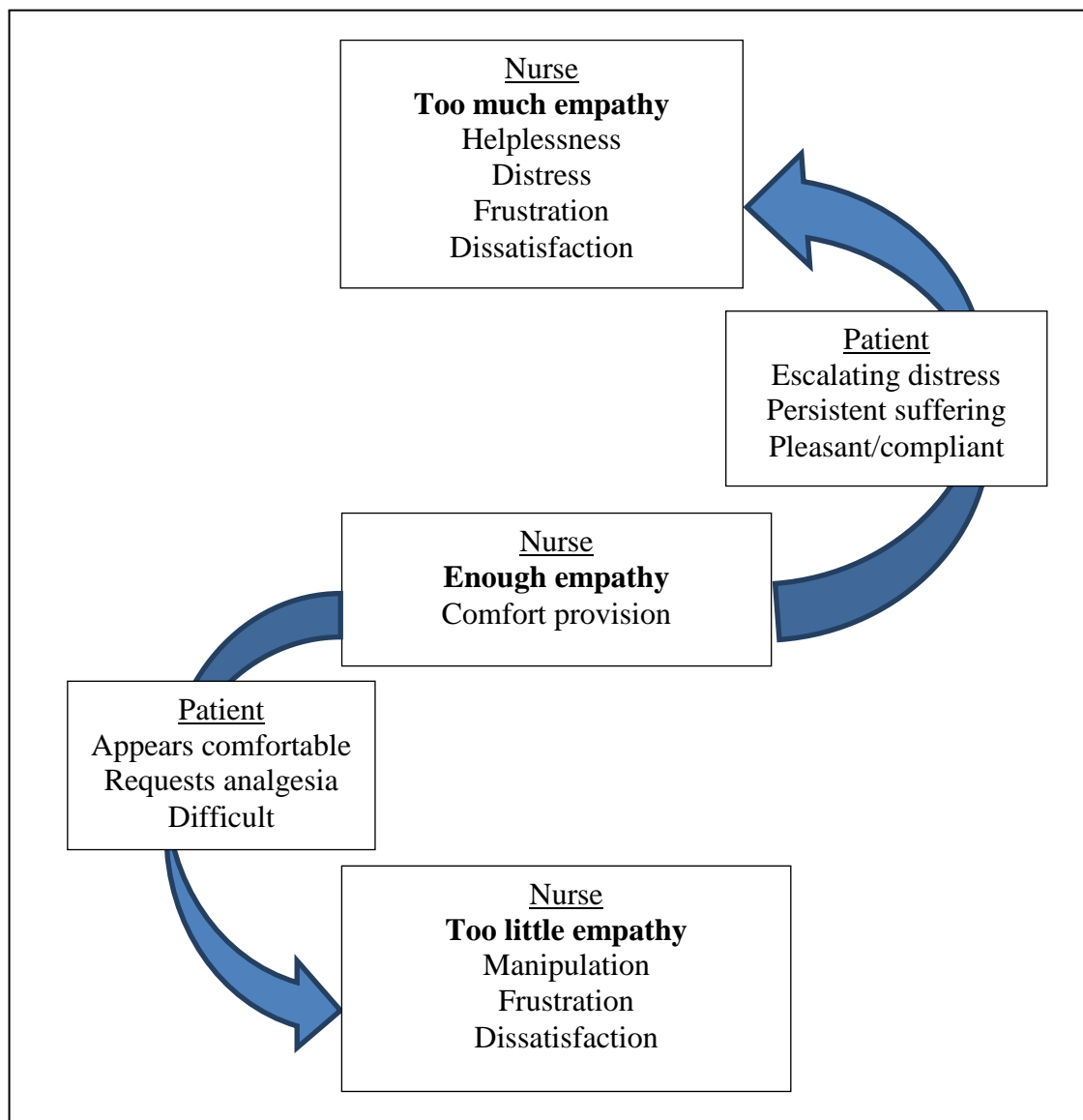


Figure 4. The association between nurses' levels of empathy and feelings of disempowerment.

pain experience and contributed to their feelings of disempowerment when patients' severe pain went unrelieved.

The suggestion that nurses' levels of empathy towards patients can vary is supported in the literature. Early debate about whether empathy was a (static) personality trait or (dynamic) state produced a consensus that people could be disposed toward empathy, although numerous factors determined how empathetic they were at any moment (Wiseman, 1996). A later systematic review highlighted

the subjective, multifaceted nature of nurses' empathy (Yu & Kirk, 2008). Nine studies were included in the review, which reported levels of empathy in nurses ranging from "low to moderately well-developed" (Yu & Kirk, 2008, p. 442). The authors sounded a note of caution however, acknowledging considerable inconsistency in instruments and methods. They concluded that the difficulty of measuring nurses' empathy merely emphasised its subjectivity (Yu & Kirk, 2008).

Nurses in the current study did not express feelings of empathy, although they were aware their responses to patients varied. Their descriptions suggested that well-developed empathic responses alerted nurses to the impact of severe pain and prompted their proactive intervention to alleviate distress and promote recovery. This finding supports other research linking individuals' empathic concern with higher estimates of pain and enhanced communication in the clinical setting (Green, Tripp, Sullivan & Davidson, 2009; Moore, 2010). In the current study, three factors were found to affect how much empathy nurses felt for their patients. These factors were (a) nurses' pain experiences, (b) patients' behaviours, and (c) patients' physical pain cues.

Nurses' pain experiences.

Findings indicated that personal experiences of pain tended to sensitise nurses to their patients' experiences. Nurses were aware that their own pain helped them to understand its impact on others, with one observing: "if you experience it yourself usually you are more sympathetic to somebody else" (N27). Another remarked:

I can empathise with patients who are in that pain . . . from pains . . . I've had in the past and . . . watching my mother suffer with rheumatoid arthritis . . . it's a very personal experience . . . I really listen to patients when they say they've got pain. (N08)

The memory of pain seemed to facilitate nurses' emotional engagement which had consequences for their interactions with patients. As one nurse stated: "I have experienced the pain and what I have gone through, I am more gentle . . . I listen to them" (N07). The data indicated that nurses' personal suffering with severe pain disclosed distress in patients that may not have been immediately evident:

Nurses who've had personal experience of patients' pain . . . the empathy that they demonstrate to those patients is a lot stronger than for somebody who hasn't had that experience, who only see the surface side of things. There's the emotional component with watching someone go through that type of pain . . . they can feel it a lot stronger . . . a lot more attentive, a lot more thorough and they'll go the . . . extra mile to resolve a situation. (N08)

A junior nurse demonstrated the contrasting situation where she felt unable to truly understand the impact pain had on her patients having not experienced it herself. She declared:

As nurses we don't always think about pain . . . the type of pain that someone would experience having a PE [pulmonary embolus] or . . . lung cancer . . . until you yourself actually experience it . . . we don't know what it's like . . . to feel it, so I think it's really hard. (N27)

This finding may explain why Australian (n=52) nurses were observed to respond primarily to surgical pain whilst ignoring pain from other causes in postoperative patients (Bucknall et al., 2007). In that exploration of nurses' practices after analgesic administration, 74 blocks of two-hour observation in two hospital surgical units captured 316 pain activities, of which 14 were reassessments. Apart from the overall paucity of reassessment, it was noted that in 36% (five activities) nurses focused only on the wound when reviewing the patient. The number of reassessments was small, however over a third were concentrated upon evaluation of the wound. Nurses were also observed to leave patients who reported nonprocedural pain waiting for pain relief (Bucknall et al., 2007).

Data from the current study suggests a possible explanation for the findings reported by Bucknall et al. (2007) may be that nurses' own experiences tends to focus them on the impact of surgical pain. For example, one nurse declared: "we've all cut ourselves . . . so imagine having your guts [*sic*] cut open, you go 'that's really hard'" (N27).

The findings also suggested that nurses' concerns for their patients in the distress from severe pain could personalise the experience. When this happened, nurse' levels of empathy and consequent distress increased, as was demonstrated by one senior nurse who observed:

I take a lot emotionally home with me I think and I will . . . lie there and think, “well, if that was my father . . . I wouldn’t want him to be in pain like that” . . . like a lot of nurses do, you take it home with you. (N24)

The proposed impact of nurses’ personal experiences of pain is summarised in Figure 5.

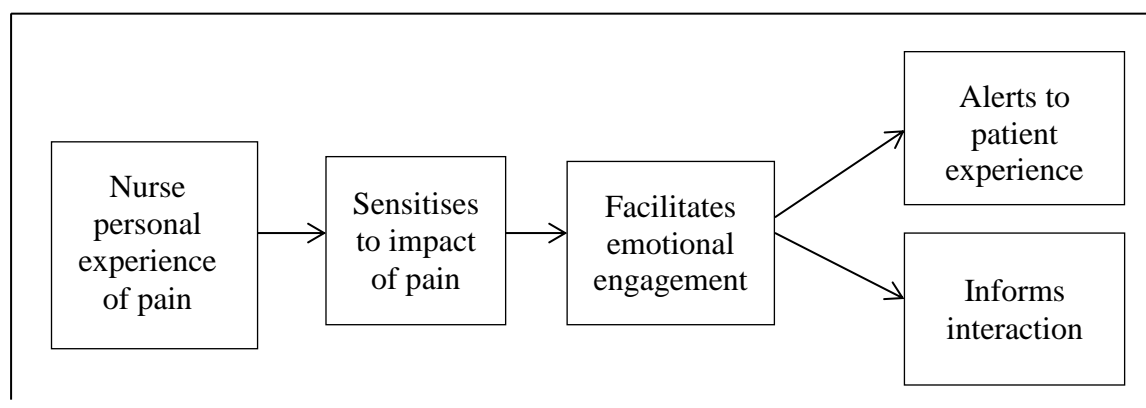


Figure 5. The impact of nurses’ personal experiences of pain

The proposal in this research that nurses’ own pain sensitised them to patients’ experiences supports other work suggesting that previous experiences become particularly important when behavioural pain cues are diminished or absent (Campbell-Yeo et al., 2008). Evidence in the literature demonstrates that, while not imperative for basic empathetic arousal, personal experience of pain can increase neural responses and individuals’ perceptions of pain intensity (Botvinick et al., 2005; Campbell-Yeo et al., 2008; Jackson et al., 2005). Data from the current study indicated that personal experience helped nurses understand the impact of pain on the whole person. Those who had felt pain themselves knew there were effects within, which were not always evident to others. In brief, nurses’ previous pain tended to disclose patients’ experiences facilitating emotional engagement.

While nurses’ personal experiences helped them recognise the impact of severe pain on others, overt evidence of patients’ pain also shaped nurses’ responses. For example, behaviours communicating patients’ emotional distress and willingness to cooperate tended to intensify nurses’ emotional engagement. In contrast, patients’ apparent emotional calm and resistive behaviours tended to dampen nurses’ empathic

engagement. The following section outlines the influence of patients' behavioural and physical pain cues. Nurses' diminished empathic responses to patients who had used pain relieving medication over prolonged periods will also be discussed.

Patient behaviours.

Nurses included in the current study demonstrated that they were able to engage emotionally when patients' distress was obvious. This was particularly apparent when patients seemed to welcome this engagement. However, having engaged emotionally, nurses could encounter feelings of disempowerment when they felt helpless to assist patients whose pain persisted. The contrasting situation was also described.

Nurses described a tendency to dismiss patients whose behaviour did not communicate the emotional distress of severe pain or who appeared disobliging. The data revealed that patients' apparent calm failed to alert nurses to pain. Additionally, patients' seeming resistance to nurses' input tended to dampen natural empathic responses. This lack of engagement could leave nurses feeling manipulated by patients they saw as undeserving. An explanation of the data supporting these findings follows.

Nurses keenly felt patients' distress with severe pain when this was on display. One observed: "if they're crying in pain, that's when it's just awful because you can see it so it has more of an effect" (N23). They demonstrated a tendency to share patient' discomfort with recollections such as: "clearly she was in pain. She was really very restless in the bed" (N05), and "obviously you could see in his face that he was in pain . . . I think he was in a lot of pain and it's not like he was . . . faking it" (N06). This sharing engaged nurses with patients' pain problems. Furthermore, patient behaviours which communicated a pleasant and cooperative nature facilitated this engagement:

She was such a sweet lady . . . you know that she's not going to . . . tell you that she's in extreme pain for attention. She's actually in a lot of pain . . . even with that pain she was still polite and still appreciative of what I was trying to do. (N18)

The data suggested that nurses who engaged with the emotional distress of patients' pain were inclined to accept and act upon patients' self-reports. One demonstrated this point by making the following comparison:

When you get distressed you're quite quick . . . [you feel] "I've got to make them feel better, got to get them comfortable." If you [don't] feel too distressed you don't respond as . . . quickly. (N27)

Such comments suggest that patients' evident distress engaged nurses sufficiently to prompt the proactive approach associated with comfort provision.

If patients' anguish persisted, however, nurses' empathic engagement could intensify to distressing levels. One nurse described her emotional response to the suffering of one patient who had a large, agonising abdominal wound: "she'd . . . just get so distressed . . . howl and cry and it was just awful" (N24). Another recalled her amiable patient, remarking: "she was a really nice lady and it . . . make[s] it hard for me to see her in pain" (N17). Similarly, a nurse recounted caring for a male patient who was under the care of the pain management physicians and experiencing severe back pain. Her description showed how his accepting behaviour increased her feelings of empathy. Moreover, her helplessness at her inability to improve outcomes for this patient was also evident:

The patient was reasonable. Obviously a nice guy, obviously in pain . . . saying "I know it's not your fault." You feel even more for them . . . more compassion . . . he was apologetic to me and saying . . . "I know you're waiting for the doctors . . . I know there's nothing you can do" . . . because he was so understanding . . . I felt even more sympathetic and felt even more bad. (N26)

Later, the same nurse compared her responses to patients on the basis of their behaviours:

I feel . . . so much sympathy for a really, really sweet old man whose got heaps of pain but is not swearing at me [compared] to someone who has some pain and is making my job really, really difficult. (N26)

Nurses' suggestions that they were influenced by subjective feelings for patients supports the conclusion of a small phenomenological study conducted in a hospital in the USA (Richards & Hubbert, 2007). In-depth interviews conducted with three experienced surgical nurses revealed they were aware of personal biases that affected

how “sympathetic” (p. 22) they felt and how willing they were to confront patients’ pain problems. The considerable struggle it took for nurses to put such feelings aside was also described.

In the current study, nurses clearly showed they engaged easily with pleasant, cooperative patients who communicated the emotional discomfort of severe pain. If this engagement intensified however, such as when patients’ pain persisted, nurses could become distressed and experience the helplessness associated with feelings of disempowerment.

This finding may be explained by the proposition that empathic engagement sensitises individuals to others’ pain, mediating caring behaviours but also potentially leaving them vulnerable to distress and anxiety (Decety, 2011). As evidence, a recent study demonstrated decreased empathic neural activity in physicians who are regularly exposed to others’ pain and postulated that this was a protective response that conserved their emotional resources (Decety, Yang & Cheng, 2010). In that study, brain imaging compared the neural activation of physicians (n=15) and matched controls (n=15) who had no medical experience, when viewing images of body parts receiving a needle (painful) prick or cotton bud (nonpainful) touch. While control participants demonstrated increased neural activity when viewing the painful images compared to the nonpainful images, no such differential was seen in the physician group. The authors postulated that physicians’ previous experience “down-regulates” (p. 1682) their emotional responses, dampening the distress and anxiety of watching suffering.

Nurses included in the current study clearly demonstrated that they became distressed when patients experienced obvious ongoing severe pain. This distress prompted them to accept and act upon patients’ self-reports. However, no such inclination was observed in nurses whose patients complained of pain but seemed comfortable or resistant to the care they offered. Rather, some nurses dismissed these patients and deferred comfort provision. Additionally, they described feelings of manipulation, frustration and dissatisfaction when such patients constantly requested analgesia.

The findings indicated that patients’ lack of emotional distress and normal behaviours communicated comfort rather than suffering. Nurses found it difficult to

share patients' pain experiences when these were not evident. For example, one nurse cared for a male patient who experienced severe postoperative pain but said the experience "wasn't as distressing as it usually is because he . . . was . . . internalising a lot of the pain" (N23). Another opined: "you can't visually see that they're in distress . . . if we actually could experience it and feel it, we might actually be better with it" (N27).

These data revealed that watching patients who appeared relaxed and, therefore, not in severe pain tended not to cause nurses to feel distress. Rather, nurses saw little of the emotional anguish expected of severe pain and were inclined to discount patient' self-reports as evidenced by the following:

I know pain is what people tell you but it also has to come with some form of physical response . . . she just woke up and then she said "oh I have pain" but she has been comfortably sleeping for the last two hours . . . then I ask[ed] her "how much pain do you have?" [She answered] "seven, eight [out of 10]" which is . . . unbelievable and looking from the whole body postures and expressions . . . it just doesn't tell me that. (N17)

It emerged that nurses looked firstly to patient behaviours for objective evidence of pain and, secondly, attributed more weight to their own observations than patients' subjective descriptions. The following recollection of nurses' reactions to a female patient complaining of severe abdominal pain illustrates this point:

She seemed like one of those [patients who says] "oh there's nothing wrong with me. I'm fine . . . I'll make my own bed and don't worry about me" . . . but she still says she's in pain. It's a bit tricky . . . she's strolled out here in the middle of the night saying she's in really much pain. Standing here . . . in front of us and saying "I'm in a really lot of pain" . . . how could she be if she has walked out here and is just standing there talking. (N02)

This quotation demonstrates nurses' confusion when confronted by discrepancies in patients' verbal and behavioural communication about pain. They heard patients' descriptions of severe pain but saw patient comfort. The following quotation captures nurses' consequent tendency to question patients when lack of emotional distress seemed to betray their complaints of severe pain. It concerns a young female patient hospitalised with pulmonary embolus on the respiratory ward:

She's independent and she's walking around and she's very calm and she doesn't seem distressed . . . and when she asks for pain relief, it's like [I

think] “well why do you need pain relief? You actually look quite . . . calm” . . . she doesn’t visibly look distressed so there’s a question . . . she visually does not appear that she is in any kind of pain. (N27)

When pressed to resolve inconsistencies such as those described above, nurses showed a tendency to dismiss patients’ subjective self-reports. Their responses to patients with chronic pain provide evidence to support this proposition. Having lived with pain, patients with chronic pain often appeared neither distressed nor incapacitated. While the experience of acute pain triggers sympathetic nervous system activity, manifested by increased pulse, blood pressure, sweating, and pallor; such increased activity cannot be maintained (Berman et al., 2010). When pain is prolonged these physiologic responses diminish as the body adapts to stress, accounting for a degree of variability in the ways people outwardly exhibit pain experiences.

Some nurses in this study indicated an inclination to disregard pain complaints from such patients with implications for pain management, as demonstrated by the two following examples. The first account is from a junior nurse who cared for a patient with multiple leg fractures and a history of chronic back pain. Despite a self-reported pain score of eight out of 10, the nurse concluded the patient was “a woman who’s really not in pain, who’s not trying her best to go to sleep . . . I felt there was not much of an effort” (N17). The second example suggests that after dismissing patients’ self-reports, nurses saw little urgency to provide pain relief:

Someone with acute pain . . . you want the doctor to be there straight away so you can . . . get them the pain relief that they require. Maybe I’d take a little bit more time for somebody that’s [in] chronic [pain]. (N19)

This finding supports observational evidence of nurses (n=52) working in a postsurgical unit of an Australian hospital who similarly tended not to prioritise pain assessment when patients’ pain was intractable (Manias et al., 2004). This study captured 316 interactions, which revealed nurses’ preference for simple questioning when assessing patients’ pain. The authors noted that no assessments were observed when nurses interacted with patients who had long-term pain, perhaps because these patients displayed fewer outward signs of their discomfort. In the current study, nurses also tended to look to patient behaviours as evidence of pain with one nurse admitting:

It will change what I do. Because if he's quite comfortable . . . talking to me . . . maybe talking to someone else on the phone, laughing . . . and he say[s] "I got the pain 10 out of 10" probably you can tell that he's not suffering the worst at that moment. (N14)

The above example suggested that some nurses relied on behavioural pain cues that led them to disregard patients who reported pain but appeared emotionally calm. Again, an explanation may lie in the recent work exploring empathy.

It has been suggested that unconscious processes modify the mirror-like neuronal responses governing individuals' empathy for others in pain (Campbell-Yeo et al., 2008; de Vignemont & Singer, 2006; Decety et al., 2010; Gu & Han, 2007). For example, one study demonstrated that observing a painful event inflicted upon on a face wearing a happy expression weakened human empathic responses (Han et al., 2009). Brain imaging was conducted with volunteers ($n=22$) as they viewed video clips of people receiving a painful stimulus (needlestick) versus a nonpainful stimulus (cottonbud touch). Participants also rated the level of pain being experienced by the subject of each image.

In that study, the findings indicated that participants judged the needlestick injury to be significantly more painful when inflicted upon a face with a painful expression compared to faces with either a neutral ($t(21)=3.596, p < 0.01$) or happy ($t(21)=4.506, p < 0.001$) expression (Han et al., 2009). Analysis of participants' brain images showed that neural activity decreased when they viewed images of the pain stimulus being applied to happy faces. This led the authors to suggest that the brain uses information from both the pain stimulus and the sufferer's facial expression to process understanding of others' pain. Furthermore, observation of happy faces may weaken empathic neural responses by either diverting attention away from or decreasing the reality of the painful event. This finding builds upon previous research establishing that implicit appraisal processes shaped by the observer's judgments about the person or pain modify innate neural processes (de Vignemont & Singer, 2006; Decety et al., 2010; Green et al., 2009; Loggia, Mogil & Bushnell, 2008).

In the current study, nurses clearly indicated that they were less accepting of patients who looked comfortable, regardless of their verbal complaints of pain. The research described above suggests that an unconscious evaluation of patients' behaviours may have dampened nurses' empathic responses to such patients. A

further finding revealed that just as nurses discerned the impact of pain from patients' emotional distress; they also engaged more easily when patients had physical evidence to validate their self-reports.

Physical pain cues.

Nurses' descriptions indicated that some physical pain cues helped them understand and engage with patients' pain. Accounts of caring for patients whose pain related to a medical condition were testament. The nurse who earlier described her young patient with pulmonary embolus explained:

We can't visually see what is happening inside her internal organs . . . so some people would be really good at giving her pain relief, and other people would just go "no . . . she's just whinging" . . . she seemed calm . . . she seemed fine, so people were very reluctant to give her medications. And it wasn't until she started being sick . . . her blood pressure would go up, and her pulse would go up, that people would go . . . "she must be distressed."
(N27)

She again described nurses' questioning of patients who lacked objective indicators of pain:

Medically . . . you can't visually see what's happening inside them . . . so if someone is . . . saying they're in pain but . . . look quite calm it's really hard to judge if they really are in pain or it's just them wanting pain relief. (N27)

Another recollection contained a similar search to explain continuing appeals for analgesia from a patient who had a history of chronic pain:

A lady came in with chronic back pain . . . a long pre-existing condition . . . but the pain was acute in the fact that it was so severe . . . the patient was not able to walk around . . . blood pressure went up, resp[iration rate] went up and her pain was not being managed effectively . . . nothing you could do . . . heat packs, hot showers, massage . . . nonpharmacological interventions as well as the pharmacological interventions . . . it just wasn't working . . . there comes a point where you think is she asking for it because . . . of the addiction or is she asking for it because of real true pain. It's very hard to assess. (N22)

Other Australian nurses have demonstrated similar ambivalence about patients who had little to show for their self-reports of pain (Manias, 2003b). Six nurses working in two gastro-surgical hospital wards were observed. The findings revealed that the

nurses held expectations of how much pain patients experienced depending on their medical condition and the presence or absence of a wound. Moreover, these expectations significantly influenced nurses' pain assessments.

In the current study, nurses seemed to find it difficult to trust patients who had little visible evidence of pain. One senior nurse on the respiratory ward implied this related to the need to resolve discrepancies in patients' verbal and nonverbal communication. He preferred to back his own judgment, which appeared to impede his connectedness with patients:

There's no physical pain that I can see and we're trained to look at . . . pain control and the signs and symptoms . . . and if they're not showing it and they're telling you to give [analgesia], it's going against your grain straight away. (N33)

This nurse also demonstrated a tendency to make judgments about patients in trying to make sense of a confusing clinical picture:

They do come across as a junkie rather than . . . [saying] "I'm in pain" because they . . . don't show any grimacing. They don't show any guarding. They don't show any beading sweats . . . there's no increase of respiratory rate, blood pressure's fine and [they say] "I'm in pain" . . . they're talking on the phone . . . [they say] "can I have some morphine?" . . . [I say] "no" . . . because there's no symptom. (N33)

These data support recent evidence from experienced Icelandic nurses (n=10) who also questioned the honesty of patients whose pain seemed to have an unidentifiable cause, or those who asked incessantly for analgesics (Blondal & Halldorsdottir, 2009). In that study, nurses depicted their inner confusion and experiences of stress when such faced with these inconsistencies.

Many nurses in the current study similarly expressed doubts about patients who seemed to have little to show for their complaints of pain. They described subsequently deferring pain relief. However, one nurse captured the tendency to question the veracity of such patients' self-reports and feeling of being manipulated when she observed:

You sometimes see them looking at their charts. It's not that they know too much . . . it's just being opportunistic . . . in a hospital where you've got access to drugs legally . . . [it's] totally understandable that you would try and

get the maximum you can get while you are in here because it's easy and you can and it's sort of free . . . why wouldn't you? So they do. (N26)

This comment suggests that, having not engaged with patients' pain, nurses saw little benefit in providing pain relief. The outcome was feelings of disempowerment at the sense of being compelled to give analgesics to apparently comfortable patients.

In the present study, comparison of nurses' responses suggested their feelings of empathy affected whether they took a proactive approach to patients who reported pain. This finding contrasts with conclusions drawn by Watt-Watson et al (2000) who explored the impact of nurses' empathic responses on patient outcomes of pain and analgesic dosing (Watt-Watson et al., 2000). In that quantitative study, nurses (n=94) and patients (n=225) across four Canadian cardiovascular surgical units were surveyed. The aim was to determine whether nurses with greater empathy had patients who experienced less pain or received more analgesia.

Methods included an assessment of nurses' empathic responses to a series of vignettes using an analogue tool, the Staff-Patient Interaction Response Scale (Watt-Watson et al., 2000). Nurses' knowledge and beliefs about pain were also measured with an instrument developed by the researchers from previous research. In addition, patients were asked to complete the Short-Form McGill Pain Questionnaire and to use an analogue scale to indicate how attentive they felt nurses were to pain. Statistical analysis revealed that, in general, the nurses were moderately empathetic. There was some variation between individual nurses' levels of empathy, however patients whose nurses were more empathetic did not report less pain. Indeed, most patients reported significant pain over the previous 24 hours and were undermedicated. There was some variation in nurses' empathy according to the knowledge and beliefs about pain management and evidence that younger nurses were more empathetic than their older colleagues (Watt-Watson et al., 2000).

Evidence from the current study tend not to support the findings reported by Watt-Watson et al. (2000). Nurses included in this research demonstrated a clear tendency to accept and act upon pain reports from obviously distressed patients who welcomed the care they offered. In contrast, they were inclined to dismiss self-reports pain from patients who appeared comfortable, who lacked visible evidence of pain, or who were difficult and demanding. It was beyond the scope of this study to

quantitatively measure nurses' empathy and consequent pain management practice. However, this qualitative inquiry and inclusion of nurses from medical and surgical wards revealed that nurses' feelings of empathy towards patients can vary and contribute to feelings of helplessness or the sense of being manipulated.

Summary of levels of empathy.

The findings of this research indicated that well-developed feelings of empathy prompted nurses to acknowledge and address patients' severe pain, which led to experiences of empowerment. When nurses' empathic engagement intensified with patients whose pain persisted however, they could experience personal distress and helplessness as they watched ongoing suffering. Previous experiences of pain tended to sensitise nurses to others' experiences and enhance their empathic responses. Additionally, patients' obvious emotional distress facilitated nurses' emotional engagement. In contrast, patients' apparent emotional calm and lack of distress or physical pain cues tended to dampen nurses' natural empathic responses. A consequent disregard for patients' pain reports, deferral of comfort provision and questioning of patients who requested analgesia was evident in some nurses, which could impede their connectedness and leave nurses feeling manipulated.

Accepting pain was a first step toward comfort provision. Findings indicated that nurses' empathic engagement prompted proactive intervention to address patients' severe pain. Nurses then required resources to effect pain relief. Central to this was administration of timely and sufficient analgesia, considered most effective to treat physical pain. Accordingly, the ease with which nurses could use effective medication to soothe patients' distress and restore function was found to influence their feelings of effectiveness and consequent nurse empowerment or feelings of disempowerment.

Access to effective medication.

Nurses included in this study indicated that they looked primarily to analgesic medication to solve patients' severe pain problems. For example, nurses observed: "it's distressing when people are in a lot of pain . . . we need to sort it out. So look at their drug chart, see what we can give them for pain, how to make them more

comfortable” (N19), and “I straight away thought of, if she’s written up for [prescribed] any medication” (N09). While nurses considered emotional support and nonpharmacological comfort measures to be important, these approaches were discounted in favour of administering timely and sufficient analgesic medication. This finding reflects the actions of nurses working in five Victorian renal units who cared for patients with chronic kidney disease and who relied only on medication to relieve pain (Manias & Williams, 2007). In that study, 104 nurse-patient communications about pain were observed amid 52 hours of observation. Nonpharmacological strategies were not captured in any of these observations.

Nurses in the current study indicated that they used patients’ individual medication charts as a framework to guide their decision-making about analgesic administration. The prescription of various medications provided nurses with scope to select analgesics and choose the dosages and administration times and routes to best meet their patients’ needs. Accordingly, the medication chart provided an initial and ongoing reference for care. For example:

I just had to see what he was charted for . . . what was available that we could give him . . . regular paracetamol, which he had been having . . . the maximum dose . . . of his oxycodone [opioid analgesic]. (N06)

Participant observation of nurse caring for an elderly patient awaiting a skin graft to treat a large leg ulcer confirmed this practice. An excerpt from the field notes made of Observation Nine follows:

27/10/2008

11.15 [The nurse] had the medication chart open and referred to it as she spoke to the patient . . . the nurse expressed concern for the patient in pain, both verbally and in her facial expression. She referred to the medication chart and indicated the patient was written up for oxycodone [opioid medication], which she has been given, and could be given a further dose in an hour and a half. She then looked at the Panadol [paracetamol] order on the chart and . . . [said] “I see you have been refusing your regular Panadol” . . . the patient replied that she doesn’t like to take tablets if she doesn’t have to. The nurse gave her the Panadol tablets and then said that she could give her a further dose of oxycodone in an hour and a half. (Observation 9)

Nurses’ predilection for analgesics stemmed from the belief that pharmacological strategies were most effective to treat physical pain and that liberal

analgesic dosing was most appropriate for patients whose pain was severe. One nurse illustrated this point when she recalled:

[I] asked him his pain and he said “seven” so straight away I just looked at his chart . . . he’d missed his regular analgesia ‘cause he was in Theatre so I gave all that plus . . . I made a decision to give the breakthrough [analgesic dose] as well . . . [it was] a very painful procedure, so I felt instead of letting it . . . get worse . . . [I decided to] give everything that he’s missed and give him the breakthrough. (N26)

However, nurses were also aware that analgesics potentially caused adverse effects. Their shared regard for well-being prompted nurses to balance the prospective benefit to patients of administering analgesia with the risk of incurring detrimental side effects. Accordingly, nurses’ use of effective medication involved selecting the type, dose, time and route of analgesic administration according to the quantity and quality of patients’ pain. Comprehensive assessment provided the basis for this decision-making and numerical pain scoring was a useful tool. As one nurse observed: “someone on a two or three [pain score], we might give something like a Panadol . . . rather than giving the oxycodone [when there are] lots of side effects from it” (N09).

This evidence proposed that nurses implicitly calculated risk as they chose analgesics and titrated for effect. One nurse demonstrated how she figured patients’ functional needs into her analysis:

I believe if you’ve got pain you should take something for it. You shouldn’t leave it untreated because it will either get better with the treatment or it may be getting worse . . . obviously it depends on what you’re trying to do but . . . if a patient will be actually in bed so it doesn’t matter if they fall asleep so they’re not trying to function. (N01)

Despite their patent awareness of analgesic benefits and risks, nurses found that the subjectivity of pain meant it was difficult to gauge how medication would affect each patient. Therefore, effective comfort provision necessitated a degree of trial and error. One nurse recalled: “we were trying to give the [analgesic] to see how he goes with it . . . everyone is different. Everyone reacts differently to medications” (N09).

Notwithstanding the inherent risk, all nurses included in this study described the perception that using pharmacological strategies to control physical pain was

crucial to their ability to provide comfort. With appropriate knowledge and an effective prescription, they had tools to select, titrate and prepare timely and sufficient doses. These tools could be used effectively when patients accepted and tolerated sufficient analgesia to relieve distress and restore function. When they did so, nurses described the enjoyment and relaxation of nurse empowerment.

Findings indicated that when effective medication was available, nurses felt confident to help their patients. They relaxed as the perceived threat to patient well-being diminished and took pleasure in patients' improvement. For example, one nurse recalled feeling "good because . . . the Tramadol worked . . . [and having] analgesia . . . in place . . . so we don't necessarily have to get to where it got to last night" (N32). Another stated: "once we got the ketamine infusion started, the pain dropped . . . and went back to down to a two out of 10 and she had a quite comfortable night. So that was good" (N20). In contrast, there was a sense of struggle in accounts from nurses who were unable to give timely or sufficient medication. This particular nurse's later comment hinted at the helplessness and frustration that could result:

I think the ketamine infusion was stopped for a while . . . her pain started to increase again . . . if pain is allowed to increase it's a lot harder to bring it back down again . . . we found that once her pain had increased it was really hard to get it back down again. (N20)

The data proposed three factors which contributed to nurses' ability to use pharmacological pain relief and their consequent feelings of empowerment or disempowerment. Firstly, knowledge of patients and pain management facilitated nurses' ability to navigate the complexity of pain relief. Secondly, an effective prescription provided authority to give timely and sufficient analgesics. Lastly, a recipient patient who reported pain and accepted and tolerated analgesics allowed efficient implementation of pharmacological strategies.

Nurses' knowledge.

Nurses in this study demonstrated that knowledge of patients and pain management informed their analgesic decision-making and interventions. Knowledge of patients helped nurses to understand their pain experiences, preferences and comfort needs. Knowledge of pain management allowed nurses the flexibility to negotiate complex medication regimens. Adaptability was important as nurses in the acute hospital are required to select and titrate combinations of opioid and adjuvant analgesics using around the clock and PRN dosing to individualise pharmacological strategies and meet patient needs (Grinstein-Cohen, Sarid, Attar, Pilpel & Elhayany, 2009; Macintyre et al., 2010; Manias, 2003a; Moss et al., 2005).

In the current study, nurses demonstrated that an understanding of their patients and applied knowledge of pain relief equipped them to optimise pharmacological strategies. In turn, they reported a measure of relaxation as their concerns for patients diminished. As one nurse proclaimed: "knowledge is power" (N08).

This finding supports other work suggesting that nurses' knowledge, which encompasses theoretical, personal and ethical aspects, is integral to effective pain management (Blondal & Halldorsdottir, 2009). Analysis of the concept of knowing in nursing found it to be "a uniquely personal type of knowledge, constructed of objective knowledge interfaced with the individual's awareness and subjective perspective on personal experience" (Bonis, 2009, p. 1330). Ashley (2008) described the "Four Cs of Pain Management" (p. E74) as being competence, continuity, commitment and compassion. In her view, competence related to nurses' theoretical knowledge about pain management, which imbued confidence to safely administer medication and collaborate with colleagues (Ashley, 2008).

Knowledge of the patient facilitates application of pain management principals to meet individual need and manage perceptions of analgesic risk (Blondal & Halldorsdottir, 2009; Willson, 2000). Observation of Australian nurses has also shown the importance of knowledge for nurses' confidence and clinical decision-making, particularly in the management of complex pain in patients with comorbidities (Bucknall et al., 2007; Manias & Williams, 2007). Sources of

knowledge include written texts, senior nurses and multidisciplinary teams (Manias & Williams, 2007; Watt-Watson et al., 2001).

Nurses in the current study suggested that knowing their patients helped them individualise effective and safe pain relief. Over time, they could develop knowledge of patients' needs and wants. For example, one nurse commented: "if you're looking after a particular patient for two or three days you know what they need and, therefore, you can provide it more effectively" (N22). Knowing the patient also tended to facilitate the comprehensive assessment and holistic approach, which characterised effective comfort provision. As this nurse explained:

You can just care holistic[ally] rather than looking at a few points . . . you can see the patient not as in . . . "this respiratory problem" . . . but . . . "where are they living, how are they living? What does the illness mean to them? How does it affect them?" . . . you can go in knowing what they've experienced . . . what their supporting factors are, how they have managed other things in the past . . . where they're coming from and where they're going and whether this pain is new or old, chronic or acute . . . what other pains have they experienced and how they worked through those. (N29)

In the literature, knowing the patient has been explained as understanding an individual's unique patterns and viewpoints (Bonis, 2009). Knowing the patient was found to contribute to newly qualified nurses' (n=8) positive experiences when working on surgical wards in a UK hospital (Jackson, 2005). This study used a phenomenological, descriptive approach to explain the components and benefits of a good day for these young staff. Although not specifically focused on pain management, notions of effectiveness, relationships, satisfaction, achievement, collaboration and the "privilege" (p. 90) of providing comfort emerged in the data (Jackson, 2005). Findings of that study indicated that knowing the patient as a person was important. A link between this knowledge and nurses' ability to empathise through reflection on their patients' emotional experiences in hospital was also made. More recently, Australian nurses (n=11) working in an acute care hospital ward emphasised the importance of knowing their patients if they were to understand their needs and preferences and then tailor individualised care (Bolster & Manias, 2010).

In the current study, a senior nurse described her care of a patient who had a tracheostomy. She showed how the knowledge she accumulated over consecutive

shifts enhanced her ability to understand and respond to his experiences of severe pain:

I know him . . . I know how to communicate with him already ‘cause there’s been that communication . . . deficit since he’s been here. He hasn’t been able to talk properly because he’s had the tracheostomy . . . I know him well enough . . . to help me in that respect. (N19)

Caring for patients over time facilitated this knowledge as evidenced by the following recollection:

I looked after him before . . . with the background knowledge of the patient, you are able to look after him effectively . . . because then you know his routine, how he likes that and you can bring new things into it and he can in turn give you feedback. (N22)

A senior night duty nurse demonstrated that she could anticipate analgesic risk with knowledge of her patient, instilling a measure of relaxation. Initially she had struggled to administer sufficient medication safely to a patient with advanced mesothelioma. Without enough information to inform decision-making, she became “torn, stressed . . . really worried about his resp[iratory] rate and concerned . . . just that balancing act . . . being my first night looking after him” (N28). However, in getting to know her patient she came to understand his capacity to cope with necessarily large doses of medication and her worry eased:

I was a lot more relaxed . . . the second night looking after him because . . . he had survived . . . knowing the patient . . . just to know that they obviously do have this tolerance for the drug . . . and . . . their [oxygen] saturations are still alright even though they are breathing slowly. (N28)

This quotation indicates that patient knowledge helped nurses to handle the subjectivity of pain and analgesia. Knowing their patients’ needs, wants and responses to medication informed nurses’ decision-making and engendered the relaxation associated with nurse empowerment.

In contrast, nurses grappled with pain assessment and analgesic decision-making when they lacked understanding of patients’ needs and wants. When asked how she assessed patients who had a lot of pain, one nurse answered: “if you haven’t met them before it’s hard to gauge” (N18). Similarly, another claimed: “if you look after a patient for the first time it takes you a little bit longer to work out their needs”

(N22). Nurses who lacked knowledge of their patients struggled to read nuances in behaviour. One young nurse recalled how she took some time to realise her patient was experiencing a severe headache:

That was the first time I'd met her . . . now that I know her personality I can tell . . . she was in a lot of pain but I just saw her then so I just thought she was one of those people that just rest in bed and sleep all day but she is completely not like that. (N21)

Getting to know patients who were not admitted for long was particularly difficult:

[There are] implications of short term stays . . . the ability to get to know a person and what other things might work for them . . . and offer them alternatives to medication like a back rub or a hot pack or . . . some other form of alternative therapy . . . you have to know the person to be able to do that. With a short [stay] person you don't really get that chance to find out. (N24)

Moreover, nurses felt they were constrained not only by their lack of knowledge about patients, but also by patients' unfamiliarity with them. As one nurse explained:

I had never met her before . . . I had just walked into the room . . . this new figure standing over her . . . like this stranger coming in and when it's a stranger . . . I suppose you answer them differently. (N21)

The data from this study suggest that nurses had difficulty selecting and titrating medication without understanding the quantity and quality of patients' pain. They could only guess at the most effective approach. As one nurse observed: "I've had a new patient today and it's . . . makeshift . . . how I would normally do it, but that's not necessarily how it would be effective for that patient" (N22). Another reflected on her care for a patient diagnosed with pancreatic cancer who reported severe pain with a numerical score of nine on scale of zero to 10:

If I were looking after him again the decision would be to ask him "well how do you think that worked? Did it get it under control quickly" . . . but having not looked after him before I didn't have that judgment. (N01)

Once nurses had knowledge of patients and patients' pain problems, they integrated knowledge of pain management to optimise solutions. As one reported: "prior understanding of pain and pain management really helps you" (N07). This perspective suggested that nurses' clinical experience translated their theoretical

knowledge to practice. In her concept analysis of knowing in nursing, Bonis (2009) argued that knowing is unique for each nurse. It arises through experience, as empirical, clinical and personal information is integrated. With reflection, the clinical application of knowledge brings understanding and meaning, which develops nurses personally and professionally (Bonis, 2009). It is this personal knowledge that helps nurses to appreciate the experiences of others and tailor a plan of care.

In the current study, the data proposed that understanding the complexity of pain management gave nurses flexibility to take a holistic approach to comfort provision. For one nurse, this meant:

Looking at not just the pain but what else might be going on . . . it just comes with experience . . . knowing that pain isn't just a physical thing, that it's affected by a lot of other things. (N24)

Senior nurses were aware that the knowledge, which accumulated through clinical experience, facilitated independent practice and a sense of effectiveness. One described:

A new policy where we're allowed to . . . step down patients from PCAs [patient controlled analgesia] to oral analgesia by meeting certain criteria . . . it's given us a little bit more autonomy . . . for the more senior nurses . . . for the junior ones . . . they still need a bit more direction . . . but yes it certainly gives the senior nurses more room . . . to do what they think is right. (N15)

In contrast, younger nurses' lack of applied knowledge was thought to compromise their ability to:

Manage it [pain] in a practical sense. They may have had a theoretical background of how analgesia works . . . what [the] pain Gate Control [theory] is . . . they've had in theory in university but they haven't necessarily experienced it on a practical level. (N08)

The experience of another junior nurse supported this idea. She described how her clinical experience was developing her ability to apply generic pharmacological knowledge to her patients' pain problem:

I had a lot to learn about acute pain . . . I had to learn a lot about how to handle it with drugs . . . I've had to learn . . . how they interact with each other and which one's best to give first and if one doesn't work, what to do as well. (N21)

Another young nurse made a similar point by contrasting her practice with that of her elders. She suggested that inexperienced nurses' lack of working knowledge narrowed their pain relief options:

We are very quick to just give . . . morphine . . . as a junior nurse . . . [the senior nurses explain] "you're giving morphine to try and decrease their respiratory rate so that they can breathe easier." Ok, now I feel more comfortable giving morphine or . . . [the senior nurses say] "if someone's complaining of pleuritic chest pain, go [give] this . . . if they're still in pain, go [give] this" . . . As a junior nurse, I think when you look at pain relief you [say] . . . "I'll pick that one" or "what did they have last time? We'll just go with that again" . . . I don't think we go through why the different drugs will be effective to different people [or] what drugs would probably be a good first-line, second-line, third-line. (N27)

No nurses in the current study described sourcing knowledge from analgesic guidelines to direct their practice, nor were any instances of nurses accessing written information captured during participant observation. This finding reflects the perspectives of nurses (n=62) who cared for patients with chronic kidney disease in five Australian hospital units, 70% of whom reported a lack of available pain protocols (Williams & Manias, 2007a). Yet, when caring for patients with complex chronic illness, nurses are likely to need more direction than the WHO analgesic ladder can provide (Williams & Manias, 2008).

One junior nurse in the current study made an indirect call for guidelines to support her practice. She implied that nurses used an intuitive protocol, which had clear limitations, when she stated:

If you had a step one, step two, step three plan . . . I think our version of the "step one, step two, step three plan" is step one give analgesia. Step two . . . assess pain . . . step three, reassess pain . . . and then if you still can give any analgesia, just give it all and see what happens . . . if not controlled, call the doctor . . . and after that, no, there's nothing else to do. (N17)

However, another young nurse suggested that guidelines, if available, may not be used when she remarked:

I know . . . there's like a pain flow chart and I haven't read that yet and I know I should (laughs) . . . that's probably what would help me Is there a pain one there? (gestures to filing cabinet in handover room) . . . Yeah it's at the bottom. I haven't had to open it yet but I know that it's there (laughs) I always just ask the nurses. (N21)

The data revealed that nurses who lacked pain management knowledge could struggle to protect patients from suffering. Two senior nurses suggested that inflexibility hampered their less experienced colleagues. The first nurse described the need for:

Not just knowledge but physical experience of doing things . . . for comfort and pain . . . they [junior nurses] can get really distressed by people in a lot of pain because . . . they're thinking "well I've given all the pills I can give them . . . that should have worked" and they can't necessarily think and develop their own ways of . . . wrangling around a bit with people. (N24)

The second nurse had found that both the experience of watching suffering and unfamiliarity with pain management magnified new nurses' feelings of ineffectiveness. She observed:

For them it's very . . . distressful [*sic*] . . . until they find the strategies to be able to manage that particular patient's pain . . . first exposure is really quite traumatic . . . they may have had a theoretical background of how analgesia works . . . in university but they haven't necessarily experienced it on a practical level . . . dealing with the emotion that comes with the pain that the patient's experiencing . . . the sense of initial helplessness until they get their thought processes back [and say] "right this is the way we manage the pain." (N08)

In brief, nurses found that knowledge of patients and pain management allowed them to map a path through the complexity of analgesic decision-making. Understanding patients' pain problems and having the flexibility to use medication to best effect tended to increase nurses' feelings of effectiveness. In contrast, unfamiliarity with patients, their pain problems and with analgesia could constrain nurses' ability to respond with timely, tailored pain relief. The potential for nurses to be left feeling helpless as their patients continued to suffer with severe pain was evident. While knowledge was a starting point for nurses' pharmacological strategies, a further requirement was an analgesic prescription authorising the administration of sufficient analgesia to alleviate patients' distress and incapacitation.

An effective prescription.

In the acute hospital, it was the responsibility of the patient's doctor to prescribe analgesia in the medication chart. Findings indicated that nurses felt comfortable when a prescription authorising appropriate analgesic medication was at hand. For example, two nurses remarked: "he's charted for the morphine two hourly . . . it's comforting to know that if my patient's in pain I can give him something" (N30), and "I took comfort in that I was giving the maximum [dose of analgesic] that I could and that I was doing everything I had available to me" (N29). In contrast, nurses described a sense of helplessness without the guidance and authority of an appropriate prescription as evidenced by one nurse who recalled: "her pain had started to creep up . . . there was nothing else to help her 'cause there was nothing else prescribed" (N18).

From another perspective, nurses indicated they felt less frustrated when they had authority to give analgesia to patients who made repeated demands for analgesia. As has been shown, nurses could feel a sense that they had capitulated when giving painkillers to patients who appeared comfortable but seemed to demand analgesia. Having a prescription on hand, while not necessarily alleviating feelings of manipulation, tended to reduce the frequency of patients' request. This point was made by the nurse who earlier described caring for a patient with multiple leg fractures and history of chronic pain. After describing the patient's apparently normal function despite a self-reported pain score of eight out of 10, the nurse declared:

[What] helped me? Well the doctor's orders . . . I am allowed to give [analgesia] two hourly so that . . . this lady wouldn't be . . . telling me that she's in pain for the next four hours. (N17)

Accordingly, from these nurses' perspective, an effective prescription was one that allowed them to give sufficient medication either to address severe pain or to forestall baseless demands for pain relief.

An effective prescription was also one that enabled the nurse to match the most appropriate medication to the type of pain being experienced and to give a dose that decreased pain intensity without causing adverse effects. One nurse summed up this optimal approach when she described her perception of regional analgesia: "I

find it is very good . . . regional analgesia can give adequate pain relief with the benefit [that] you haven't got those side effects" (N14).

In contrast, a prescription was considered ineffective when the medication dosage was insufficient, as one nurse lamented: "[the] most annoying is . . . [a] piddly [trifling] dose of analgesia, like for a 150kg person . . . 1mg of morphine or something, six hourly . . . what's that going to do?" (N27). A similar helplessness emerged in the description of another nurse who observed:

[A] really heavy, big patient and the dosage they've charted is really small . . . it may not touch them and you have to get in touch [with the doctor]. By then the time has gone . . . the level of pain or threshold . . . has gone and then it's too late . . . it doesn't help. (N07)

An inadequate prescription tended to preclude nurses from taking a proactive approach. For example, one nurse observed: "if . . . the patient doesn't have what they need for you to be able to give them . . . you're chasing that up. That can take . . . ages" (N23). She described implications for both patients, who remained in pain, and nurses, who became tired with ongoing worry: "I was so . . . frazzled. I was so glad to leave that day . . . there's this poor man who's not written up for enough [analgesia], bent over, grimacing" (N23).

Nurses who had a prescription authorising administration of sufficient analgesia tended to feel confident to respond promptly and effectively to patients' pain problems. Patients who accepted and tolerated analgesia allowed nurses to use this authority to administer timely and sufficient medication. In contrast, patients' unwillingness to take analgesics or sensitivity to medication could preclude nurses' capacity to give painkillers in amounts they felt necessary to alleviate distress and incapacitation.

Patients' willingness.

In this study, patients' willingness referred to their preparedness to disclose information about pain experiences and to use pain relief medication in doses offered by nurses. Patients' descriptions of pain, expressed as words or numerical scores, alerted nurses to pain problems and facilitated analgesic decision-making. For

example, one recalled caring for a patient who had undergone extensive skin grafting and was willing to share his experiences and stated:

He's able to communicate his needs very, very well and what works best for him. His feedback . . . has been excellent . . . if the dressings were causing him pain . . . or what we were using . . . he would always give feedback. So he was very aware and very knowledgeable of his condition plus his treatment which also helped us a lot. (N22)

However, not all patients volunteered information about pain. This was evidenced by the researcher's experience during participant recruitment for the first structured observation. A male patient with pancreatic cancer had reported severe pain, which he scored at nine out of 10 on a zero to 10 scale, and expressed interest in participating. When the researcher approached the senior nurse caring for him, she conveyed surprise and remarked: "he didn't express pain . . . he never expressed anything about his pain at all" (N01). In a later interview, this particular nurse lamented her patient's reluctance to report pain and suggested his unwillingness prevented her from using medication effectively:

If he communicated it with me, just told me . . . if I had realised he had that degree of pain I would have actually given him . . . something else to get right on top of the pain straight away. (N01)

This experience reflects the findings of two research endeavours exploring patient participation in pain-related decision-making in Australian hospitals. The first study was conducted in two surgical units, involving 52 nurses and 312 postoperative patients who participated in 316 pain activities (Manias, Botti & Bucknall, 2006). The second study captured 103 pain activities in five renal units, involving 14 nurses and 53 patients with chronic kidney disease (Manias & Williams, 2008). Both investigations revealed that the majority of patients' decisions about their analgesia were made using a passive style in ways that suited nurses. The findings demonstrated that 60% of postoperative patients and 76% of renal patients were passive recipients of nurses' analgesic decision-making, preferring to be approached about pain. Some relied completely on nurses, who kept control of the interactions, to solve their pain problems. In each study, less than a quarter of activities involved more collaborative problem-solving, where nurses and patients discussed options and worked together toward pain relief. Even fewer, 17% of postoperative patients and

6% of renal patients, were observed to initiate the interaction, consider options and make the final decision.

In those Australian studies, patients who participated in collaborative or active decision-making appeared confident, communicative and likely to receive analgesia. In contrast, those who eschewed decision-making were feeling vulnerable in the unfamiliar hospital, emotionally upset, experiencing cognitive effects of depression or confusion, or preferred not to bother busy nurses (Manias & Williams, 2008). These conclusions tend to support the suggestion from the current study that nurses valued collaborative relationships, but found that patients' reluctance to communicate about pain was common. Moreover, Manias and Williams' finding (2008) that passive patients received less analgesia offers support for the notion arising from the current study that patients' unwillingness to report pain precluded nurses' proactive use of analgesic medication.

This proposition was supported by evidence that patients' unwillingness to communicate left nurses oblivious to their need for pain relief until pain became severe. One nurse observed:

[The patient] hadn't let them know . . . she'd put up with it and then she only told . . . staff when it was unbearable . . . they don't want to take medication and they . . . only let you know when it's unbearable. (N18)

A paradox also emerged when nurses found patients reluctant to report pain but relied upon them to do so. For example, the nurse who cared for her patient with pancreatic cancer acknowledged his reserve and then anticipated he would initiate pain communication nonetheless:

[He] didn't communicate a lot about it so and so I left it for him. I made that assessment that he was capable of communicating . . . I left it for him to decide and I think I might have said "look, don't leave it too long. We want you reasonably comfortable but I will let you decide." (N01)

A similar tendency was observed in Canadian hospital nurses (n=94) who also recognised some patients were reluctant to broach the subject yet waited for them to voluntarily report pain (Watt-Watson et al., 2001). These perspectives reflect those of Australian renal nurses (n=62) who were surveyed about pain management and identified the reluctance of their patients to communicate as a major barrier to their

ability to control pain (Williams & Manias, 2007a). In that study, 164 nurses working in five Victorian renal units were invited to complete a self-administered questionnaire exploring their knowledge, perceptions and practices. Of the 39% (n=62) who responded, 47 nurses found patients' preference not to report pain and 36 nurses found patients' refusal to take analgesics limited their ability to provide comfort. One nurse in the current study demonstrated how this unwillingness to communicate could increase nurses' levels of anxiety and worry. She recalled caring for a patient with peritonitis and increasing abdominal pain:

He was . . . hunched over and just being very, very quiet so it took me a while to realise, because . . . he wasn't verbalising, that he was in lots and lots of pain . . . it took me like an hour . . . and then I started getting a bit worried about him, a bit stressed. (N23)

In an effort to explain these behaviours, some nurses cited patients' preferences not to bother staff or concerns about medication side effects. One nurse mused: "you wonder if they [don't] . . . tell you how they're feeling sometimes because they don't want to bother us" (N05). Others made comments such as: "he didn't want to get hooked . . . he did have the perception that if he used too much now it might not be beneficial for him" (N01), and "she was having the Panadol [paracetamol] but she was really reluctant to have anything else . . . she thought that . . . morphine . . . was going to interfere with [blood clotting]" (N32). These perceptions are supported in the literature with a number of other studies attributing patients' unwillingness to report pain to their lack of knowledge and confidence, perceptions they ought not to talk about pain, or reluctance to interrupt busy nurses (Bédard et al., 2006; Blomberg et al., 2008; Bucknall et al., 2007; Carr & Thomas, 1997; Manias et al., 2002; Manias et al., 2004; Manias & Williams, 2007; Watt-Watson et al., 2001).

In the current study, nurses commonly described perceptions that patients' exaggerated fears of side effects fuelled their refusals of the analgesics offered to them. One recalled her patient's concern about "problems with her bowels . . . she was reluctant to take it [analgesia] so she went almost all day since [*sic*] the morning till about five o'clock at night without anything. She was just in agony" (N04). Observational data confirmed these perceptions. Observation Three captured a nurse

working on the orthopaedic ward caring for an elderly patient who had undergone hip surgery. An excerpt from the field notes follows:

25/10/2007

1055: The patient stated that she had been sitting in the chair for so long that her leg was cramping . . . The patient was unable to straighten her legs and weight bear on the first attempt. She asked for more time to allow the cramp to settle. As the patient was waiting to attempt to stand again, she moaned and grimaced. The nurse spoke a few times and then asked “do you want some painkillers?” The patient replied “no.” (Observation 3)

This observation involved an elderly patient. In their interviews, nurses suggested it was often older people who worried about analgesics and consequently refused medication. For example, one nurse recalled:

He has just had a knee replacement and . . . he thinks that he shouldn't take it [analgesia] too much because you keep offering it and he says “oh, I've had enough painkillers to last me a year” . . . but he says he's still in pain. . . . any movement it [the pain] would increase and finally he did say “yes, I'll have some painkillers” . . . I guess 'cause he's elderly and he's not used to taking them that often . . . he just felt that he'd had enough, that taking them too regularly was a bad thing. (N10)

The nurse's account supports other work suggesting that fear of addiction and side effects, particularly against a background of pre-existing organ damage, often prompts patients to eschew analgesics (Bédard et al., 2006; Grinstein-Cohen et al., 2009; Sawyer et al., 2010).

Regardless of the underlying reason, patients' unwillingness to take analgesics offered to them often left nurses feeling helpless and frustrated. They described feelings of disempowerment such as:

[It was a] hopeless situation . . . because I knew what she needed but she was reluctant to have it . . . [I was] seeing her in pain I knew that she needed analgesia but she didn't want to take it . . . I knew it would be effective . . . [but] she was just reluctant to take it . . . it was just . . . hopeless. (N04)

This finding is supported in the literature where patients' unwillingness to accept pharmacological measures has been considered a significant barrier to effective pain relief and cause for feelings of powerlessness in nurses (Bédard et al., 2006;

Blomberg et al., 2008; Carr, 2002; de Schepper et al., 1997; Manias & Williams, 2007; Passik et al., 2007; Schafheutle et al., 2001).

In the current study, patients' willingness or unwillingness to report pain and accept medication determined nurses' ability to give timely analgesia. A further finding was that patients' physical conditions influenced nurses' ability to give sufficient medication to alleviate distress and incapacitation. The evidence suggested that nurses felt comfortable giving analgesics to patients who could safely absorb, tolerate and eliminate medication. In contrast, nurses could feel disempowered when patients' physical sensitivity to medication meant they were unable to safely tolerate enough analgesia to relieve pain.

Patients' analgesic tolerance.

Nurses included in this study did not explicate how they appraised analgesic risk and benefit in analgesic decision-making. However, their descriptions indicated that nurses felt more or less comfortable depending upon patients' physical ability to tolerate medication. Nurses generally felt comfortable administering sufficient pain relief to patients who were experiencing severe surgical pain because they saw significant benefit and little risk in doing so. In contrast, nurses often described helplessness and frustration when the perceived risk outweighed potential benefits of giving analgesics to patients who were fasting, were older, or had a history of allergies, gastrointestinal upset, renal or hepatic disease or prolonged opioid use.

Nurses included in the current study seemed to feel most comfortable administering medication to patients who experienced surgical pain, which they saw as self-limiting. Accordingly, the perceived risk of harm from long-term medication use, particularly opioids, was unlikely to eventuate. As this nurse conveyed:

The postoperative patient in pain . . . the pain will subside and they will have less and less [medication] . . . I've never seen a surgical patient go home with . . . so much painkillers [*sic*] that they . . . become addicted to it. (N02)

In contrast, the perceived benefit of giving analgesia seemed obvious:

Surgical [pain] . . . easier to manage . . . because you can visually, actually see a wound . . . facially as well, they are quite grimacing and . . . you get a bit of an understanding "ok, of course they're going to be in pain, we've cut them open." (N27)

The above quotation suggests that nurses felt a measure of relaxation when they administered painkillers that they deemed necessary, appropriate and unlikely to have adverse effects.

These data proposed that nurses generally considered the significant benefits of giving medication to surgical patients in severe pain. An exception arose, however, if the postoperative patient was clinically unstable, which increased the risk of an adverse effect. One nurse described her sense of struggle when caring for such a patient who required oral opioid medication to supplement an ineffective epidural block:

The patient still experience[d] quite a lot of pain . . . quite a difficult case . . . her condition was just deteriorating . . . clinically. Haemodynamically, it's not stable and the blood pressure is dropping . . . [to] maintain the pain cover . . . this is hard. (N14)

Nurses were aware that many of the patients they cared for in the acute hospital were very unwell and therefore at increased risk of adverse analgesic effects. A demand for beds meant the sickest patients were admitted and patient acuity was increasing. One nurse explained: “they are in a lot of pain and very sick patients . . . if the patient's in a large public hospital today, they're sick and very sick” (N05). Some patients were unable to tolerate any oral analgesia at all, such as those who were fasting, vomiting or allergic to certain medications. In these circumstances, nurses described feelings of helplessness at their inability to administer neither timely nor sufficient oral analgesia. For example, when giving analgesia resulted in the vomiting rather than pain relief, one nurse lamented:

[The patient] . . . had a shoulder replacement . . . the day before . . . her pain had started to creep up and she'd had . . . the oxycodone orally and she was just vomiting it up so . . . there was nothing else to help her . . . [I had] given it to her twice and she'd thrown up straight away . . . it was just so difficult to give her any relief. (N18)

Similarly, nurses felt their options for pain relief were limited by the risk of anaphylaxis in patients with medication allergies. As one nurse recalled: “it made it difficult because he had a lot of allergies . . . there was quite a few [medications] . . . that he couldn't have, so that narrowed it down” (N31). These data suggested that

nurses felt hampered by inflexibility when the perceived risk of giving analgesia to patients who were fasting, vomiting or allergic outweighed any potential benefit.

In a similar vein, nurses suggested that older patients and those with comorbid conditions were more likely to experience medication side effects and, therefore less able to tolerate analgesics. This perception is supported in the literature where the potential for elderly and chronically ill patients, who often have diminished physiological function, to experience increased adverse effects has been recognised (Williams & Manias, 2008). In the current study, it was evident that some nurses felt uncomfortable relying on pharmacological measures to provide comfort for these patients:

We're dishing out medication . . . and I think . . . little, old ladies . . . slight, little, old man, we're giving all this huge medications [*sic*] . . . some of these people are 50 years older than me and 10 kilos lighter, and we give an awful lot of pain relief sometimes. I think "gee these patients must feel dreadful sometimes." (N05)

Nurses described a sense of helplessness when the perceived risk of adverse effects meant that giving sufficient analgesia to relieve pain brought further discomfort. One nurse made this point when discussing her care of an elderly female patient who had undergone recent hip surgery:

She's in a lot of pain . . . she suffers from delirium from the medications . . . aggressive . . . not aware of where she is or who people are . . . frustrating because you know she needs the pain relief but you don't know what to give her. (N10)

In particular, patients with kidney and liver disease, who had problems eliminating pain-killing drugs, were thought to be particularly vulnerable. One nurse expressed her sense of frustration when she stated:

It's hard when . . . some of our liver patients or some of our renal patients can't have high doses of opioids just because of their worsening renal function or liver function . . . hinders [you] because you can't give the analgesia that they need. (N04)

Research conducted in a Victorian hospital has similarly found that nurses experience difficulty providing pain relief for patients with chronic kidney disease (Manias & Williams, 2007, 2008). Observation of 103 pain-related communications

revealed nurses (n=14) who cared for renal patients titrated analgesic doses down to protect those who they felt were unable to absorb and eliminate analgesics safely. The authors suggested that nurses lacked knowledge about pharmacological pain management for their chronically ill patients. Despite their attempts to access written information and the help of senior nurses and specialised pain clinicians, these nurses were often ill-equipped to respond to their patients' pain (Manias & Williams, 2007). Moreover, none of the five renal units included in that study was found to have guidelines such as the WHO analgesic ladder available for nurses' reference.

In the current study, nurses often felt helpless to assist elderly and chronically ill patients whose decreased tolerance of analgesics meant that giving sufficient medication to relieve pain seemed unsafe. However, experiences of caring for patients who had an increased tolerance for analgesia and, therefore, seemed to need worryingly high doses to achieve pain relief were also described. Most commonly, these descriptions involved nurses' care of patients who had used opioid medication over time and were thought to have become tolerant to the effects. One senior nurse captured the challenge of providing pain relief in this situation:

It's the difficult ones that cause the most angst . . . comorbidities . . . social history of drug and alcohol abuse . . . can complicate things or the standard treatments for pain just don't work for that individual. (N08)

Another nurse explained:

A lot of the chronic pain patients come in to us because the pain relief, they've . . . reached their limits with pain medication . . . patients build up a tolerance to them . . . you find that a lot with chronic pain patients so that the drugs that you're giving them are large doses. (N20)

Although nurses understood that these patients tolerated the effects of analgesics, many were hesitant to administer the doses that seemed necessary to relieve pain.

The following observation elucidated a consequent sense of helplessness:

[Patients with a] history of drug abuse and alcohol abuse . . . they have a lot of pain relief already but they still complain of a lot of pain . . . even though we give them everything . . . I find it is really hard. So what you can do? Because . . . probably they got a high tolerance to the drugs, and you can't give them that much otherwise they are too drowsy. (N14)

Concern for patients tended to elevate nurses' powerlessness. One nurse's recollection of caring for a patient with mesothelioma who had been using large amounts of analgesia to manage chronic pain was testament:

I just thought "gosh that's such a big dose" . . . alarm bells ringing in my head . . . this chap's still experiencing . . . quite high pain scores. Something's not, right, something's not working . . . you just start thinking "my God he's having all of this and he's still got a pain score of six, seven, eight out of 10 . . . what can you do really?" (N31)

Moreover, repeated experiences of feeling ineffective when caring for these opioid-tolerant patients led some nurses to anticipate their own inability to improve patient outcomes. One senior nurse demonstrated how this expectation of failure escalated her sense of disempowerment:

You just have that anxiety inside you . . . before you go to that patient . . . with chronic pain because . . . it doesn't matter what you do most of the time, it's not good enough and you start to take it personally . . . "I'm not good enough, I can't help her pain" . . . anticipation that they are going to tell you that their pain relief is not enough already, even though you've given them all that you can . . . anticipation I think of a negative experience. (N24)

Other Australian nurses have reported similar perceptions. For example, Victorian renal nurses (n=62) whose patients commonly had complex ongoing health problems also found chronic pain difficult to assess, manage and properly control (Williams & Manias, 2007a). This finding led the authors of that study to suggest that nurses commonly anticipate challenge when dealing with pain problems in such patients.

In the current research, nurses' descriptions suggested that they implicitly appraised analgesic risk and benefit when considering pain relief. Elderly and chronically ill patients' decreased tolerance for medication often necessitated lower doses than were effective to relieve pain. In contrast, opioid-tolerant patients tended to need large amounts of medication to obtain pain relief. In both instances, nurses often felt their patients needed more analgesia than they could safely administer. The consequence for nurses was the helplessness and frustration that characterised feelings of disempowerment.

Nurses in other studies have reported similar concerns about the medication risk when making analgesic-related decisions (Dihle et al., 2006; Grinstein-Cohen et

al., 2009; Watt-Watson et al., 2001; Willson, 2000; Wilson, 2009). In the current study, nurses' worries tended to revolve around the risk of giving analgesics in higher doses than physiologically compromised patients could safely tolerate. Similarly to the findings of Dihle et al. (2006), who used observation and interview to explore Norwegian nurses' (n=9) postoperative pain management, nurses in the current study tended not to express concerns about the addictive potential of analgesics unless patients had used opioid medication over a prolonged period.

Summary of access to effective medication.

Nurses shared an understanding that pharmacological strategies were crucial to their ability to provide comfort and felt a measure of relaxation when able to assist patients with timely analgesics. In contrast, many described feeling at a loss to help patients when prevented from giving effective analgesia. Knowledge of patients and pain management, and an effective prescription were necessary tools for nurses seeking to provide pharmacological comfort measures. Knowing their patients helped nurses to understand pain problems, while experience in pain management enabled them to navigate complex treatment regimens.

An effective prescription provided the framework to support nurses' decision-making and authorised administration of sufficient medication to alleviate patients' distress and restore function. In addition, patients' willingness to report pain and accept painkillers allowed nurses to respond proactively. In contrast patients who were reluctant to bother nurses or who refused medication could cause nurses to feel concern and frustration. Finally, nurses felt comfortable giving analgesia to patients in pain who they felt were able to safely tolerate enough medication to be effective. In contrast, nurses felt disempowered when the perceived risks of giving painkillers to patients who were unstable, allergic, elderly, or had comorbid conditions, seemed to outweigh the benefits.

Nurses' reliance on pharmacological strategies as well as the importance of knowing their patients and having an appropriate prescription on hand have been outlined. These data emphasise the necessity of collaborative relationships with patients and colleagues to expedite feasible pain relief. The following section

describes the factors found to influence nurses' collaboration with those around them and their consequent experiences of empowerment or disempowerment.

Collaboration with patients and colleagues.

Collaboration in this study meant communication and cooperation between nurses, their patients and their colleagues to implement feasible comfort measures. Cooperation with patients helped nurses to understand their pain experiences and tailor pain relief. Communication with doctors elicited directions for treatment and provided nurses with the authority to administer timely and sufficient medication. Lastly, collaboration with other nurses lent physical and emotional support, and knowledge to use analgesics confidently. The data proposed that these associations facilitated nurses' involvement in analgesic decision-making and use of effectual strategies for comfort provision. However, factors identified in the acute hospital were found to influence nurses' (a) collaboration with patients, and (b) collaboration with colleagues, which affected their experiences of empowerment or disempowerment.

Collaboration with patients.

The findings indicated that nurses wanted collaborative relationships with patients who experienced severe pain because they saw care as participatory. This meant that patients made choices to accept or refuse the care offered by nurses. One nurse explained: "when you work with patients . . . they are not the one just to receive the care . . . they can co-op[erate] . . . we can work better" (N25). This perspective had the patient as a valued member of the team. Working together ensured all parties had opportunity to contribute to discussions and decision-making. For example, collaboration with patients facilitated comprehensive assessment:

If you say that "you are part of the team" they feel more relaxed . . . [they] feel "oh yeah, I am part of the team. I can ask questions. I can tell them anything . . . how I feel, what I think, what I want." (N25)

This perspective supports other literature suggesting that meeting the requirements of patients in pain depends upon them expressing their needs and taking an active role in care (Bell & Duffy, 2009). As evidence, observation of Australian surgical nurses

(n=52) identified two elements of pain management as patient involvement in decision-making and an agreed approach to pain relief (Manias et al., 2005).

In the current study, nurses suggested that collaborative relationships developed as they communicated with their patients. Cooperation meant “not just telling the patients ‘this is what I want you to do’ . . . [it] is good if you build the trust and good communication . . . it saves you time, it saves you hassle” (N25). In turn, connectedness between nurse and patient solidified and enhanced other comfort measures:

He knew that we were really, really working for him . . . [he felt] a lot of confidence. I think trust is very important for . . . nurse, doctors, for the patient. If they feel they can trust you and they feel and believe that your medications or techniques that you use are good for them, that they will seem more effective. (N25)

This perspective reflects the conclusion drawn from observation of interactions between Australian surgical nurses (n=52) and postoperative patients (n=312) in two hospital surgical units that patients’ trust and confidence fosters participation in effective pain relief (Manias et al., 2006).

In the current study, collaborative nurse-patient relationships centred on open communication and shared decision-making. One nurse clearly suggested that these elements went together when she recalled:

He realised everybody is working together . . . I told him that “you are part of the team” so he know[s] that he got some control, autonomy. Not . . . a receiver [of care] . . . he can tell us how bad is the pain . . . when it start[ed], when it stop[ped] . . . how long the pain medications last[ed]. (N25)

Other nurses demonstrated how they sought their patients’ perspectives to tailor pain relief. For one nurse this meant:

Asking the patients, getting their experience and saying “what works for you at home” . . . ‘cause when patients are at home they’re having to deal with pain by themselves, particularly if it’s a chronic pain and they know what works well for them. (N08)

Another gave the following account of caring for her postoperative patient who had been incapacitated with knee and back pain:

[The patient was] talking to me . . . yesterday . . . when the physio[therapist] and the nurse tried to get him up, he experienced quite a lot of pain. So I planned] today . . . before I got him up I made sure he's [*sic*] got enough pain cover . . . I checked on his chart . . . talked to the physiotherapist to find out more information . . . gave him the immediate release [analgesic] to make sure he got enough cover before we got him up. So . . . he's pretty good today . . . taking into consideration he had a long time history of chronic pain . . . I'm pretty happy about the result today. (N14)

The central point was that communication about pain enabled nurses and patients to develop pain-relieving strategies together, which were likely to be effective. As this younger nurse had experienced:

[I wanted to] give him some oxycodone 30 minutes prior to his meals and . . . he was able to work with us to say . . . at 4.30, before dinner . . . [he says] "oh I would like the tablet now," which was perfect because it worked out very well and I was able to manage the pain from there. (N22)

As these examples demonstrate, nurses felt able to work with patients when communication flowed both ways. One junior nurse described how she tried to include patients in their care when she stated: "I normally tell them what I could give them and . . . we make the decision together in a way" (N21). These nurses' perspectives reflect literature expounding the importance of nurses' communication in order to respond to patients, assess pain, and foster patient involvement in pain relief (Bédard et al., 2006; Manias et al., 2006).

In the current study, nurses suggested that open communication promoted shared control of their interactions with patients. For example, one nurse declared: "honesty is definitely the best policy. Sometimes people might not always like what you say to them, but at least it can then make an informed judgment and they feel a bit more control because they're in the picture" (N31). In turn, this collaboration nurtured comforting connections:

You have to be honest because . . . they say "yes she is an honest person so I trust her. I trust what she says" . . . trust is very important . . . if they feel they can trust you and . . . believe that your medications or technique that you use are good for them, then they will seem more effective. (N25)

Accordingly, communication and cooperation with patients were found to be instrumental to nurses' ability to tailor effective pain relief for patients who experienced severe pain.

Nurses' descriptions demonstrated that they felt more able to collaborate with patients who held similar goals for pain relief and with whom they agreed upon comfort strategies. The data suggested that nurses responded positively to compliant patients who seemed to accept the care they offered. For example, one recalled a patient who had undergone extensive surgical debridement of necrotising fasciitis and needed numerous complex nursing interventions. Despite the arduous care requirement, she described him as:

Not a difficult patient . . . he just accepts care, which . . . makes it easier . . . low maintenance in that his attitude is very laid back and I think he just trusts that we're doing what we have to do and he accepts it . . . a really nice guy to look after . . . makes it easier. (N26)

Similarly, another nurse described the ease of caring for an amenable patient saying:

It was her good nature that actually helped me to . . . to help her . . . she was really tolerant . . . she was being compliant . . . not demanding so that makes it easier for me to nurse her. (N17)

These data suggested that nurses interpreted patients' passive behaviours as tacit agreement with their strategies for pain relief.

Observational research from two Australian hospital surgical units, which captured 316 nurse-patient interactions, found patients were often passive recipients of nurses' pain relief (Manias et al., 2004). While some declined and others delayed taking medication, patients usually let nurses initiate and control analgesic administration. Less often, patients engaged in problem-solving, shared responsibility or worked with nurses toward feasible pain relief. Even fewer patients actively negotiated pain management by initiating and finalising decisions about analgesics. The findings suggested that patients who deferred to nurses' judgments received less opioid analgesia than those who actively participated in care. Later research investigating nurses' communication with chronically ill renal patients also suggested that many felt vulnerable in the unfamiliar hospital environment and their passivity contributed to suboptimal pain management (Manias & Williams, 2007).

In the current study however, nurses did not explicate a view that passive patients were less involved in care or were the recipients of poorer pain relief. Rather, as the previous quotations indicate, nurses felt their patients' acquiescence implied trust and communicated a willingness to adopt their approaches to comfort provision. In turn, some nurses could embrace patients' knowledge and experiences as they grappled with the subjectivity of pain management. For example, one declared: "sometimes chronic [pain patients] are easier because they know what drugs are good for them and what does what and they'll go 'no I don't need this one, I want this one instead'" (N21). Another nurse appreciated patients who understood the constraints she faced in the acute hospital:

The [patient's] knowledge was good . . . he was very familiar with the hospital system. He knew I couldn't give him anything without an order . . . he understood . . . he's probably been on a ward before as a chronic pain patient. (N26)

From these data, it appeared that nurses felt able to collaborate with patients who seemed to share their understanding of pain management. The consequence for nurses was a sense of ease and effectiveness. In contrast, nurses described difficulty caring for patients who seemed noncompliant as evidenced by one nurse who recalled:

It was a night shift. You expect everyone to be sleeping and she was not . . . there was not much of an effort on her part . . . if she had been more cooperative maybe . . . I'll feel better. If she had been a cooperative patient, a more compliant patient I would have . . . it would have been easier on my part to look after her. (N17)

The findings suggested that nurses interpreted uncooperative behaviours as patients' resistance to the care they offered. For example, one nurse observed: "a difficult, difficult person or someone who wasn't pleasant . . . it's harder . . . harder for them to allow you care to care for them and to make them comfortable" (N24). Others understood that difficult patients were often affected by the stress of severe pain, with one commenting: "it can just depend on . . . the personality of the patient . . . if they're going to get angry or upset . . . which is what pain can cause some people" (N20). Nevertheless, they described feelings of helplessness when patients seemed to oppose rather than work with them, such as: "sometimes you just can't help them . . .

they're difficult to look after. It's not our fault . . . but . . . when it falls apart, it falls apart" (N26).

This finding supports literature suggesting that patients' behaviour influences nurses and affects the degree to which they agree about pain and pain management. As evidence, a number of studies have suggested nurses tend to disbelieve, ignore and blame patients they see as difficult, potentially leading to undertreatment of pain (Brockopp et al., 1998; Lauzon Clabo, 2008; Walker, 1994; Wilson & McSherry, 2006). In a similar vein, one Swedish study reported nurses and allied health workers' perceptions that uncooperative patients exaggerated pain (Blomqvist, 2003).

A prominent finding of the current study was that nurses commonly experienced difficulty collaborating with patients who had a history of chronic pain or substance abuse. As described in an earlier section, nurses shared an understanding that patients who used opioids over time developed an increased tolerance for the effects of the medication. This increased tolerance meant these patients often required higher doses to achieve pain relief. While nurses described feelings of concern about giving such large doses, they also found that these opioid-tolerant patients could continue to report ongoing pain. A tendency to anticipate failure and consequent feelings of anxiety when interacting with these patients were evident. The findings further suggested that these feelings increased when opioid-tolerant patients were also difficult and demanding:

If they are an aggressive patient or . . . got a drug history who it's difficult to deal with their pain anyway, you still feel that distress and anxiety . . . you are already anxious before you go to the patient . . . you already have that attitude of "oh I've already given him everything I can. It's not going to make a difference now what I do so I'm just going to put up with . . . the language or the abuse or the carry-on" . . . so it does make it more difficult. (N24)

Previous encounters with such patient behaviours seemed to prime nurses to expect difficulty. Two nurses' remarks indicated these prior experiences could be their own or those of their colleagues. The particular nurse quoted above stated:

I think it's the anticipation that they are going to tell you that their pain relief is not enough already even though you've given them all that you can . . . or you've heard from other people "oh I've done this and it doesn't matter what I give, it doesn't help." (N24)

In addition, another nurse declared:

[Patients] watch the clock and ring the bell when they know they can have [analgesia] . . . even on the handover sheets they're . . . labelled . . . flagged straight away . . . people are aware of it . . . some people find it difficult to look after them. (N26)

It was evident that it was difficult for nurses to share an understanding of pain management with people whose experiences of pain were so different from their own:

Chronic pain [patients] . . . every two hours they're on the bell . . . it's difficult because I find it hard to understand . . . I can't imagine what it would be like to . . . constantly live in pain and need medications two hourly . . . I find that . . . hard to understand. (N18)

Moreover, some nurses realised that patients were also influenced by their prior experiences. For example, one nurse recognised that patients with a long history of pain were used to managing their own medications and could become frustrated in the acute hospital. She observed:

At home . . . if they were in pain they'd go and get Panadol and they go and get something else . . . at least they feel like they are doing something . . . whereas I think when that gets taken off them and we're really dictating when they get pain relief . . . they get frustrated . . . pretty quickly if you're not giving them . . . enough . . . pain relief. (N27)

Other research has established that patients can feel constrained by hospitalisation. A recent exploration of nurses' (n=32) perceptions about patient empowerment found hospital inpatient routines tended to limit patient autonomy, particularly for those used to managing medication prior to admission (Piper, 2010). Nurses working in various clinical and management settings in a UK hospital participated in interviews and focus groups. These participants described the importance of supporting patients to make informed decisions in order to assist with their coping, build self-esteem and confidence and promote independence. Within this context however, power imbalances and knowledge gaps meant that health professionals controlled patients' access to treatment options and resources. The authors referred to a tension between "nurse defined therapeutic need and patient

choice” (p. 176), in which nurses judged their patients’ requirements for care and decided how these were met (Piper, 2010).

Research conducted in Western Australia has identified how patients are affected by perceptions of having limited control during hospitalisation (Williams & Irurita, 2004; Williams & Irurita, 2006). Grounded theory method was used to explain the therapeutic effect of interpersonal interactions on hospitalised patients. Semi-structured interviews conducted with 40 patients and 78 hours of participant observation revealed that patients’ perceptions of personal control were central to their emotional comfort. Patients’ personal control, which meant their actual or perceived ability to influence the situations and environments, was found to directly influence their feelings of self-esteem and contribute to recovery.

Building on this earlier work, a further 16 semi-structured interviews with patients explored aspects of the hospital environment that influenced perceptions of personal control (Williams, Dawson & Kristjanson, 2008). Three conditions were identified which influenced the degree to which patients experienced personal control during hospitalisation. These conditions involved patients’ level of security, level of knowing and level of personal value. Of these, patients’ personal value related to how reliant they felt upon others in the hospital environment, which was diminished by a sense of dependence.

In the current study, some nurses offered insight into how patients’ experiences of decreased autonomy during hospitalisation, particularly about analgesia, could fuel difficult behaviours. This nurse’s account of a conversation with a patient in chronic pain elucidated a tussle for control that could arise:

[The patient said] “you can’t see I’m in pain but . . . I have to control it” . . . it was her way of saying . . . as nurses we’re controlling how she’s feeling and what level of pain relief she gets . . . she says “at home I sometimes have more [analgesic] than this” and I’m like “well that’s good but that’s in your own home. In a hospital we legally cannot do that” and she [said] . . . “well that means that you’re literally dictating how much pain cover I get” . . . they’re in pain, they’re losing a bit of control . . . she was right and I felt a bit bad after that. (N27)

The data proposed that this tussle for control was often underpinned by nurses and opioid-tolerant patients’ differing goals for comfort provision. Patients in pain focused on the benefit to be had from timely and sufficient analgesia. However,

nurses who tended to disregard self-reports from such patients saw only risk in giving medication. For these nurses, protecting patients' well-being meant protecting patients from excessive dosing as evidenced by this recollection from a young nurse who had cared for a patient with bilateral ankle fractures and long-standing back pain:

If [the patient] had . . . the painkillers . . . something that she has been taking for the past . . . six years if my memory doesn't fail . . . she might have gone out of control if the medication was in her own hands because . . . if not for us, if not for the hospital system . . . she would have gotten what she wants, as much as she can as much as she wants but we are restricting it to every two hours . . . she would have gone out of control with the medication if she had hold. (N17)

There was a suggestion that nurses believed themselves to be best placed to understand the ramifications of giving analgesics. One nurse admitted that she and her colleagues often resisted sharing control with chronic pain patients, who often appeared to want excessive doses of analgesia:

We want the control because . . . we know everything that's going on . . . [and] if an adverse event . . . happens we can sit there and go "well, I've done all of this and I've followed all of these rules and protocols" . . . I think we're controlling to probably protect ourselves at times more than actually protect . . . the patient, which is not good. (N27)

The perceptions of nurses in the current study that opioid-tolerant patients requested more analgesic medication than they needed contrasted with observation of nurses' interactions with patients who had chronic kidney in an Australian renal unit (Manias & Williams, 2007). The patients included in that study, who lived with long-term pain, were observed not to ask for medication and to refuse analgesics when offered them. Nevertheless, findings in the current study tended to indicate that nurses often experienced conflict when caring for opioid-tolerant patients, which was underpinned by diverging goals for comfort provision. Rather than collaborating through trust and shared decision-making, some nurses included in the current research seemed to struggle for control of the decision-making around analgesia.

This finding that nurses engaged in a tussle for control with some patients is supported by other literature. In 2001, researchers in the USA also described a "struggle for control" (p. 324) which became apparent when they analysed video-

taped recordings of three physicians as each consulted with a patient about pain management (Eggly & Tzelepis, 2001). These doctors were included in the study because they had reported previous experiences of conflict and feelings of frustration when discussing analgesia with their patients. Coding of the taped conversations revealed that both physician and patient attempted to control their interactions, using strategies such as instructing, negotiating and disagreement.

Each of the three interactions showed that the physician attempted to refuse their patient's persistent requests for an analgesic prescription (Eggly & Tzelepis, 2001). Physicians engaged in two consultations were found to capitulate in the face of patients' steadfast, and sometimes angry, tenacity. In the third, the physician eventually prevailed by suggesting an over-the-counter alternative without clarifying that it was a different medication. While resolution was finally reached in each discussion, nearly half of the exchanges between doctor and patient were found to be bids for control. It was further noted that patients did not attempt to negotiate with their physicians.

The small study by Eggly and Tzelepis (2001) focused upon interactions between medical staff and patients. Nevertheless, the struggle they described resonates with the experiences of nurses in the current study when their goals and strategies for comfort provision conflicted with those of their opioid-tolerant patients. Within the context of these tussles, rather than embracing their input some nurses came to resent patients' knowledge and experiences. For example, one nurse claimed:

Pain is subjective. You can't say [to the patient] "I'm pretty sure you don't have 10 out of 10 pain and you've had masses of Oxynorm [opioid] today" At the end of the day you have to go by their pain score and you . . . have to give them . . . but it does make it difficult when . . . they know what the pills look like. (N26)

Moreover, patients with long-standing pain issues also came with expectations that influenced their perspectives of pain management in the acute hospital. For example:

Patients might feel judged as well when they come in to hospital. They might have that preconception that people are going to judge them because of their history . . . chronic pain or they've had a history of drug use . . . so already there's like a barrier that you can't offer those extra things that may help them. (N24)

In brief, the data proposed that nurses and opioid-tolerant patients often found it difficult to share an understanding of pain management. A struggle for control could arise as such patients sought the benefit of pain relief, while nurses sought protection from the consequences of giving excessive medication. Each party brought expectations to this struggle. Moreover, nurses described anxiety and frustration as patients resisted their efforts to care.

Other studies have also shown that patients with complex issues who may require frequent care can be unpopular in the acute hospital when they are difficult to look after (Parker, 2004; Williams & Manias, 2008). Parker examined nurses' work on medical wards through the end of shift handover and found that caring for patients with chronic health problems who return multiple times to hospital was heavy, messy and chaotic (Parker, 2004). She described nurses' role of "constructing and maintaining order" (p. 214) when patients incessantly demanded medication and responded to nurses in accusatory tones (Parker, 2004). She acknowledged the personal stresses and interpersonal tensions that led to nurses' unconscious defensive behaviours and which could undermine the nurse-patient relationship.

While communication and cooperation with patients was important if nurses were to tailor comfort measures, collaboration with medical and nursing colleagues expedited feasible pain relief. A large category was identified in the data, which was labelled "collaboration with colleagues." Nurses' many references to problematic communication and cooperation with medical staff, upon whom they depended for the authority to administer analgesia, were evident. The support offered by nursing colleagues was also described.

Collaboration with colleagues.

Communication with doctors provided nurses with direction to administer analgesics, while collaboration with other nurses provided knowledge and confidence to tackle complex pain problems. Nurses demonstrated that they felt supported, well-resourced and more effective when able to access colleagues' expertise and authority. For example, one nurse remarked: "if you're working together I guess you are happier" (N06). Another opined: "everybody work[s]

together and you're not alone. It is good for the nurse . . . you are more confident to suggest, more confident to . . . carry out actions" (N25).

Nurses described feeling less concerned for patients and a consequent degree of relaxation when medical assistance was at hand, as evidenced by the following: "once the doctor comes and then it's better" (N07). Others described feeling "a bit better because I know that the Pain Team will come and assess him" (N06), and "relieved that . . . it's been reviewed . . . by the [medical] team" (N26).

Communication with medical staff enabled nurses to respond promptly to patients, which involved:

Doctors actually understanding and listening and then acting on our advice . . . the Anaesthetic Reg[istrar] didn't actually come up and review the patient. She listened to my story and then . . . the charts got sent down there and she sent the ketamine infusion up with the charts . . . it was good . . . doctors and nurses . . . communication is key and in listening to each other. (N20)

One very inexperienced nurse recalled caring for a patient who had been hospitalised for treatment of haematuria (blood in the urine) and persisting severe abdominal and back pain. This enrolled nurse had been qualified for only five weeks but felt supported by medical staff and stated: "the doctors have . . . been good . . . they've understood . . . where I am coming from and . . . accommodate . . . as quick as they can" (N32).

Communication with doctors about patients' pain and about analgesic treatments provided nurses with direction for their decision-making. One nurse recounted: "I stayed with the doctors . . . so I could answer any questions that they may have had or fill them in on results" (N03). Another stated: "you've just got to try and tell them everything . . . pain scores and give them as much information [as you can]" (N06). With this information, medical staff could initiate and amend prescriptions to meet patients' needs. One junior nurse illustrated this point when she recalled a recent phone conversation which involved:

Telling the Reg[istrar] about the patient's previous history with pain management . . . [the doctor] said "yep it sounds like we need to put her on a ketamine [analgesic] infusion" . . . an hour after I paged the Reg[istrar], we had the ketamine infusion up on the ward. So that was good. (N20)

Nurses' descriptions revealed that they collaborated with both ward-based medical staff and the specialised hospital pain teams. Ready access to ward doctors meant nurses could respond quickly to patients. For example:

You can just walk into them and . . . discuss it with them . . . things that you're not sure of . . . A Resident [Medical Officer] is the way we communicate with the doctors . . . are great, couldn't live without them . . . they can change things on the chart . . . do it in a second. You've just got to walk in there and when you page them, they page [answer] pretty much straight away. (N26)

Additionally, consultation with specialised pain teams within the hospital assisted nurses to negotiate analgesic risk and benefit. As evidence, one nurse recalled caring for an elderly patient who had experienced troubling side effects when given medication after extensive orthopaedic surgery. She recalled: "[the] pain team's had to be very involved in her care . . . they've had to try so many different things to get her to normal mental state whilst you are covering her pain" (N10). This finding supports other work showing that nurses rely on specialised medical staff to help them manage analgesic dosing with minimal adverse effects when patients have challenging pain problems (Manias & Williams, 2007). In that study, Victorian nurses (n=14) working in hospital renal units were observed conferring with more qualified doctors to formulate effective pain relief for the particular analgesic needs of patients with chronic kidney disease. Pain management was complex for these patients. Nurses often lacked analgesic knowledge and sought the counsel of multidisciplinary pain teams (Manias & Williams, 2007).

In the current study, nurses' collaboration with specialised pain teams was underpinned by a shared imperative to address pain problems. One nurse observed:

A good thing about the pain team is . . . they would see what I was calling about . . . whereas the [ward doctors] actual team . . . might not see pain . . . as their priority . . . [they say] "I'll come when I can" whereas for the pain team it's . . . "that's bad, that's a priority. Let's go see and sort it out" . . . the [ward] team wouldn't have come for another hour or two . . . they have different priorities. (N18)

These consultations provided nurses with options for pharmacological pain relief. For example, one junior nurse observed: "the Acute Pain team will come up and [say] . . . 'if this is not working, try this bit' and you sit there and . . . feel like you've

got a plan of attack” (N27). Nurses indicated that they felt reassured and more confident with a plan for treatment. As one nurse remarked:

Having the two different services . . . the Acute Pain Service and the palliation [Palliative Care team] . . . combined with the knowledge base on the ward . . . there’s a bank of people . . . [to] call on . . . utilise those extra resources to come up with a management plan . . . and just knowing that if a pain management regime doesn’t work that we have got alternatives that we can utilise to manage the patient better. (N08)

These data suggested that nurses felt more effective with input from specialised clinicians, a finding supported by other research conducted with nurses working alongside people with pain management expertise. For example, an audit of 14 hospitals in the UK that demonstrated that Recovery Unit nurses, who have increased training and work with expert doctors, were better at managing postoperative pain than ward nurses (Moss et al., 2005). Furthermore, access to specialised pain teams has been considered particularly valuable for monitoring pain management and education of junior nursing and medical staff, and has been associated with lower levels of pain (Chung & Lui, 2003; Courtenay & Carey, 2008; Moss et al., 2005).

In the current study, nurses reported feeling more able to access medical expertise when they were caring for patients with surgical, rather than medical pain. It seemed there was a shared expectation in the acute hospital that surgical patients would experience pain related to recent tissue damage. For example, one nurse claimed: “surgically, pain is a huge focus” (N27). This shared understanding translated to preemptive analgesic prescribing and readily contactable doctors, which facilitated nurses’ timely provision of analgesia. This meant that patients “come back up from surgery . . . post op[erative] patients . . . with pain . . . they’ve always come back prepared” (N23). As another nurse explained:

Surgical patients, if they say they’re in pain . . . [people say] “they’re post op[erative], they’re going to be in pain” and . . . two hourly or three hourly or four hourly pain relief is given and it’s not even second guessed. (N27)

In turn, nurses felt supported and resourced to implement pain relief:

[With the] surgical patient that was in pain, you’d be getting Acute Pain [Service] on the phone, you’d be calling like the on-call anaesthetist.

Everyone would be . . . “we’ve got to get this pain under control. We cannot have this person in pain.” (N27)

The implication was that this shared understanding facilitated consistent analgesic dosing, which accorded with the proactive approach needed to keep control of patients’ pain.

While input from medical staff provided directions and authority to administer analgesics, nurses also benefitted from collaboration with nursing colleagues. For example, one remarked: “[the] acute pain team . . . their role works well and they do their job, but . . . you end up getting more support from your colleagues . . . at a nursing level” (N24). A younger nurse showed how the nursing collective helped him develop effective comfort measures when he recalled: “it has taken a long time . . . I myself did not think of that combination [of strategies]. It’s just something that . . . all of us as a team have worked through” (N22).

A number of junior nurses demonstrated increased confidence when implementing pain relief with the backing of their more experienced colleagues. One observed:

Once you’ve got that advice and once you’ve got people saying “call the Anaesthetic Reg[istrar]. We should be doing the ketamine infusion” . . . you’ve got a bit more back up there to think “I’m probably doing the right thing here” . . . always a healthy thing. You always should ask advice I think from your peers especially if . . . you haven’t dealt with something like that. (N20)

In another example, a graduate nurse recalled the stress of caring for a patient with mesothelioma and a history of chronic pain, whose severe discomfort persisted despite liberal analgesia. Worried and upset by the patient’s ongoing complaints of severe pain and his clearly angry doctor’s insistence on large doses of medication, this young nurse lauded:

[The] support of my shift coordinator, which was constant . . . he was confident in what he was doing . . . [saying] “this is what we are going to do” . . . letting me assess and . . . double check so we were both confident in each other and how it was going . . . sure of what you were doing and your plan for the future. (N29)

It was apparent that the senior nurse's physical and mental attention lessened her sense of struggle. Similarly, other nurses described feeling more able to provide complex comfort measures when they shared the load. One recalled enlisting help to dress her patient's large, infected and painful abdominal wound. She described how dividing the physical and emotional labour helped nurses feel more effective and relaxed:

[One nurse] would just sit and just distract [the patient] . . . because it was so big and awful. They could just focus on doing it [the dressing] . . . because it . . . would get very tiring and quite distressing for the nurses to have to do it all . . . you'd have to stop all the time . . . talk her through . . . two nurses in there just as support for the nurse as well as the patient. (N24)

This nurse also referred to the emotional support ward colleagues could provide when nurses were struggling with challenging patients and pain problems:

You might come out of a room and . . . have a look on your face and everybody automatically seems to know . . . rapport that you develop with your colleagues . . . when you work together, and especially if you know the patient . . . you just have understanding . . . it's almost an unspoken sort of thing. (N24)

These data indicated that nurses appreciated the physical and emotional support of their nursing colleagues when managing problematic pain. While this support increased nurse' confidence, the findings also suggested that nurses' collaboration facilitated consistent pain management across the nursing shifts. Continuity has been called the "cornerstone" of effective pain relief (Ashley, 2008, p. E74). Nurses included in this study suggested that they were more able to provide continuity of care when colleagues shared their attitudes and beliefs about pain and painkillers. For example, one nurse appreciated the initiative of her colleague on the previous shift who had obtained an effective prescription so she could address her patient's severe migraine headache. She described a measure of relaxation in:

Knowing that something [analgesia] was already ready for me to give her . . . I could see that she was in pain and straight away and I'd come onto shift and somebody has already got an order written up for the Pethidine [opioid] . . . if I turned up and it wasn't written yet . . . then I would have been a lot more concerned and a lot more panicky. (N21)

Such collaboration secured the tools nurses required to select, titrate and prepare timely analgesics and they described feeling effective and confident to address pain problems as a result.

In contrast, many nurses offered accounts of feeling helpless and frustrated when collaboration with doctors and other nurses faltered. In particular, the lack of authority to administer timely and sufficient medication was keenly felt when doctors seemed unavailable or uncooperative. Two nurses' recollections captured a consequent sense of diminished control and impotence. The first quotation is taken from the interview with a junior nurse who had cared for an elderly lady during a recent morning shift. The patient had undergone shoulder surgery the previous evening. She reported increasing pain but was unable to tolerate oral antiemetic medication. The nurse described her escalating feelings of disempowerment when she recalled:

There was no point in giving her any more pain relief . . . I couldn't make the pain go away. I couldn't make the nausea go away until someone came, like a doctor came . . . I had no power and it was all medical staff. They were the ones who had to come and save the day by charting something for her. (N18)

The second account was from another young nurse on her first surgical ward placement. She also described a recent morning shift when she had taken over the care of four patients, one of whom was experiencing severe pain following spinal surgery the previous evening. Despite receiving an infusion of opioid medication, the patient was becoming increasingly distressed. The nurse attempted to facilitate a medical review without success. She described her bewilderment as she took up the story:

[The patient] would suddenly scream in pain after Theatre . . . [She was having a] morphine infusion or something. She was screaming in pain. She was in pain. She was in lots and lots and lots and lots of pain and . . . I didn't know what to do . . . I called the RMO [Resident Medical Officer] . . . [who said] "if her pain is uncontrolled like this you're better off getting the APS [Acute Pain Service] . . . so I called the APS and the APS said . . . "better let the [ward medical] team see her first . . . so I called the RMO again and he said . . . "I'll come down and see her now, but you give the APS a call again and tell them to come and see as well" . . . and meantime while I was sitting at the [nurses'] station . . . I've got the patient screaming. (N17)

When asked if she had anything to add at end of her interview, this nurse returned to her account saying:

I just sat there and I [thought] . . . (laughs) “what am I supposed to do? Who’s coming?” (laughs) Yeah, ‘cause it was eight o’clock . . . in the morning. [I thought] “No-one wants to come and see this patient who’s in pain” and eventually this patient stayed in our ward for more than a month I think, a month, two months. One of our longest staying patients. (N17)

The findings clearly indicated that instead of feeling supported, nurses could feel not only helpless but also isolated when unable to collaborate with medical staff. Two nurses captured this experience vividly. Firstly, the young nurse quoted above stated:

[The nurse is] the only person who sees all this agony . . . the duty doctor didn’t come and see for herself . . . [she] doesn’t really know what I’m experiencing or what I’m looking at . . . it just wasn’t easy for me to be witnessing it myself . . . let them come down to my position and . . . sit in the same room as the patient who’s actually sobbing and crying and in lots of pain. (N17)

This particular nurse clearly described feeling alone with her patients’ distress at the bedside. In doing so, she suggested that doctors’ absence protected them from the spectre of patients’ suffering, whilst nurses’ evident inability to help only crystallised their feelings of disempowerment.

The second account was from a senior nurse who also described a sense of isolation at the bedside when caring for opioid-tolerant patients. She described the challenge nurses could face when trying to enact an amended prescription without the obvious backing of the prescribing doctor:

Nurse[s] as the front line people . . . [are] confronted by the patient if they [*sic*] don’t got [*sic*] enough pain cover, especially for those drug users . . . the pain team, if they want to reduce the dose then they might reduce the dose, tell the patient and then they walk away . . . the patient [says] . . . “I’m not going to take that. This is not my normal dose. I need to see the doctors right now” . . . Sometimes they’re abusive, verbally . . . so we have to go back and face the situation again without any support . . . and say “this is the order. You have to take it. I can’t change the order because we just give whatever is written on the chart” . . . you [the nurse] are the one to be blamed. You are the one to be subject to abuse . . . You’re the scapegoat in between . . . you know it’s good for [the patient] to reduce the dose but the patient’s history of substance abuse is not day one, maybe 10 years, 20 years and . . . we are not

able to change it anyway . . . probably the patient going back to the community they will just increase the dose. What we can do? (N14)

Nurses indicated that problematic collaboration with medical staff commonly stemmed from doctors' unavailability or apparent unwillingness to listen. A number of nurses reported that there were times when doctors could not communicate because they were needed elsewhere in the hospital. They were aware that doctors had responsibilities in multiple clinical units and could not always review patient in person, particularly outside business hours. For example, one nurse reported: "the doctor . . . there's one between all the wards on the floor" (N23). Another recalled: "it was after hours. It was in the evening so actually getting the medical staff that I wanted to sort it [the pain problem] out was quite difficult" (N15). These perceptions are supported by other research involving observation of Australian nurses which has revealed how communication with medical staff can be not only time-consuming but also delayed and fragmented by hospital organisation (Bolster & Manias, 2010; Manias, 2003b; Manias et al., 2005).

Nurses in the current study understood the constraints on doctors' time. Nevertheless, they could experience considerable helplessness when disjointed communication with medical staff delayed analgesic decision-making. The effects on patients were obvious:

If the doctors are busy it can take a while to get . . . any changes in the pain management for patients and . . . all the while this is happening the patients are still there in pain. (N20)

However, there were also implications for nurses who having assumed responsibility for resolving pain problems, had to return to the bedside without answers. Proximity to patients' distress kept nurses' perceptions of their own ineffectiveness at front of mind. The following comments reveal how this experience increased nurses' feelings of helplessness:

I'm the only person that she's in contact with to tell that she's in pain and I go in there and I . . . can't really do anything . . . I paged everyone and no-one was getting back to me. (N18)

[To] some people, especially when they've got pain and they are not familiar with the hospital system, it seems ridiculous when you say "I can't give you

anything because I'm waiting for a doctor to ring me back. I've paged them." . . . [The patient says] "well you can give me something. You're a nurse. Just give me something now." (N26)

Accordingly, it emerged nurses who were unable to contact medical staff for direction or to facilitate an effective prescription were often left feeling helpless and frustrated at the bedside.

A further finding was that nurses could find collaboration to be problematic when medical staff were available but seemed uncooperative. A number of nurses described feelings of powerlessness when doctors seemed not to act and feelings of frustration when doctors seemed not to listen. For example, one junior nurse working on the orthopaedic ward recalled caring for a patient who had recently undergone a knee replacement. After struggling to address the patients' problematic pain for some time, the nurse contacted the duty doctor to convene a medical review. Her sense of helplessness was apparent when the doctor elected to delay attending the patient:

[The patient] was in a lot of pain. She rated it up to a 10 out of 10 [pain score] . . . on the right knee and then she was in agony . . . so at half [past] four I gave her what [analgesia] I could give . . . half hour later it just doesn't [*sic*] work . . . between half [past] four to half [past] five she was actually in tears. She started sobbing . . . she was in really extreme pain. I contacted the doctor . . . I said "look this lady's pain is just not going away" . . . They asked me . . . "Why? What happened? Is that a new thing?" Then I had to say that "no, it's actually not a new thing. We've been struggling with some sort of pain issues" . . . after hearing that . . . they just said "oh, just wait for it to work a while more" . . . and just left it at that . . . [I felt] ridiculous . . . sitting there watching a woman sob and cry and there's nothing I can do about it. (N17)

A number of other nurses described experiences when they felt medical staff did not seem to value their perceptions, opinions and suggestions. For example, a junior nurse working on the respiratory ward remarked:

As nurses you get very frustrated because you're trying to help the patient that is in pain . . . especially when they're really distressed . . . and you're [saying] "this person looks really, really uncomfortable" and you have a doctor going on the phone "oh that analgesia's fine. They should be ok" . . . [You feel] really frustrated going "do you not care about this person? Do you not care that this person is in pain?" (N27)

Similarly, one of her senior colleagues recounted an unproductive exchange with a doctor about a patient with mesothelioma who was experiencing intractable severe

pain. She described her significant frustration at not feeling heard by the patient's angry doctor after the specialised pain team changed the medication regime. As she recalled:

The pain team . . . got involved again and . . . crossed all the regular analgesia out . . . ended the syringe driver [continuous delivery of opioid medication via subcutaneous route] . . . [but] his pain score was still the same . . . that was a little bit stressful for me because I felt like Dr [the consultant] wasn't listening to me. He almost wasn't even talking to me. He was talking about me but . . . getting quite angry at what had happened and I was trying to explain to him that it wasn't like that . . . [I thought] "oh . . . will someone listen to what I'm saying?" (N31)

Retelling this experience prompted the nurse to suggest that doctors who seemed to disregard nurses' contributions were unlikely to share an understanding of patients' pain management. Communication and cooperation was difficult when nurses and doctors' perspectives diverged:

I was feeling frustrated . . . felt a divide between doctors and nurses and not a collaborative approach and I think that . . . communication is a wonderful thing, I mean if people just open their ears a little bit more and I know he's a consultant and I know we're just nurses, but you know as I say the end result should be the same. (N31)

The same nurse described situations in which nurses and doctors were at "loggerheads" (N31) about pain management. She depicted the discord with medical staff that could leave nurses at the bedside excluded from clinical discussions. The knowledge that patients continued to suffer with pain only increased her sense of disempowerment:

You feel for the chappie [patient] . . . being in pain and . . . you're just trying to do your best and you don't want to be at loggerheads with the doctors, you want to be able to work with them . . . I felt as if I was on my defensive . . . bit difficult really. (N31)

Nurses described a number of situations where a shared understanding of patients and pain management was not apparent. The first of these was when nurses cared for patients whose pain was related to a medical condition. In contrast to surgical pain, there was a view that "medically, pain is not really looked at as a main concern" (N27). Nurses suggested that this meant preemptive prescribing and readily

accessible medical support were less likely to be in place. As evidence, one nurse recalled: “he hadn’t had surgery so he didn’t have a backup plan” (N23). While pain was an immediate problem for patients and nurses, less recognition of medical pain could leave nurses without solutions at the bedside. As one nurse observed: “with medical pain . . . some patients will [say] . . . “you’ve given me this and it hasn’t worked. I am still in pain” and we [say] . . . “there’s not much we can do about that” (N27).

This particular nurse, who worked on the respiratory ward, had also experienced differences of opinion about the value of involving the hospital pain teams in the care of medical patients. As has been described, nurses in this study sought help from these pain experts to manage analgesic risk and benefit for complex patients. When ward doctors did not, similarly, see the usefulness of consulting specialised clinicians, this junior nurse had found herself without access to this support. She lamented:

Doctors . . . who don’t think that the Acute Pain Service is actually beneficial . . . and don’t like giving particular drugs to particular patients and they’ll document it . . . “this patient is not to have this” and so you [think] . . . well what do we do? (N27)

In the quotation above, the nurse was left feeling helpless when she felt doctors’ lack of collaboration limited her options for pain relief. Recollections from two other nurses, vividly retold, provided further evidence of the effect that problematic collaboration could have on nurses at the bedside. The first account was from a senior nurse who recalled an incident from four years previously:

[The patient] was in agony with sciatica . . . and he’d been given some oxycodone and then became really narcotised [showing signs of opioid overdose; sedation: respiratory depression, pupil constriction] . . . almost going to have a respiratory arrest . . . [I was] sitting with him keeping him awake and keeping him breathing . . . we had two different doctors treating who had two different ideas of what was causing . . . the respiratory depression and the drowsiness . . . an anaesthetist who was saying “it’s the pain relief” and we had a respiratory doctor saying “he’s CO² retaining.” So we had two doctors arguing over the cause . . . and giving us very different instructions and we’re . . . [saying] “who do we listen to here? Who do we follow?” Because they were very different means of treatment . . . we were having issues with his pain and . . . dealing with the respiratory depression . . . a difficult situation . . . I felt really frustrated that we were in the position with

the two different medical staff giving us conflicting instructions . . . really annoyed. (N15)

The nurse who told this story revealed that her memory of frustration and bewilderment remained fresh despite the intervening years.

Lastly, a senior nurse on the respiratory ward described the frustration of nurses who disagreed with medical staff about patients who experienced pain as they neared the end of life. In particular, he referred to nurses and doctors' contrasting views of the appropriateness of either curative or palliative approaches to care. From his experience, clinicians who held differing goals were unlikely to agree on strategies for comfort provision. Consequently, without the authority to administer analgesia considered suitable for dying patients, nurses could experience considerable feelings of disempowerment:

Sometimes you can look at a patient and think "oh well they'll be gone [dead] by Monday." The doctors are still struggling away . . . to keep them going . . . we're not offering pain relief. We're not offering palliative relief or comfort relief . . . even though the nursing staff will sit there and say "look doc[*sic*], things are not good here," they won't acknowledge it. (N33)

It was beyond the scope of this study to explore nurses' perceptions about pain management at the end of life. The quotation above is included only to illustrate how clinicians could see patients differently and hold conflicting goals that precluded collaboration.

The importance of effective collaboration with physicians to nurses' ability to provide comfort effectively is well recognised (Brown & Richardson, 2006; Courtenay & Carey, 2008; Grinstein-Cohen et al., 2009). Nevertheless, nurses have consistently described consequences for them and their pain management practice when doctors are unavailable or uncooperative. In an early study, Dutch community health nurses (n=21) who delivered home care for cancer patients with pain described the difficulty of communicating with physicians which could leave them feeling powerlessness (de Schepper et al., 1997). More recently, Swedish district nurses (n=20), who provided care to people with chronic pain demonstrated a reluctance to actively respond to patients' pain problems when doctors were not collaborative (Blomberg et al., 2008).

In Australia, nurses working in neonatal intensive care units found that their patients' lack of obvious pain fed into problematic collaboration with medical staff and difficulty convincing doctors to prescribe analgesia (Nagy, 1998). Additionally, Tasmanian nurses (n=1015), who completed a mailed survey, described barriers to their ability to provide pain relief including lack of cooperation with physicians (Van Niekerk & Martin, 2003). Australian nurses caring for patients with chronic kidney disease who rely on the expertise of senior colleagues and specialty pain teams to manage analgesics find this resource is not always available (Manias & Williams, 2007).

Nurses in the current study were aware that their behaviours also influenced how effectively they collaborated with medical staff. They described a need to speak up and be heard in clinical discussion. The data proposed that some nurses encountered a power imbalance in the acute hospital, which limited their collaboration with medical staff. In particular, younger nurses who often lacked knowledge, experience and a consequent belief in themselves could experience feelings of disempowerment in this situation. This was evidenced by a new graduate who suggested she required:

Confidence . . . I knew what I was doing was right. It's hard when someone questions that but you just go "no . . . I can't overdose this patient" . . . The most senior doctor you can think of . . . I have only been a nurse for . . . 10 months now and . . . you're putting your opinion up against a doctor that is very senior It's tricky . . . that was hard. (N29)

In contrast, more senior nurses spoke up when they felt it necessary. One senior nurse who worked on the respiratory ward made this point when he described how he intervened to limit painful medical procedures:

The older nurse will do that . . . the more . . . confident you get, the more you can . . . say [to the doctor] "excuse me, you've had two attempts. No more." For the patient, 'cause you can see the look on the patient's face. Well someone's got to speak up for them, they're obviously too frightened . . . a senior nurse's role to start advocating more. (N33)

A further finding was that patients could also influence the degree to which nurses and medical staff collaborated to effect pain relief. Patients provided information that helped nurses and doctors to understand the pain problem. If patients painted a different picture for each, clinicians could develop a differing understanding of their needs, preferences and appropriate treatment. As one nurse explained:

The patient will tell the nurse “oh I don’t feel well . . . this [analgesia is] not working” but when the doctor comes to see the patient and say[s] “hi, good morning, you look great” . . . patients say “oh, yes I am” . . . The doctors leave and after that they will turn to the nurse [and say] “I am nauseated. I am vomiting. The drug’s not working. I can’t move.” [I say to the patient] “But five minutes ago you tell [*sic*] the doctor you are ok.” (N25)

Another demonstrated how patients’ input could spark discord between nurses and doctors. She recalled a recent incident involving her patient with mesothelioma and his consultant doctor. She said:

I’d just been in [to see the patient] five [or] 10 minutes previously . . . to see if he wanted some analgesia and he said “no . . . the 12 o’clock [medication round] is coming up soon. [I will wait] otherwise I’d be singing like a canary” . . . so I said “ok fine . . . see how you go after that” . . . Five or ten minutes later Dr [Name] had come round and spoke to the patient and the patient said his pain was scoring an eight out of 10 so then Dr [Name] turned around and was a bit angry . . . with me. (N31)

This nurse’s account captured the doctor’s reaction when the patient intimated she had neglected to offer him medication. Although she did not explicate feelings of disempowerment, it could be inferred that these exchanges led to feelings of frustration and manipulation.

In the current study, nurses commonly described feelings of disempowerment when unable to communicate and cooperate with medical staff to provide comfort for patients who experienced severe pain. A few nurses however, also experienced difficulty working with other nurses. For example, one junior nurse interpreted a more senior nurse’s comment as a judgment that she had not acted decisively. Her sense of ineffectiveness was evident as she tried to defend herself:

There was another nurse with me . . . she was saying to me . . . “this isn’t good enough and you should tell the doctor” and I was just going “I know. I know this. I have gone to him” so it was . . . pressure from his wife and the other nurse . . . it was something I already knew, and I didn’t need to be told again . . . It wasn’t like I wasn’t looking after him properly. (N06)

From another perspective, lack of collaboration with other nurses was also thought to preclude continuity of patient care. This was most important in terms of consistent analgesic administration and nurses’ ability to keep control of pain. One senior nurse illustrated this point by again referring to the issue of comfort provision for patients nearing the end of life. He described how nurses’ differing considerations of analgesic risk and benefit could lead to ineffective pain relief:

When the doctors have made them [the patient] palliative and . . . they’ve been given breakthrough morphine . . . [but other nurses] just won’t give it because . . . for some reason [they] perceive themselves as a killer for giving . . . comfort measures. I see as comfort measures . . . I’ve seen patients when I have come on, [who were] totally sedated when I . . . [went] home, thrashing around in the bed because the sedation’s been removed for 10 hours. (N33)

While this study did not focus on nurses’ end of life care, this quotation provides further evidence that clinicians’ varying thoughts and feelings about patients and pain management tended to constrain collaboration and leave nurses with feelings of disempowerment.

Summary of collaboration with patients and colleagues.

To summarise, collaboration with patients and colleagues involved communication and cooperation with patients, doctors and fellow nurses to implement feasible pain relief. The findings indicated that collaboration increased when nurses shared an understanding of pain management with those around them. Nurses interpreted patients’ compliance as acceptance of their care they offered, and evidence of shared goals for pain relief and a sense of trust. In contrast, they found it difficult to collaborate with patients who seemed to resist their care, leaving nurses feeling helpless and frustrated. A tussle for control was described when nurses and opioid-tolerant patients held different goals for comfort provision. This tussle seemed to emerge when nurses sought to protect patients by restricting doses of analgesics

they considered inappropriate, whilst patients focused on obtaining liberal medication to relieve pain.

Collaboration with medical and nursing colleagues involved nurses in analgesic decision-making and enabled them to respond promptly to patients' pain problems. Ready access to medical staff, who held similar perspectives of pain management, increased nurses' ability to provide feasible comfort measures. In contrast, nurses could feel isolated at the bedside and excluded from clinical discussion when doctors were unavailable or seemed uncooperative. Without medical direction, nurses described feeling helpless and frustrated as they watched patients' ongoing suffering. The findings indicated that nurses, doctors and patients all shaped the communication that occurred between them. Shared goals facilitated consistent approaches to comfort provision. Without them, nurses described frustration at their inability to provide the continuity of care that kept patients' pain under control.

Nurses' descriptions indicated that communication and cooperation with patients, doctors and other nurses took time. Therefore, a prominent finding of this study was that nurses needed time to care for patients who experienced severe pain. Sufficient time facilitated nurses' comprehensive assessment and use of holistic approaches for patients who were suffering with pain. However, factors identified in the acute hospital were found to influence how much time nurses had available to conduct pain-related interactions. The following section describes these factors, which primarily concerned staffing and workloads.

Time to care.

Nurses included in this study recognised that they needed time to attend to patients who experienced severe pain. Time enabled them to provide a physical and emotional presence, to get to know patients, and to use nonpharmacological measures. As one nurse observed: "you're spending more time in that room because you have to because that's where you're needed. The patient needs you" (N05).

The findings indicated that nurses experienced a measure of relaxation when they had sufficient time to attend to patients who were suffering from severe pain. The senior nurse who earlier described caring for the patient with agonising sciatica,

drowsiness and respiratory depression recalled: “I felt fine . . . I understood what was going on . . . and I was just sitting with him and talking to him so . . . I felt fine about it” (N15). Spending time with patients allowed nurses to get to know their needs and preferences to inform holistic care. For example:

One thing I do if I have any spare time is to sit with the patient. It’s hard to get an idea of someone from just handover [report] and . . . you just need to make that picture so much more than those few words that you’ve got written down. (N29)

Sufficient time also enabled nurses to augment analgesic medication with emotional support and other nonpharmacological interventions in accordance with a holistic perspective. As one nurse explained:

On a quieter shift it’s easier to look after someone with pain just because they need more than just . . . the painkillers . . . they need to be distracted . . . someone to talk to them . . . you feel better if you can spend more time with them explaining things . . . showing a bit of compassion. (N26)

Nurses tended to differentiate between interactions with patients to accomplish clinical tasks, such as administering medication, and interactions with patients to establish human connections. With time, nurses were able to nurture these connections with patients that communicated how they were valued and would be cared for:

Alternative things are good . . . I think they need to be incorporated . . . more into pain [management] . . . I think patients feel as if “well, here’s a couple of pills, it’s all going to be better” . . . and it’s not until you do something else that actually helps, makes them feel that you are actually doing something. (N32)

In doing so, nurses provided a physical and emotional presence to reassure patients that help was at hand, which fostered confidence and relieved anxiety. One nurse stated: “if you acknowledge that they do have pain but . . . you’re doing everything that you can, they seem to respond better” (N27). Another explained it in the following way:

They are anxious and . . . they obviously want you to give them analgesia to take away the pain but they also want to know . . . why they've got the pain and when is it going to go away . . . sometimes they think . . . "something might be wrong" . . . reassurance is good. They just want to know . . . just not what you're giving them for pain . . . why and when is it going to go away? (N26)

Patients' increased emotional comfort tended to potentiate physical pain relief measures. For example:

Rather than . . . just say[ing] "two Panadol, swallow it" . . . you say to them "these [are] . . . for your pain. We will give it to you regularly, six hourly, and on top of that we can give you something stronger. Panadol is . . . very good for your pain" . . . they . . . understand why they have swallowed these two white round tablets . . . they feel they know more . . . and then they are happy to hear that . . . once they take it, they really feel it works and they think "I can trust this nurse or this doctor because they promised and they telling me the truth." (N25)

Nurses felt patients were more secure when they understood what was happening and felt confident in the people caring for them. Taking time to reassure patients was important and involved:

Informing them what we'd done to help with the pain and what we're going to do and . . . reassure them and their family . . . so they . . . they don't feel like we're not doing anything for them . . . not leaving them . . . wondering "oh, well when am I going to get something?" (N06)

Moreover, patients seemed comforted when they knew there was a plan for pain relief. Nurses felt patients shared their understanding that pain management was subjective and required a degree of trial and error. A plan reassured patients that alternatives were available if treatment proved ineffective:

They [patients] want to have a plan. They want to know what you're doing and "what can you do if this doesn't work? If this pill doesn't work then what are you going to do?" and "are you going to make me get up and walk? Is the physio going to come in?" So they just want reassurance and . . . they want to know the plan. I think people with pain; they want to know exactly what you are doing about it and . . . what happens if this pill doesn't work? (N26)

However, nurses who lacked time could find themselves excluded from planning and unable to provide the comforting human presence that they knew patients who experienced severe pain needed. Firstly, insufficient time meant nurses were not present for pain-related discussions, as this nurse explained:

I was feeling very frustrated . . . you're not involved in the planning . . . they say that you should be, but you're just too busy . . . you don't have time to . . . listen or discuss . . . I just get really frustrated because things are happening and I don't feel I am involved with the planning. (N02)

Secondly, a lack of time tended to cause nurses to dispense with the interactions that nurtured emotional connections. For example, one nurse declared:

It's very clinical . . . in the hospital . . . there's not enough time. Not time to sit there with one patient when . . . and if there's nothing further that you can do . . . except for sitting with them, sometimes you think I just . . . can't do it because there are three other people who need you. (N23)

Nor could nurses provide the reassurance they felt patients needed. As evidence, one senior nurse recalled caring for her patient with pancreatic cancer: "he did have the perception that if he used too much [analgesia] now it might not be beneficial for him . . . when you're pressured for time I didn't sort of get into any of that" (N01). There was also a suggestion that lack of time could increase nurses' already evident reliance on pharmacological pain relief. One nurse described her misgivings when insufficient time limited the alternative comfort measures she could offer patients:

We use a lot of . . . pain relief and analgesic . . . because . . . we're so busy . . . we're putting on patches or putting up ketamine infusions and PCAs [patient-controlled analgesic delivery] and I think . . . from my own experience I know . . . how ill it can make you feel. (N05)

A number of nurses bemoaned the heavy workload and increasing patient acuity, which they felt limited the time and attention they could devote to meeting the needs of patients in severe pain. Interview data elucidated the effect on nurses of caring for multiple patients. Participant observation captured the reactive nature of their work. Figure 6 describes the influence of these factors on the time nurses perceived was available to care for patients who experience severe pain.

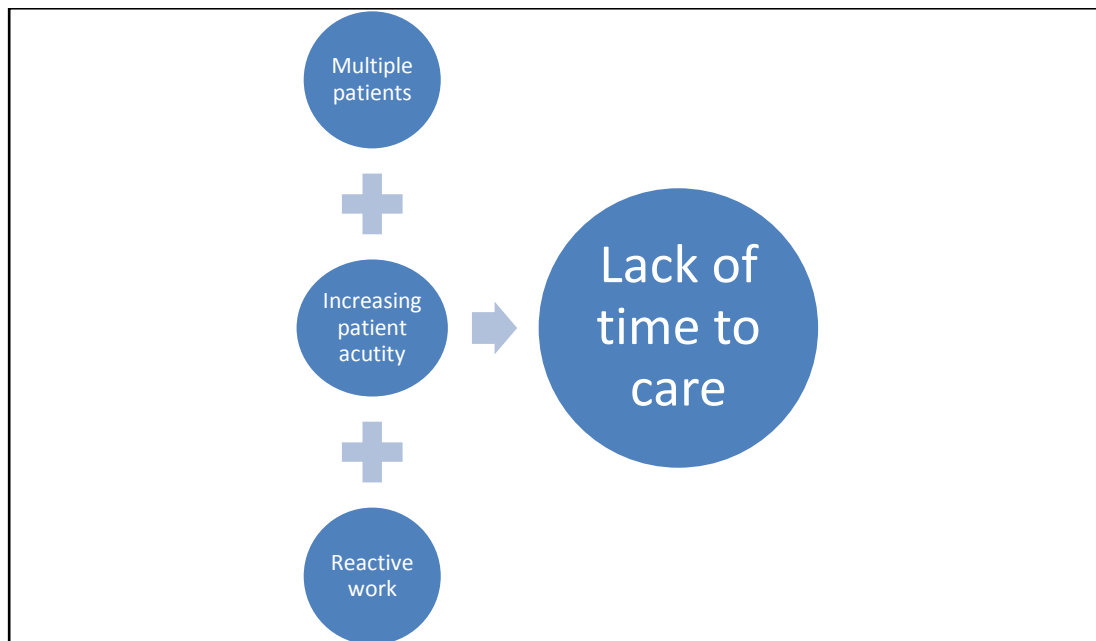


Figure 6. Factors contributing to the lack of time to care.

Nurses' ability to use a holistic approach decreased with interruptions and the necessity to respond promptly to patients' unplanned, and often concurrent, needs. Three excerpts from the field notes and the researcher's reflective journal are included to illustrate this point. The first example is from the field notes made from Observation Two. The nurse was caring for a patient, who had been complaining of severe abdominal pain, in a four-bed room. She was noted to be responsible for all patients in the room during a busy morning shift:

4/06/2007

0925: Patient is still on phone . . . nurse is still busy caring for another patient. At this point I considered one of Charmaz's (Charmaz, 2006) questions as a reflection about the nurse, *What is affecting and determining her activities* (p. 24). I noted that her activities are directed at meeting the needs of other patients in the room as they arise – mobility assistance, assistance for patient in wheelchair who is vomiting, and assistance to complete showers. (Observation 2)

The reactive nature of nurses' work was also captured in one of the researcher's reflections made after a period of participant observation on the eye/ear/plastics ward. The following entry recorded the observation of a nurse working in a four-bed room:

13/11/2008

I got an inkling of the reactivity that can occur in a nurse's day. I was helping [to make] beds in a four-bed room where the nurse was moving quickly giving IVABs, dressings, helping patients to mobilise, get to the toilet, complete hygiene etc. (Reflective journal)

A proportion of nurses' work, such as medication administration, dressings and hygiene activities, could be planned. However, participant observation indicated that many patient care activities such as assisting with toileting and mobilising were done only when the need arose. The previous entry captures, not only the sense of nurses' busyness and constant motion, but also the subsequent diminished control in their day-to-day activities. Reactivity in nurses' work emerged as a major theme in an exploration of the influences of time and context in Australian surgical nurses' pain management (Manias et al., 2005).

Finally, an excerpt from field notes made from Observation Ten as the nurse intended to ask her patient, who had undergone extensive surgical debridement for necrotising fasciitis, about his pain. This example illustrates how interruptions could compromise nurses' ability to provide timely care:

3/11/2008

1717: Nurse enters room and looks at patient. She doesn't speak. Nurse picks up patient notes. An announcement can be heard over the ward intercom requesting this nurse to come to the desk to answer a patient query. She leaves room.

1722: Nurse re-enters patient's room. She puts on gloves and looks at charts. Tells patient she is going to check his observations . . . She asks the patient how much pain he has and he answers "seven [out of 10]." (Observation 10)

Nurses in the current study were aware that time was a finite resource to be apportioned. They suggested that the multiple patient load fragmented care, as evidenced by comments such as: “harder to manage her pain would be lack of time . . . you can’t just focus on that patient. It’s always you have another . . . four, in this case.” (N02). This perspective was confirmed in observational data. For example, the following excerpt from field notes made at the beginning of Observation Three describes the general activity and ambiance of the orthopaedic ward during a morning shift:

25/10/2007

0915: Ward seems very busy this morning. Nurses noted to be hurrying in their activity. One grad[uate] nurse explained that she and another grad[uate] nurse have five patients each. Other nurses have higher acuity patients. There are some agency care assistants on the ward who are showering and mobilising patients. I noted to the CNS that the ward seems very busy and she responded “this is normal.” The [graduate] nurse participating in this observation has five patients: two [are situated in] in one four-bed room, one in another four-bed room, one in another four-bed room and one in a single room. She has a patient going to Theatre and a number of dressings to do. (Observation 3)

Nurses’ perceptions of short staffing and heavy workloads in the acute hospital captured in this study were supported by a report published in the state newspaper during data collection (O’Leary, 2007). Western Australia’s public hospitals were said to be over 800 nurses short, with the study hospital unable to fill 120 of the 1330 Full Time Equivalent positions. According to the article, nurses were delaying taking leave, and working longer and extra shifts to fill gaps in staffing rosters. Consequently, one large hospital had informed inpatients that some aspects of their care were likely to be delayed. This story demonstrated the effect that increasing workloads and consequent fragmentation of care were thought to have on nurses and their patients. The importance of the issue was such that it was the subject of the newspaper’s daily cartoon, which appears in Figure 7.

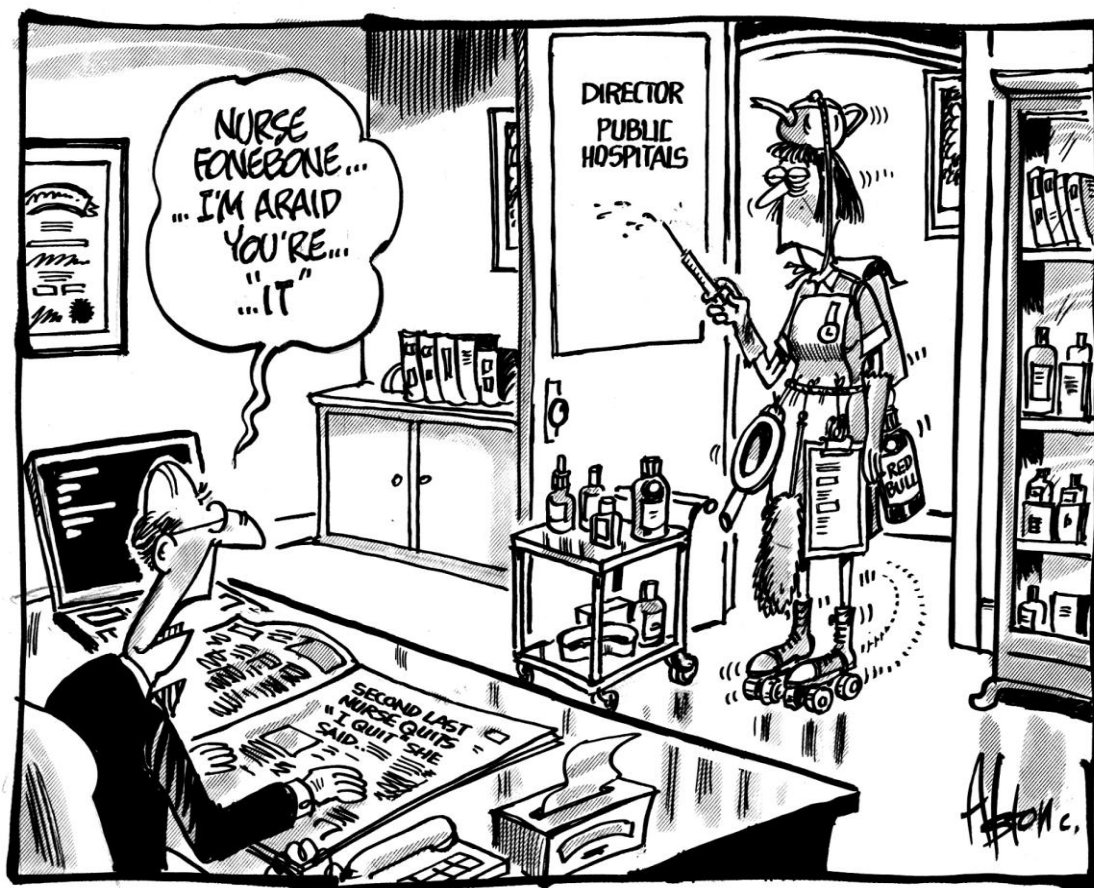


Figure 7. Cartoon appearing in The West Australian newspaper, 16th October, 2007. Reproduced with permission (See Appendix P)

A further report in January 2009 in the state's Sunday newspaper entitled, "800 nurses short" suggested that little had changed 16 months later (Deceglie, 2009).

The effect on nurses of competing demands and interruptions when they cared for patients experiencing severe pain was captured in the current study. An early example came in Observation One, which involved a nurse who was caring for two patients. The first patient had breathing problems from a malfunctioning tracheostomy, while the second was experiencing severe pain related to pancreatic cancer. Field notes taken during the observation testified to the nurse's inability to respond promptly to the patient in pain. As the following excerpt demonstrates, 24 minutes elapsed before the nurse could leave her other patient:

30/05/2007

0826: [The researcher] went to patient's room . . . he answered that his pain was a "nine" . . . I located the registered nurse caring for the patient. She was busy in the adjacent patient's room. . . when she came out I . . . asked her if I could observe the care of her patient who had rated his pain at nine out of 10. She expressed surprise that he had rated his pain that highly. She stated that when she had given him his regular morning pain medication he had not told her that he had pain. She was happy for me to observe.

0832: I located myself out in the ward hallway. The nurse went into the adjacent patient's room . . . Nurse remained busy with adjacent patient.

0850: The nurse went in to see the participant patient. (Observation 1)

When the nurse was interviewed later that day, she explained how she was unable to meet the concurrent needs of both patients. She delayed attending to the patient in pain who she deemed less urgent because, despite his severe pain, he was safe to be left alone. As she stated:

You have to prioritise . . . it was more important that I fixed the lady, fixed the trache[ostomy tube] and I see she's breathing . . . I was aware [and thought] "well I need to get there as soon as I can to sort out his pain", but that was still more pressing; her airways . . . than the pain. (N01)

Observational research has revealed that Australian nurses similarly prioritise other clinical tasks, as well as nonclinical interruptions, over pain management (Manias et al., 2002; Manias et al., 2005; Manias & Williams, 2007). In one study, nurses caring for patients with chronic kidney disease in five Victorian hospital renal units deferred pain communication when juggling the clinical needs of multiple patients needing surgery, procedures and treatments (Manias & Williams, 2007). Earlier, observation of Australian nurses providing direct patient care in a postsurgical ward captured 41 pain activities, demonstrating that interruptions were a major impediment to their timely responses to patients' complaints of pain (Manias et al., 2002). The authors were struck by the degree to which nurses had to contend with the competing needs of other nurses, doctors and patients and their consequent tendency to defer provision of pain relief in favour of other tasks.

The current study builds on this evidence by revealing the effect of interruptions which prevented nurses from spending time with patients they knew

were suffering with pain. One described a sense of frustration at being pulled away from someone who needed her:

The patient load . . . morning workload which is fairly heavy and you're trying to do just everything . . . I think when someone's in that much pain you don't feel comfortable sometimes just leaving them, but you have to because . . . you've got to rush off and do other things . . . you are rushing out of the room saying "I'm sorry I will be back in five minutes. Take this pill . . . call me in 20 minutes" . . . just rush in and rush out and I think sometimes they [patients] might see that, not necessarily that you don't care but maybe that you're not giving them as much attention. It can be difficult when you're busy. (N26)

Another spoke of abandoning patients who needed her physical and emotional presence. She intimated that not being there eroded the trust and rapport underpinning collaborative relationships:

We can't spend that much time so . . . I'm actually going to leave the patient there . . . and this patient will be there in pain. And this patient might be thinking "gee she's abandoning me. No-one cares about me . . . because the first one to know that I have pain . . . has not come back" . . . I don't want the patient to feel abandoned. I don't want the patient to feel . . . "this is a hospital and I'm being left here with pain." (N17)

These examples suggested that nurses could feel the dissatisfied when they felt constrained in this way. For example, one nurse remarked:

It's just hard because we are just so short staffed . . . hurrying and you can't spend the time that you want to . . . sometimes it would be nice to be able to stop at the bed . . . and talk to the patient and spend a bit more time but sometimes it's just not possible . . . that's probably the hardest part. (N05)

This finding that insufficient time to care constrained nurses' comprehensive assessments and holistic comfort provision is supported in the literature. A plethora of studies demonstrate how a lack of time, heavy workloads, staff shortages, and the requirement to manage multiple acutely ill patients place considerable demands on nurses who assess and manage pain (Bell & Duffy, 2009; Bolster & Manias, 2010; Manias et al., 2002; Manias et al., 2005; Tapp & Kropp, 2005; Williams & Manias, 2007b). This literature suggests that the experiences of nurses in the current study are typical. Lack of time has been suggested to contribute to opportunistic rather than planned, and simplistic pain assessments, as well as deferral of pain management in

favour of other clinical activities (Bucknall et al., 2007; Manias et al., 2002; Rejeh et al., 2009). The problem is exacerbated when patients with complex chronic health problems require detailed assessment and planning (Williams & Manias, 2008).

Recently, Australian nurses working in an acute care hospital ward (n=14), which embraced the patient participation and an individualised person-centred care, revealed that lack of time diminished their relationships and in-depth conversations with those in their care (Bolster & Manias, 2010). This finding tends to support the apparent challenge faced by nurses in the current study who valued comprehensive assessment and holistic approaches, but often lacked the time to properly discuss patients' problems and tailor physical and emotional comfort measures.

Summary of time to care.

The findings indicated that sufficient time to care for patients who experienced severe pain enabled nurses to provide prompt, comprehensive pain relief augmented with ample emotional support. However, nurses often found staffing constraints, heavy workloads and the competing demands of multiple, high acuity patients fragmented care and interrupted the provision of comfort. Accordingly, they described feeling increasingly reliant on analgesic medication, despite concerns about side effects, and suggested the possibility that distressed patients could feel abandoned. Nurses' consequent frustration when unable to stay with patients or contribute to planning and decision-making was evident.

Summary of Chapter Four

This chapter has defined the core problem encountered by all nurse participants of *feelings of disempowerment*. Disempowerment in this study referred to nurses' perceived inability to facilitate positive outcomes and enhance the wellness of patients who experienced severe pain by providing comfort. Feelings of disempowerment were characterised by helplessness, frustration, dissatisfaction and, eventually, exhaustion, which damaged nurses' well-being.

The findings indicated that nurses were affected by their patients' distress from severe pain and their sense of ineffectiveness. Four conditions were identified,

which influenced nurses' experiences of the core problem. These conditions involved nurses' *levels of empathy, access to effective medication, collaboration with patients and colleagues, and time to care*. All the conditions were found to have either increased or decreased the amount of empowerment to provide comfort or feelings of disempowerment that nurses experienced at a given time.

Evidence proposing that well-developed feelings of empathy prompted nurses to accept patients' self-reports of pain and take a proactive approach to comfort provision was presented. It was also argued that if nurses' empathic engagement intensified with patients in persisting pain, they could experience personal distress. The contrasting situation, in which patients' apparent emotional calm and lack of physical pain cues dampened nurses' empathic responses leaving some feeling manipulated, was also described.

With pharmacological strategies considered most effective to alleviate severe pain, nurses' experiences of empowerment when able to access effective medication were presented. Evidence that nurses felt at a loss to help patients when they lacked appropriate knowledge or an effective prescription, or when patients were unwilling to report pain was also outlined. Additionally, it was argued that nurses felt comfortable giving analgesia to patients they saw were in severe pain and able to tolerate sufficient analgesia to relieve distress and restore function. This experience was contrasted to nurses' helplessness and frustration when patients eschewed medication, or when they perceived the risk of giving painkillers to unstable, allergic, elderly or complex patients seemed to outweigh the benefits.

This chapter emphasised nurses' collaboration with patients, medical staff and nursing colleagues to implement feasible pain relief. It was proposed that collaboration increased when nurses shared an understanding of pain management with those around them. Nurses' tendency to interpret patients' compliance as acceptance of the care they offered, shared goals for pain relief and a sense of trust was described. Evidence that nurses found it difficult to collaborate with patients who seemed to resist their care, which could leave them feeling frustrated was also provided. A potential tussle for control was described when nurses and opioid-tolerant patients held different goals for comfort provision. It was argued that this tussle emerged when nurses sought to protect patients by restricting doses of

analgesics they considered inappropriate, whilst patients focused on obtaining liberal medication to relieve pain.

The importance of nurses having ready access to medical staff who valued their input and senior nursing support if they were to feel effective and confident to provide comfort, was also discussed. The contrasting experience of feeling alone with suffering patients and excluded from clinical discussion when doctors were unavailable or unwilling to listen and nurses' consequent helplessness and frustration was explored. While reports of nurses feeling unsupported by their nursing colleagues were few, the implications for continuity of patient care of nurses' differing perceptions of analgesic risk and benefit were noted.

Finally, it was proposed that sufficient time enabled nurses to use a proactive and holistic approach to provide ample physical and emotional support for patients who were distressed with severe pain. The influence of heavy workloads and competing demands of multiple, high acuity patients on nurses' reliance on analgesics, concern for suffering patients and consequent feelings of disempowerment were described.

The findings from this research indicate that when nurses encountered the core problem of feelings of disempowerment they employed a basic social psychological process, entitled *seeking empowerment to provide comfort*, in an attempt to resolve it. The basic social psychological process identified in this study is described and explained in Chapter Five.

CHAPTER FIVE

Findings

The Basic Social Psychological Process: Seeking Empowerment to Provide Comfort

Introduction

Chapter Four described the core problem identified in this study of feelings of disempowerment, which related to the inability to provide comfort. The findings indicated that nurses working in medical and surgical wards in this acute hospital at times encountered the core problem when they felt unable to help patients who experienced severe pain. Regardless of the ward setting or level of seniority, all nurse participants in this study experienced the core problem to a greater or lesser degree when intervening conditions constrained their comfort provision for distressed and incapacitated patients. These conditions involved nurses' level of empathy, access to effective medication, collaboration with patients and colleagues, and time to provide care. The data proposed that encounters with the core problem threatened nurses' well-being. In response, nurses employed a basic social psychological process, which was labelled *seeking empowerment to provide comfort*. Nurses were found to have used this process to empower themselves to provide comfort and to protect themselves from escalating feelings of disempowerment.

Glaser (1978) refers to a basic social psychological process as a core variable, which has at least two clear stages. He describes this as durable, sequential and able to explain changes over time (Glaser, 1978). Strauss and Corbin (1998) highlight

participants' actions and interactions, and how these evolve, as fundamental to process. The grounded theorist's goal is discovery of participants' main concern and its resolution (Artinian, 2009). It is the basic social psychological process that can explain how participants act and interact as they work through a particular situation, context or problem (Glaser, 1978; Strauss & Corbin, 1998).

In this study, participants' main concern was disempowerment, which was defined as a perceived inability to provide positive outcomes and enhance the wellness of patients who experienced severe pain. Nurses were found to use the basic social psychological process of seeking empowerment to provide comfort to avoid or resolve the distress, frustration, dissatisfaction and exhaustion of disempowerment. Actions and interactions were undertaken to overcome the intervening conditions that were preventing nurses from comprehensively assessing pain and providing holistic care. The findings indicated that nurses progressed through the process of seeking empowerment to provide comfort when feelings of disempowerment increasingly threatened their well-being. This chapter describes and explains this overall process and its emergent stages. Excerpts from nurses' texts and ward observations are included to demonstrate fit and to illustrate emerging categories.

Seeking Empowerment to Provide Comfort

The basic social psychological process of seeking empowerment to provide comfort described strategies used by nurses to secure the resources they required to alleviate patients' pain and distress, or to shield themselves from experiences of disempowerment. During the initial stages of the process, nurses focused on overcoming barriers to collaborative relationships, access to medication, and lack of time to provide care. Later, however, nurses sought to manage the uncomfortable and unhealthy emotions of persisting disempowerment and the significant threat to their own well-being. Three stages were identified in the basic social psychological process of seeking empowerment to provide comfort. These stages were:

- 1) Building connections.
- 2) Finding alternative ways to comfort.
- 3) Quelling emotional turmoil.

Firstly, nurses attempted to *build connections* with patients, doctors and other nurses to enable more time to provide care, secure effective medication and increase collaboration. Secondly, when unable to administer timely or sufficient analgesia, nurses looked to *find alternative ways to comfort* by being there for patients and using nonpharmacological approaches. Lastly, nurses tried to *quell their emotional turmoil* with strategies, such as venting, reappraising and, ultimately, disengaging from the care of patients experiencing severe pain. The basic social psychological process is represented diagrammatically in Figure 8.

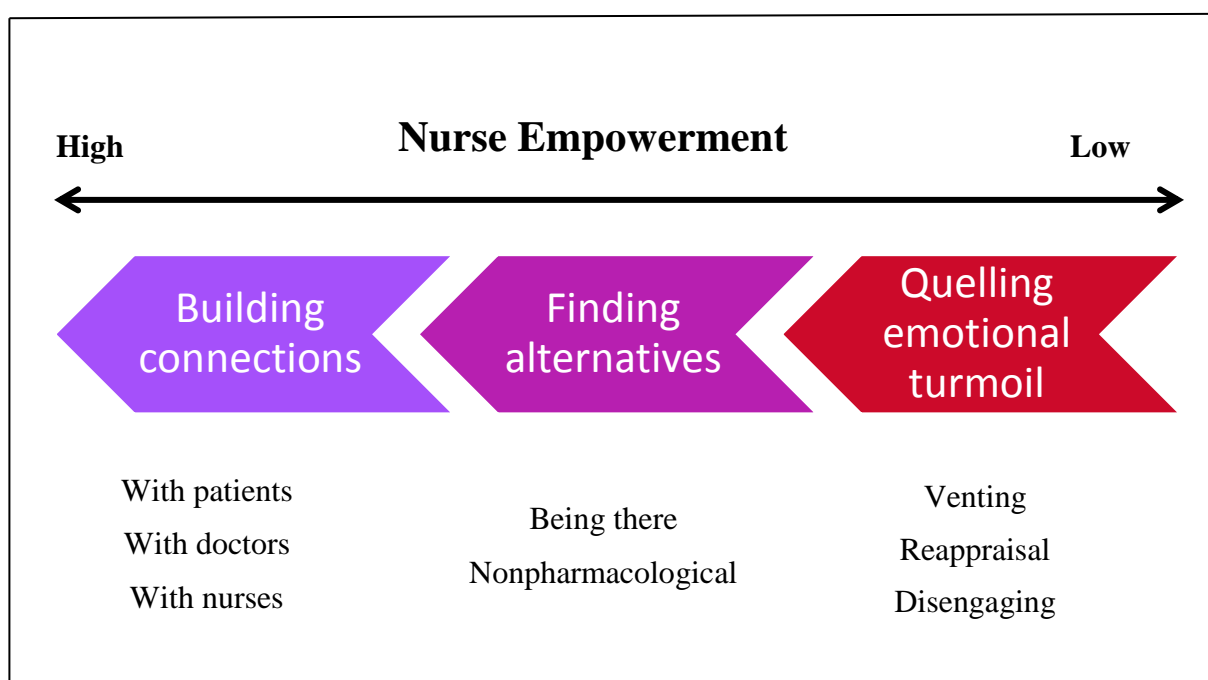


Figure 8. The basic social psychological process: Seeking empowerment to provide comfort.

The basic social psychological process identified in this study was essentially a quest for empowerment. As described in Chapter Four, nurses' empathic responses prompted them to provide comfort to relieve patients' distress from severe pain and to promote healing. It was further found that when faced with patients' ongoing suffering with pain, nurses similarly sought to bring situations under their control in order to improve the outcome. The last lines of the following recollection are evidence of this:

I gave him five [mg] of morphine and then . . . when you think it would have really kicked in, it hadn't and . . . his wife called up and [said] . . . “what's going on? Is he going to die?” And I [said] “no, he's not going to die, he's just in lots and lots of pain . . . I'm waiting for the doctor to come . . . being Saturday there's not really anyone around” . . . I eventually got that happening. Got it under control. (N23)

This quotation shows how nurses used this process to secure resources and drive relationships in order to empower themselves for more effective comfort provision. Initially, these strategies revolved around building connections with others to overcome uncooperative behaviours, garner knowledge and confidence, and increase emotional support to patients. Accordingly, this first stage of the basic social psychological process was entitled *building connections*.

Stage One: Building Connections

When conditions in the acute hospital prevented nurses from assisting patients who experienced severe pain, they sought to connect with those around them who could secure the resources they required. Engaging with patients procured time to develop feasible pain relief, overcome resistive behaviours and provide calm reassurance to soothe anxiety. Productive interactions with medical staff provided nurses with the authority to administer timely and sufficient analgesia, which was considered most effective to relieve physical pain. The data also showed that increased collaboration with more experienced nursing colleagues provided greater access to the body of knowledge residing in the acute hospital. This gave nurses confidence to participate in clinical decision-making and use analgesic medication effectively.

The findings indicated that nurses built connections with people who they felt had power to develop and implement effective strategies to alleviate patients' pain and distress. They described actions and interactions with patients, doctors and other nurses that revolved around (a) prioritising patients, (b) initiating contact, and (c) negotiating differences. Figure 9 provides a diagrammatic representation of nurses' strategies to build connections, which are then described.

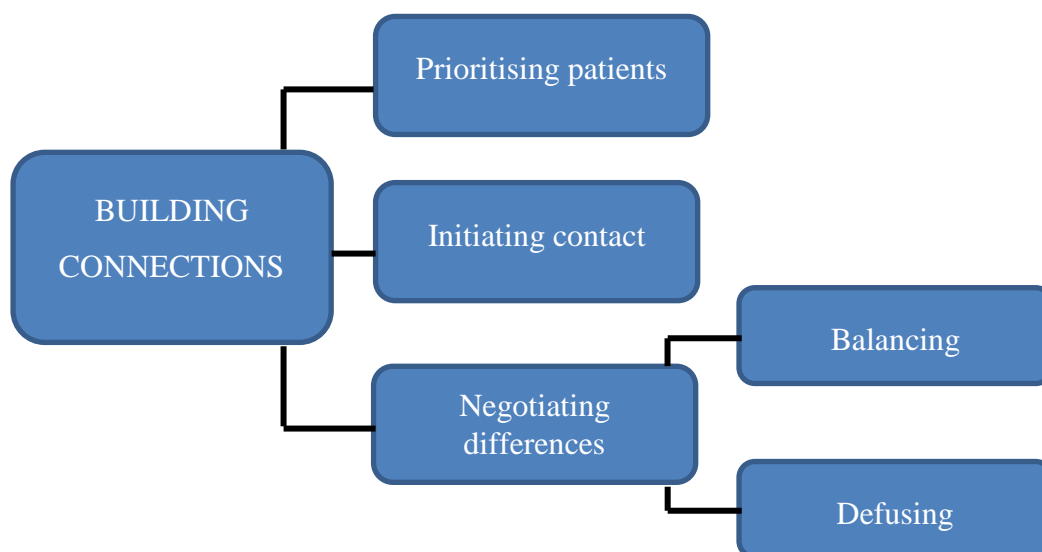


Figure 9. Nurses' strategies to build connections.

Prioritising patients.

Chapter Four outlined nurses' tendency to prioritise physical pain relief to avoid a cascade of other problems and protect patient well-being. This section discusses the finding that when patients' severe pain and distress continued, nurses further prioritised their care above that of other patients. For example, one nurse recalled:

My priority . . . to sort her out before any of the other patients . . . getting her comfortable . . . was more important than . . . doing my eight o'clock medication [administration] on time . . . she was the most . . . unwell . . . vomiting and in unbearable pain. (N18)

Nurses indicated that prioritising these patients procured time for comprehensive assessment, problem-solving and provision of physical and emotional support. One nurse reflected: "it's all just priority. That's where you are needed . . . you've just got to be in the room at the time and do what you have to for that patient and prioritise" (N05). With extra time, nurses could pursue interactions with colleagues to secure access to effective medication. This was demonstrated when one nurse recalled: "devoting a lot of time to . . . that particular patient if pain is a problem . . . not

necessarily always with the patient but talking to medical staff and sorting out treatment” (N15).

This example provides evidence that nurses sought to create time for more frequent and productive interactions with those who were instrumental to comfort provision. In doing so, they tried to influence the behaviour of patients and medical staff and draw upon the resources of other nurses in order to facilitate more effective pain management. The data proposed that nurses empowered themselves through building positive and useful connections with these people. Strategies involved initiating contact and then negotiating differences by balancing competing concerns and defusing nonproductive interactions.

Initiating contact.

Rather than wait for others to address patients’ persisting pain problems, nurses attempted to empower themselves by instigating interactions that would facilitate the administration of appropriate analgesia. Firstly, they initiated communication with patients who appeared reluctant to report pain, and they sought to influence those who were unwilling to accept analgesia. As outlined in Chapter Four, nurses often felt that patients’ reticence to communicate about pain prevented the timely administration of analgesia. While some nurses expected patients to report pain, others took a proactive approach as explained by one nurse: “some people [patients] are afraid to ask for it so . . . offering it and reassuring them . . . [saying] ‘we’ll give it to you every two hours’” (N06). This same notion of taking control also emerged in this senior nurse’s observation of her colleague who instigated analgesic administration to provide consistent pain coverage:

He was once again quite settled. (RN Name) who looked after him overnight had done a wonderful job . . . she just decided that she would give him regular pain relief whether he asked for it or not. (N19)

Another nurse recalled regularly prompting her patient to use a patient-controlled analgesic delivery device:

Her pain had gone up to a six out of 10 . . . she was in quite a lot of discomfort and as much as I was encouraging her to use the PCA [patient-controlled analgesia]. . . there was no decrease in her pain level . . . I also

found that she was really quite . . . sleepy, a little bit spaced out, couldn't focus on anything so I had to keep reminding her to use the button because she'd just leave it by her side and forget. (N20)

The data proposed that nurses initiated these interactions to encourage patients to overcome their unwillingness to disclose information about pain experiences. Nurses' descriptions indicated that these proactive approaches emulated the around the clock prescribing considered most effective to relieve pain (World Health Organisation, 2012). Initiating contact with patients allowed nurses to use analgesic prescriptions more effectively. However, situations were also described in which medication administered at the appropriate time was insufficient to relieve severe pain. Nurses found that they needed to overcome ineffective prescriptions in these circumstances, and described initiating contact with medical staff for further direction.

The findings indicated that nurses attempted to liaise with doctors to secure the authority to administer sufficient pharmacological pain relief when they felt unable to assist patients who were experiencing severe pain. For example, two nurses observed: "we were basically giving it [analgesia] every two hours on the dot . . . when I didn't think that was . . . holding it, that's when you speak to the doctor" (N06), and "if it [analgesia] doesn't appear to be adequate enough then you ring the doctors, ring the Pain Team . . . ask them to come and help" (N19). It was clear that nurses felt their limitations keenly in such circumstances. This was evidenced by the comment: "we really need to pass it on to someone with higher expertise and . . . ability to do something" (N17). Accordingly, the cooperation of medical staff who prescribed analgesia was important to nurses as they cared for patients who were suffering with severe pain.

Nurses' descriptions showed that they sought to build connections with doctors who they saw had the expertise and authority to expedite their delivery of pain relief. This was evidenced by one nurse who recalled:

Trying to collaborate with the doctors . . . even though it is frustrating . . . they want to treat them as well and they don't want them to have pain so it's no use just being annoyed at them and saying "well this isn't good enough" . . . he's obviously concerned too and just trying to work together and figure out a solution. (N06)

Building connections with medical staff involved nurses instigating productive interactions through proactive and assertive behaviours. One junior nurse recounted her dismay when the doctor appeared in no hurry to review her patient with severe abdominal pain. She felt she had to intervene: “[the doctor said] ‘we’ll come and see her in our rounds’ and it wasn’t until I . . . said ‘well we need something now’ . . . that’s when he tried a stat [analgesic] dose” (N32). Another recalled:

The minute I saw the Resident [Medical Officer] coming in I just went and spoke to him straight away . . . and [later] I thought “no she’s still in a lot of pain and it’s not resolving and it’s not changing” . . . I paged him again and said to him “should I call the Pain Team?” And he said “yes.” . . . I just rang them straight away. (N05)

These data support findings from a phenomenological study of Swedish nurses (n=14) who cared for postoperative patients who were in pain. (Söderhamm & Idvall, 2003). These nurses described how they dealt with problematic situations. Similarly to nurses in the current study, they frequently sought pharmacological solutions to pain problems and advocated for medication changes when they felt patients suffered unnecessarily.

Nurses included in the current research frequently instigated contact with doctors to circumvent delays in reviewing and amending analgesic prescriptions. Having initiated an interaction, a number of nurses explained that they then attempted to influence doctors’ responses to patients’ pain problems. For example, one used assertiveness to secure specialised medical input:

After the second time it didn’t work I said [to the doctor], “you really have to review him and do something and I think we really have to get the Pain Team involved” . . . a bit more assertive. (N06)

Another described stepping in to resolve medical indecision:

I got the Resident [Medical Officer] out of the room . . . it was a very junior Resident . . . and I said . . . “You need to make a decision and if you’re not comfortable making that decision you need to contact your Reg[istrar]” . . . because he was very ambivalent as to who to listen to as well. (N15)

One senior nurse explicated nurses’ shared understanding that they often needed to intervene to procure comfort measures when she described an advocacy role for patients who suffered with persisting pain. She observed:

You have to act as an advocate on behalf of the patients, especially when they are in the situation when they can't express themselves, they can't convey . . . "I'm having a really bad day" . . . one essential role of the nurse is that of an advocate because . . . that's sometimes their lifeline. (N31)

Being an advocate meant speaking up to overcome a perceived power imbalance in the acute hospital that limited collaboration with medical staff. As one nurse explained:

I'm the advocate. So I've just got to say, "look . . . the stat [immediate] dose is fine but you really should come up and see him because . . . what are we going to do next time? What are they going to do tonight with him when you're not here?" (N26)

Advocating also meant persisting when their patients could not. However, whilst nurses spoke for their patients, they were also empowering themselves by securing the means to administer timely and sufficient analgesia. These included clear medical direction and an effective prescription. With these resources on hand, nurses felt more in control and able to achieve positive change for their patients.

Initiating contact with medical staff involved nurses consulting not only with ward-based doctors but also with specialised pain teams. As was outlined in Chapter Four, nurses valued the input of these expert clinicians when patients experienced problematic pain. Consequently, they often sought assistance from these doctors and nurses who had the advanced knowledge that they required. This was conveyed by one junior nurse who recalled: "it was the pain team that came and . . . sorted it out . . . I just paged them and said 'look, please come and see this lady' and they came to her" (N18). Another senior nurse intimated that contacting the specialty pain team secured not only expertise, but also dispassionate and independent medical opinion that overcame a clinical impasse:

It was quite a difficult situation. I had one doctor telling me "turn the oxygen down" and one doctor telling me "turn the oxygen up" . . . I was trying to . . . listen to both instructions and . . . make up my own mind . . . I was voicing at both doctors "you talk to each other and come to some consensus" . . . in the end we got the Acute Pain [Service] consultants to come up as well so we had the whole team there eventually which was good. (N15)

Finally, initiating contact with expert clinicians enabled nurses to have more time to address problems that were more amenable to nursing input. This was evidenced by

one nurse who observed: “the pain team can . . . get the [epidural analgesic] block right then at least one problem is solved instead of you having to look after both problems at the one time” (N14).

These data proposed that nurses attempted to empower themselves by accessing medical expertise that secured an effective analgesic prescription and provided direction for safe and effective pain relief. However, there were times when they lacked the confidence to initiate contact and interact with patients or medical staff. As outlined in Chapter Four, nurses valued the knowledge and support of nursing colleagues. Therefore it was not surprising that those who felt distressed at their perceived inability to provide comfort for patients with persisting severe pain often sought the help of other nurses.

In this study, the body of nursing knowledge residing in the acute hospital emerged as a potent resource for nurses attempting to address problematic pain. Senior nurses particularly had ready access to this collective knowledge base:

[We have a] clinical nurse base . . . we discuss it [the pain problem] and we find that discussion . . . helps us to come up with alternatives . . . we don't keep it to ourselves. . . a diverse group of nurses who can come up with a lot of good ideas . . . channelled to the co-ordinator . . . a nurses' station discussion and utilise the CNS. (N08)

While senior nurses turned to peers, junior nurses interacted with more experienced colleagues for guidance and reassurance. Typical comments from less experienced nurses included: “she [the patient] was in lots and lots and lots and lots of pain . . . I didn't know what to do . . . I had to ask the seniors as they worked” (N17), “I told . . . other nurses on the ward . . . the [shift] coordinator . . . about what was happening, just to get advice and . . . back up” (N20), and “when I'm not sure . . . asking staff members or the [shift] coordinator. They're always a good help . . . good support . . . when stress levels are rising . . . there's always someone there” (N12). This finding reflects the actions of inexperienced nurses observed during two studies conducted in Victorian hospitals. In the first study, observations revealed the tendency of junior nurses in a gastro-surgical unit to refer to senior nurses to discern the type of pain patients experienced (Manias, 2003b). In the second study, younger nurses relied on their senior colleagues when managing analgesia for patients whose chronic disease and comorbidities limited their options (Manias & Williams, 2007).

In the current study, junior nurses showed that they empowered themselves by involving senior nurses in interactions with patients to develop feasible pain relief. One graduate nurse illustrated this point when she described how the senior nurse coordinating the shift helped her manage a patient who was experiencing significant pain following the application of silver-based dressing to a leg ulcer. She appreciated her colleague's intervention with reassurance and advice:

[The patient] still had pain and I just pulled the [shift] coordinator aside and just explained about what I had done . . . and the coordinator explained . . . then she went around to the patient and explained it, and I think the patient was happy with that. (N26)

Younger nurses suggested that solidarity with more experienced clinicians empowered them to find workable solutions to problematic pain. One junior nurse remarked: "I couldn't just go against the [medical] team . . . so I thought I've got to explain it to the [shift] coordinator and see if maybe they've got a suggestion" (N27). It was also evident that those who felt helpless to protect patient well-being could also seek the protection of more senior colleagues. The recollection of a junior nurse on the respiratory ward illustrates this point:

Tell the [shift] co-ordinator so she knew that at least I had tried. If anything happened she was aware that at least I had tried to contact [the duty doctor] and he hadn't responded . . . and got the . . . more senior nurse, the clinical mentor, to come and have a look at him. (N23)

Nurses also sought out coworkers to secure more time to provide care. Recruiting other nurses to share the patient load released nurses to attend to patients who were in pain. For one nurse this involved "asking someone if they could check on your other patients if you're tied up with that patient. So you can just spend the time and give them the care they need" (N04). In effect, nurses empowered themselves with more time to care by prioritising patients who were suffering with severe pain and coopting others to care for patients they deemed to be comfortable and, therefore, lower priority. Another strategy was to enlist the help of other specialised clinicians when necessary. Consultation with staff who were more equipped to manage long-standing or complicated issues allowed nurses to focus on pain problems they felt were more amenable to their input. For example:

We refer them on to people whose job it is to try and get people off drugs. I'm not going to do it. I don't have time to actually, literally don't have time . . . there's other people that come and talk to them . . . psych[iatric services] people. There's that Drug and Alcohol Liaison lady, they do it. (N26)

Nurses demonstrated that they prioritised and initiated interactions with those around them to secure time to care and circumvent delayed access to effective medication. They then facilitated connections with patients and colleagues by negotiating the differing perceptions of pain relief. In doing so, nurses sought to build a shared understanding of pain and pain management that increased their access to effective medication and improved collaboration.

Negotiating differences.

The data proposed that nurses negotiated differing concerns and demands to facilitate a shared understanding of pain management with patients and colleagues. Negotiating these differences involved two primary strategies. These strategies were:

- 1) Balancing competing concerns about analgesic benefit and risk to overcome lack of access to effective medication.
- 2) Defusing nonproductive interactions to increase collaboration.

Nurses described actions and interactions through which they balanced perceptions of analgesic risk and benefit, or defused divisive behaviours in order to agree on goals and strategies for comfort provision. *Balancing* revolved around increasing nurses' access to effective medication by finding ways to give medication safely, or formulating feasible pain relief to overcome patients' unwillingness. *Defusing* referred to nurses managing patients' or doctors' divisive behaviours to increase collaboration.

Balancing.

Nurses' descriptions indicated that balancing strategies enabled them to deliver at least a partial analgesic benefit, despite the risk of adverse effects. Primarily, balancing empowered nurses to negotiate competing needs to provide workable solutions to problematic pain while protecting patients from medication side effects. Nurses often encountered such conflicting imperatives in situations

when a patient's clinical condition increased his or her sensitivity to medication. In these cases, nurses explained that they supplemented decreased doses with other comfort measures. For example:

We didn't want to give her too much [medication] because of her hypotension . . . so basically we used other resources . . . Panadol as a back-up . . . tried to position her comfortably . . . one thing is you want to control the pain and the other thing is the patient is not stable clinically so in that way you tend to focus more . . . on stabilising her condition rather than getting the pain under control. So you have to balance which one is more important. (N14)

In other instances, nurses demonstrated that they balanced patients' apparent need for large amounts of medication with their own concern that high doses would damage patient well-being. One nurse remarked:

When you're in a situation when you're using such large doses and you're trying to balance between pain relief and overdosing them . . . and you're concerned about what the doctor's prescribed . . . you do need to take into account all aspects of your assessment. (N29)

Balancing analgesic benefit and risk provided a way forward. Strategic action was taken to meet each party's need:

I do come across patients that say "oh, I have pain" . . . there's no expression in their speech . . . they're not trembling [*sic*] . . . don't appear in extreme pain . . . I have my own interpretation for it, but I never doubt anyone with pain so I'll just give accordingly . . . I have a range to work within so I would actually determine what my dose is going to be . . . if it's not severe pain as I observe and can interpret it, I will actually start with a lower dose. (N17)

In these examples, nurses balanced their own concerns about analgesic risk with their perceived need to deliver analgesic benefit to ease severe pain. However, there were also times when nurses balanced patients' worries about side effects with their own knowledge that these patients required pain relief in order to mobilise and recover. In these instances, nurses balanced the contrasting notions of analgesia using compromise and reassurance to encourage patients to agree a way forward. In doing so, they built connections with patients to enable cooperation rather than conflict.

The data proposed that compromise was a common strategy through which nurses empowered themselves to negotiate diverging perceptions about pain and pain relief. Compromise involved nurses accepting patients' concerns and moderating

their actions to develop an approach acceptable to both parties. For example, one nurse recalled “[I] didn’t give her the full analgesia . . . but we came to like a halfway mark and that was quite effective” (N04). She went on to describe her enjoyment when compromise resulted in improved patient outcomes:

I feel pretty good . . . because patients can refuse whatever they like even though they are in agony . . . [we] came to an agreement . . . and I feel good now because she’s having a much better day. (N04)

Compromise was also useful when nurses encountered behaviours they felt were likely to imperil patients’ comfort. For example, one junior nurse working on the orthopaedic ward recounted caring for a patient who was recovering from knee surgery and who insisted on continuing her exercise machine overnight. While the patient focused on her recovery, the nurse was more concerned about having limited medical support during the night if this exercise triggered significant pain:

I told her “no lets control your pain first then I’ll put you on the . . . [exercise] machine” . . . she said that she really ought to be on it so that she can move onto a rehab[ilitation] centre . . . but I told her . . . “I can’t stand having you . . . sobbing again throughout, through the night . . . the pain cannot be controlled and there’s no one to help” . . . so . . . [I] gave her a painkiller . . . [she] had a really good four hours at least of sleep . . . woke up quite fresh and she was on the machine again . . . the pain score was about two or three [out of 10] then I was willing to put it back on. (N17)

Along with compromise, reassurance was a particularly useful strategy for nurses to negotiate contrasting perceptions about pain and pain relief. Reassurance involved nurses providing information that would ease patients’ concerns and build confidence. In doing so, they sought to shift patients’ focus from risk to benefit, in line with their own. One very junior nurse recalled her ultimately unsuccessful attempt to use reassurance to overcome her patient’s unwillingness to accept stronger medication to relieve severe abdominal pain:

[I asked the patient] “how are you feeling?” . . . she was grimacing . . . she said it [the pain] was probably about a six [out of 10] and she was having the Panadol but she was really reluctant to have anything else because for some reason she thought that . . . opioids were going to interfere with her [blood clotting] . . . and I explained that they [analgesics] weren’t going to [affect her] . . . it’s beneficial for her to have as minimal pain as she can so she can move around . . . I said I can ring up and . . . contact a doctor and get you written up for something and she was really reluctant. She was like “no I just

want to try and stick with the Panadol” . . . Later on that night . . . she was pale and [reported the pain was] about an eight [or] nine out of 10 and that’s when I rang [the doctor] and got her charted for codeine [weak opioid] and then she had the codeine and she seemed to settle. (N32)

These data suggested that nurses were more able to agree upon strategies for comfort provision with patients who shared their understanding of pain relief. Accordingly, they used reassurance to sway patients’ attitudes and behaviours. One nurse described how she used a combination of reassurance and initiation to overcome her feelings of helplessness when patients were unwilling to report pain or accept medication:

All you can do really is offer and explain to them that . . . the doctor has prescribed it . . . they’re not having it too much if they have it every two hours while they are in pain, and that they shouldn’t be afraid to say “yes I am in pain and I do need some help” . . . regularly ask them “are you sure you would not like some painkillers?” Or just keep reminding them that they are available if they need them. (N10)

This finding supports earlier observational work in which nurses working in an Australian gastro-surgical unit were found to frequently remind patients to self-report pain to increase analgesic administration (Manias, 2003b). In the current study, nurses’ belief that they could influence patients in this way emphasised the importance of trust to their collaborative relationships. The findings indicated that compromise and reassurance not only empowered nurses to negotiate diverging perceptions about pain relief, but also consolidated their connectedness with patients.

As nurses provided information and explanation about pain relief to patients, many found they shared an understanding that enabled more effective communication and cooperation. For example, one nurse educated his patient about numerical pain scoring to facilitate a common language through which to describe pain:

Reeducate about the pain score . . . if you’ve got a patient . . . and they say, “yes, I’m in a little bit of pain, it’s seven out of 10.” Well to me, seven out of 10 pain is quite severe and you . . . look at the patient . . . they are quite calmly laying down in bed, half asleep saying “my pain is seven out of 10, it’s not that much.” You just then say “well seven out of 10 is quite severe. Ten out of 10 would be . . . excruciating pain . . . you’re rolling on the floor, whereas zero would be nothing when you’re just lying down at home

normally. How would you feel about your pain score now?” And then [the patient says] . . . “oh, I see what you mean.” (N22)

Another nurse explained to her patient about medication prescription in the acute hospital so they shared an understanding of the constraints they were both subjected to:

Sit down and rationalise with a patient [and say] “look I understand you’re in pain. I’m doing every single thing I possibly can at the moment to get you pain relief. The reason the doctors don’t want you to have pain relief is ‘cause they’re worried that your respiratory rate” . . . a bit of explanation and a bit of rationale . . . instead of making them feel you don’t believe they’re in pain. (N27)

This nurse went on to suggest that sharing knowledge was a useful strategy to manage her own feelings of disempowerment experienced when caring for opioid-tolerant patients. She was aware that such patients, who were used to managing their own medications, could resist losing control of analgesic administration upon admission to the acute hospital. Her view was that a shared understanding of the acute ward environment helped nurses negotiate the struggle for control that could arise in these situations. Her experience suggested that when nurses and patients similarly understood hospital routines and regulations, they were more able to work within these constraints. Providing information seemed to reassure patients of nurses’ concern and, as they relaxed, a degree of compromise was possible:

Instead of being quite short with her and just going “yes! I’m getting it [analgesia] for you. Yes! I know you’re in pain. I’m going to get your analgesia . . . Yes! Can you not press the button for the 50th time in the last hour?” . . . I like to deal with patients that . . . seem to be in pain but it’s that borderline of “are you in pain?” . . . and they’re wanting pain relief quite frequently . . . I try and give the control back to them and go, “I can’t give you the pain relief for another two hours . . . at quarter past four I can give you your next lot of pain relief. Would you be able to manage until then?” . . . let them feel that they’re back in control and that they’re not reliant on us to give the medication. (N27)

This account was an example of how some nurses attempted to negotiate tussles for control with opioid-tolerant patients to overcome common experiences of helplessness and frustration. In essence, sharing knowledge enabled compromise, reassurance and, ultimately, some shared control. These strategies empowered nurses

to provide comfort with more effective collaboration, and defused nonproductive interactions with patients who they often found to be demanding. Nurses described other situations in which they negotiated divisive behaviours by defusing emotional interactions.

Defusing.

Nurses described defusing nonproductive exchanges that threatened to derail collaboration with patients and medical staff. Initially, defusing involved the nurse staying calm in order to deescalate increasing anxiety or aggression and to keep control of the interaction. However, if the situation deteriorated nurses described withdrawing from the interaction in order to deprive an aggressor of a target. While withdrawing was effective, it meant the interaction was terminated. Withdrawing was subsequently considered a measure of last resort.

The findings indicated that nurses attempted to stay calm to protect patients and keep interactions on track. Staying calm required considerable effort when tension and stress levels were rising; however, nurses consciously moderated their behaviour to appear relaxed and to communicate a sense that all was as it should be. As one nurse observed:

You've got to try to stay calm for all of them but inside you're not . . . in their presence you've got to try and look like you're always in control, but I was . . . feeling quite flustered. (N05)

Projecting a sense of calm was thought to reassure patients and encourage their trust. Moreover, nurses suggested that staying calm built patients' confidence and promoted physical and mental relaxation:

I just try and . . . stay calm and try and keep the patient calm and not sort of flap around because it tends to make them more anxious . . . I'm always very mindful that I don't show it in front of patients . . . you don't want to undermine medical staff either . . . I'm just mindful about the way I voice my . . . concerns. (N15)

Nurses' calm demeanour soothed patients' anxiety, meaning the patients were more able to communicate and cooperate because they were less distracted by increasing stress. One nurse recalled: "speak[ing] very calmly and quietly and be[ing]

reassuring . . . It did help her. She would often then be able to focus on her breathing or using the gas better” (N24). Staying calm was also thought to help nurses to concentrate on the patients who needed them. For example, staying calm enabled one nurse to overcome her feelings of helplessness and remain at the bedside to be there for her patient who had severe abdominal pain:

[The patient] was laying in the bed all covered up and crying and saying “this is horrible” . . . I kind of tried to . . . feel comfortable . . . just be there and stand there and [say to myself] “yes she is crying a lot,” but not try to freak out about it . . . the easy thing is to freak out and run away and call the doctor or get someone else or do something but . . . I learnt that the best way is just to be calm and be there and of course you have to act on it. (N02)

Staying calm emerged in this data as an important strategy through which nurses negotiated interactions when stress, anxiety and worry undermined effective collaboration with patients.

In other situations, nurses described staying calm to negotiate nonproductive interactions in which strong emotions fuelled conflict and precluded effective communication. The data proposed that by staying calm, nurses tried to present a small target for others’ tirades. One nurse stated:

If you’re angry, they’re angry. It really doesn’t help. If you calm down . . . you have to take two or three deep breaths before you go in because we are human . . . you have to be humble at times . . . I’ve just learnt humility is the best thing . . . if you try to raise your voice, it doesn’t really help. (N07)

Nurses suggested that staying calm helped them keep some control over difficult interactions and preserved collaborative relationships. Moreover, defusing angry exchanges by staying calm protected vulnerable patients as was evidenced by this nurse’s recollection:

[The doctor] kept asking me “have you had a pain of nine out of 10?” This is in front of the patient so I didn’t really want to make it personal . . . the patient . . . he didn’t need any more anxiety around him . . . he doesn’t need to deal with nurses and doctors having conflict . . . so I . . . tried to stay as calm as I could. (N29)

These data clearly showed that nurses consciously stayed calm so they could communicate with equanimity and inspire confidence, rather than alarm or irritate patients. This findings supports Parker’s (2004) exploration of nursing work, which

referred to nurses' presentation of themselves as a calm, caring presence to manage psychological tensions and create order in the practice environment. In the current study, nurses described staying calm to reduce discord and maintain control in order to facilitate communication and cooperation. If conflict ensued despite their efforts, nurses often first sought to assert themselves more forcefully in the interaction, and then to withdraw from the interaction.

The findings indicated that nurses defused conflict with angry or aggressive patients or colleagues through active or passive means. Some senior nurses were sufficiently confident to use assertiveness and impose their perspectives into the interaction. For example, one older nurse remarked: "if they [patients and family members] are abusive I say to them 'there's no need to speak to me like that'" (N03). Her next response was to retreat: "I tried to explain it and then they just kept talking me down and so I just stopped talking. There was not much point" (N03). Retreat could mean physically absenting oneself from the interaction, as this next example describes:

He [the patient] was just there getting louder and louder . . . I said "I can't do anything." I said "can I get you a drink? Can I get you some water?" [He replied] "Forget about water. Just get rid of the pain" . . . I can't do anything . . . the longer you stand there and you can't help . . . can't resolve the patient's problem, the patient just keeps talking louder and louder in a louder voice and then if you don't walk out and cut that hostility . . . he's just ventilating on me . . . before I react I better walk out . . . cut him off so . . . he would not ventilate and he would not raise his voice . . . disturbing the other patients and I really didn't want that . . . it feels like I'm a point of attack for him . . . so I had to walk out. (N17)

Alternatively, nurses could withdraw by choosing to desist in the exchange. For example:

When he . . . started ranting I just went silent, and there was a big pause and I just said "I will address that medication that hasn't been given yet, and I'll do everything I can to try and get on top of the pain, ok?" and then tried to end the conversation as quickly as I could because . . . it was just out of control. (N29)

The point was to make oneself a small target for others' anger or aggression. This last comment suggested that when anger went out of the exchange, the parties were able to maintain a degree of control.

One senior nurse described how the strategy of withdrawing helped her negotiate a nonproductive interaction with an angry doctor whose patient had intimated he had not been offered painkillers. The patient, who had long-term pain despite receiving substantial analgesia, had joined the nurse and doctor in a discussion about his analgesic dosing. As tensions rose, the nurse withdrew in an attempt to circumvent the patient's perceived ability to manipulate the nurse-physician relationship to his advantage. She recalled:

I was just trying to explain to Dr [Name]. I said "It [analgesia] has been offered" and . . . he was getting a little bit heated and he said "well this is not my understanding. I've just asked him [the patient] and his pain's eight out of 10" . . . I said "throughout the morning he's been offered it at regular intervals . . . and I've just been in to him and asked him. He told me he'd be singing like a canary if I gave him anything above what he's having." So I said "if he refuses what can I do?" And he [the doctor] said "well if he's refusing that's a different matter" . . . I said "Go and ask him yourself." (N31)

These data suggested that nurses tended to withdraw from interactions in which they felt out of control and which appeared counterproductive to effective comfort provision. Withdrawing deprived an aggressor of a focus for escalating emotions, which may have lessened nurses' feelings of distress. However, this action could also leave nurses feeling frustrated at their inability to assist patients. One approach was to involve a dispassionate third party who replaced the withdrawing nurse. For example, one nurse observed:

Pain team involvement would depersonalise the management and perhaps take the emotional perspective out of it . . . allowing someone else to actually see it from an outside point of view and not be so personally involved in things . . . maybe manage the pain a lot easier. (N33)

Summary of stage one: Building connections.

Nurses built connections with those around them who could secure them the necessary resources for pain relief, such as an effective analgesic prescription, appropriate knowledge and time to care, when intervening conditions meant they felt disempowered from assisting patients who experienced severe pain. The strategies of prioritising and initiating ensured nurses could secure sufficient time to care, and enhanced communication with patients and colleagues in order to overcome patients' unwillingness and expedite feasible pain relief.

With time and established connections, nurses negotiated productive interactions by balancing diverging perspectives of pain relief, and by defusing the stress and conflict that derailed collaboration. Building connections with patients procured time to develop feasible pain relief, helped overcome unwillingness and provided calm reassurance to soothe anxiety. Constructive associations with medical and nursing colleagues delivered nurses the authority to administer timely and sufficient analgesia.

In effect, nurses sought to empower themselves by building connections with the people who they felt had the power to develop and implement effective comfort measures to alleviate patients' pain and distress. Most commonly, these measures revolved around pharmacological strategies. When effective medication was not available, despite the nurses' efforts, they looked to alternative means of comfort provision. They described using connections with those around them to increase emotional support for patients and to supplement ineffective medication with nonpharmacological measures.

When nurses watched patients' ongoing suffering and their feelings of disempowerment persisted, they focused on finding alternative ways to comfort their patients. In doing so, they sought to resolve their own helplessness and consequent distress, frustration, dissatisfaction and exhaustion. As these feelings escalated, nurses entered the second stage of the basic social psychological process, entitled *finding alternative ways to comfort*. In this stage, nurses sought to empower themselves to provide comfort by increasing their emotional support and by using nonpharmacological pain relief.

Stage Two: Finding Alternative Ways to Comfort

Nurses included in this study demonstrated that lack of access to timely and sufficient analgesia prompted action to empower themselves to provide comfort through other means. As was described in Chapter Four, nurses considered analgesic medication to be the most effective way to relieve physical pain; therefore they first turned to medicines to address severe pain. However, when this response was ineffective, nurses described using other nonpharmacological comfort measures to relieve their sense of helplessness. For example, one remarked: "as a nurse I just find

other ways, whatever way I can make the patient comfortable. That I can achieve” (N14).

Nurses commonly intensified their efforts to ease patients’ distress by being physically and emotionally present. Where possible, they also incorporated nonpharmacological means as alternates to medication. Two major strategies identified in this stage of the basic social psychological process were (a) being there and (b) using nonpharmacological strategies. Figure 10 describes the strategies used by nurses when finding alternative ways to comfort, which are then described.

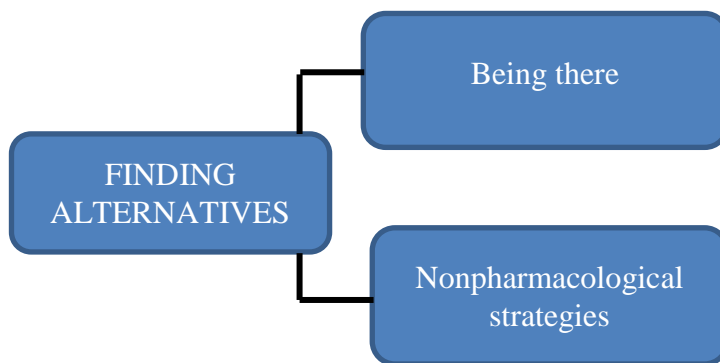


Figure 10. Nurses’ strategies to find alternative ways to comfort.

Being there.

Nurses clearly demonstrated that they sought to overcome their inability to provide pharmacological solutions to patients’ pain problems by increasing emotional support. When nurses couldn’t ease physical discomfort, they addressed emotional discomfort. Many spoke of being there for patients when they felt otherwise unable to assist. For example, one recalled: “in terms of pharmacology I couldn’t give her anything but . . . I could . . . comfort her by being with her” (N18). Another explained:

When they are by themselves in their room, all they’ve got to focus on is their pain . . . just having a nurse there, even if you have given them everything that they can have . . . being there . . . makes it easier. (N26)

As described in Chapter Four, nurses felt their physical and emotional presence was inherently comforting for distressed patients in severe pain. Being there for patients was considered a powerful comfort measure that relieved distress when analgesia failed, as the following example conveys:

The rapport that I developed with him and his family . . . perhaps I couldn't always treat his pain medically with drugs . . . I offered him comfort in other ways. Just through interactions with him . . . sitting and talking to him . . . he used to like to sing so he'd sing to me . . . little things like rubbing his back . . . comfort measures. (N24)

Nurses described a strong desire to be there for patients who suffered with severe pain:

When you have a patient who's in such a . . . who is in pain and crying . . . you . . . want to sit down and have a chat or maybe not have a chat just sit down . . . just to be able to sit there for a while. (N02)

However, in the busy medical and surgical wards nurses often lacked sufficient time to be there for patients. They compensated for this by frequently checking in with their patients, allowing them to be there, albeit only for short periods. As one remarked: "you can stop for five minutes or in between running and getting things . . . you can stop and have a chat" (N02). While this was not ideal, checking in with patients seemed to communicate nurses' care and concern:

They know that someone else cares that they're in pain. Sometimes that helps . . . just knowing that someone's there looking out for them . . . I always kept going back, going "I'm still just waiting for the doctor. I haven't forgotten about you . . . I'm doing what I can." (N23)

This nurse suggested that she checked in frequently not only to comfort her patient, but also to feel that she was doing something constructive:

I always kept going back [saying] . . . "I'm still just waiting for the doctor. I haven't forgotten about you . . . I'm doing what I can" . . . 'cause he was fasting for the scan that had been ordered . . . otherwise I could have crushed up some Panadol and given him that . . . but I couldn't . . . do it. (N23)

Another junior nurse clearly recognised that checking in with patients helped her to manage her own feelings of helplessness. She remarked:

I can't do anything about it. I just had to step out of the room and make sure I check her every . . . at least every half hour. Like I was in there every 20 minutes but it gets really tiring. I mean I can't, I really can't keep going in to her room. I had to do other things as well. I had other patients as well. But I . . . all I can do was make sure that I go in every 30 minutes to half hour to check on her, that's all. But nothing could get rid of the helplessness feeling. (N17)

Participant observation confirmed nurses' reports of checking in frequently with patients who were experiencing severe pain. The following is an excerpt from the field notes made during Observation Nine:

27/10/2008

11.15 [The nurse] looked at the Panadol order on the [medication] chart and noted that the patient had been refusing her regular Panadol . . . [She said] "I see you have been refusing your regular Panadol since yesterday morning." The patient replied that she doesn't like to take tablets if she doesn't have to. The nurse gave her the Panadol tablets and then said that she could give her a further dose of oxycodone [opioid] in an hour and a half.

11.25 The nurse returned to the bedside with the clinical nurse who was coordinating the shift. She [discussed with the patient] . . . the silver dressing she had applied to her wound in preparation for the skin graft.

11.35 The nurse checked back with the patient. She asked the patient how the pain was going and the patient said she felt that the waves were becoming less frequent . . . the nurse reassured here she would give her some more oxycodone as soon as she could. She asked the patient if she would like to rest her leg up on a second pillow but the patient declined, saying she didn't want to move. The nurse then left the bedside and attended to other patients. (Observation 9)

This observation demonstrates nurses' use of multiple strategies, in this case initiating, reassuring and checking in, to build and use comforting connections when medication was ineffective.

The interview data also suggested that nurses believed being there for patients provided the opportunity to influence their responses to pain. For example, one nurse recalled:

Sit[ting] with him to try and reassure him . . . I think anxiety has a big impact on pain . . . if the patient's unsure of what you are going to do or where you are going or if there are other options, to reassure them and say . . . "we are going to fix this. There are other things we can try" or just sit down and try

and work just through that and get comfort out of that. That comfort, mental comfort, can affect their pain levels as well. (N29)

Another senior nurse thought that her physical and emotional presence took patients' focus away from the pain experience:

I think pain is such a complex thing and . . . tied up with emotions . . . and frustrations and if people are frightened and anxious it therefore affects their pain . . . sometimes if they are tense and if you sit and talk with them or distract them. I find distraction . . . helpful. (N24)

These data indicated that nurses found distraction to be particularly useful to comfort not only patients, but also nurses. For example, one stated:

I don't get stressed out very quickly . . . I use some measures before the medication, divert their attention. This way I cope with them and then they really understand . . . I don't even focus on their pain . . . try something general . . . till I get the medication . . . I talk about . . . what is the job they're doing? . . . [or say] "what are you watching on the television?" You know something that is, diverts their attention away from their focus of where the pain is. (N07)

This example resonates with findings from one examination of nursing work using a psychoanalytic viewpoint that also described nurses' tendency towards "making ordinary" (p. 214) situations that evoked fear and suffering (Parker, 2004). In that study, nurses were seen to protect patients by providing comfort through everyday talk, which the author suggested minimised disruption and contained distressing experiences (Parker, 2004).

In the current study, nurses clearly considered that being there physically and emotionally for patients was a powerful comfort measure. Many described their attempts to be there for patients when medication was ineffective and doctors were unavailable or uncooperative. Being there for patients meant that nurses could provide comfort without reference to other clinicians. Constrained only by lack of time, being there was an important component of nurses' autonomous practice. Other nonpharmacological comfort measures also presented nurses with options for independent pain relief practice. The data indicated that these strategies became increasingly important to avoid or resolve feelings of disempowerment the longer nurses were unable to administer timely or sufficient analgesia.

Using nonpharmacological strategies.

A finding of this study was that nurses empowered themselves to provide comfort through nonpharmacological measures when preferred pharmacological strategies failed. These approaches typically did not require medical authority, reducing both nurses' and patients' reliance upon others. One nurse captured this sense of independence and liberation from medically prescribed pain relief when she explained:

[Patients] are able to breathe through the pain. They're relaxed enough to work through pain in a different . . . way and they're . . . not just waiting for that next injection . . . [where] all they're thinking about is "it's been this amount of time and how am I feeling and . . . and what's going to happen next?" (N29)

Most commonly, nurses described attempts to use heat, positioning, a restful environment and massage to provide comfort to patients in severe pain. Independent practice was the key element. Although technically pharmacological, mild analgesics that are sold over the counter in Australia and given without medical prescriptions were also included. As one nurse observed, "positioning, reassuring, give the Panadol. That I can do" (N14).

Participant observation revealed that nurses incorporated the application of heat into comfort provision. The following excerpt from the field notes made of Observation Two provides evidence of this:

4/06/2007

9.00 Nurse has prepared an antiemetic tablet for the patient and went behind the curtain to bedside. I did not visualise but could hear the interaction. The nurse gave the antiemetic and offered her hot packs. When the patient agreed to the hot packs, the nurse said she would fetch them and left the bedside.

9.53 Nurse went to patient behind curtains and gave her a hot pack for her abdomen. She lowered the sheets, asked the patient for directions as to how best to position the hot pack on her abdomen. She then asked the patient if she would like some painkillers. The patient declined. She asked the patient whether she wanted her blanket to cover her but the patient said a sheet would suffice. When the nurse emerged I asked her what she had done. She said that she had given the patient a hot pack for her abdomen as these had helped her before. (Observation 2)

The interview data elucidated the value ascribed to using heat when one junior nurse admitted contravening hospital policy. She stated:

I know we don't use hot packs in the hospital, but we used hot packs and . . . getting her [the patient] to lay [*sic*] down, turn the light off . . . did help . . . she said the hot packs really helped even though they're not allowed in the hospital. (N04)

The nurses included in this study indicated that they had few nonpharmacological resources on hand other than their own physical and emotional presence to comfort patients. Other studies have similarly reported that nurses face constraints in the practice environment that limit the use of nondrug comfort measures. For example, one evaluation of an education programme that examined the use of relaxation for surgical patients found that nurses' (n=81) attitudes and utilisation improved, although they encountered barriers, such as patients' refusal and lack of time (Lin, Chiang, Chiang & Chen, 2008). Norwegian hospital nurses (n=9) included in a study investigating the gap between what nurses say and do when managing pain were found to value nonpharmacological measures, despite feeling that they used these approaches only infrequently (Dihle et al., 2006).

Perusal of the literature reveals that interventions such as music, guided relaxation, massage, pleasant imagery and "stress balls" (small, soft, squeezable balls) have been used before, during and after surgical procedures for pain relief (Pellino et al., 2005). Investigations of the effectiveness of such interventions have yielded mixed results, although small samples and methodological weaknesses limit the findings of many studies (Crowe et al., 2008). Nevertheless, nurses in the current study often sought nonpharmacological comfort measures when they were required to look beyond the "default" option of analgesic medication.

Nurses' descriptions indicated that using nonpharmacological strategies involved increased problem-solving. In seeking to empower themselves, nurses endeavoured to "think of other ways to improve the situation" (N14), and to "be very creative but safe at the same time" (N22). One nurse explained how she worked around the problem of ineffective analgesic medication:

If you've given them all the medications you can give them I usually say "do you want the blinds pulled down? Close the door, so there's not so much noise. Give you a hot washer to put on your face or a cold washer to put on

your forehead?” Make sure they’ve . . . got enough blankets on so they’re warm, so they’re well perfused . . . I usually try those little things . . . some patients feel better with a cold washer on their forehead. (N03)

Many nurses described using their connections with patients and colleagues to develop productive solutions, as the following examples demonstrate:

I find that patients who don’t get the pain relief that they’re requiring . . . you try to position them . . . [and ask] “do you need a heat pack?” . . . you just try and work with them harder. (N27)

Call[ing] the team again to come up and review again and give the bolus [analgesic dose] . . . it didn’t help . . . finally . . . we spent a lot of time on her trying to position her, making sure she is comfortable. (N14)

It was also apparent that when nurses were unable to relieve the symptom of pain with timely and sufficient analgesics, they focused on addressing the cause. An example of this was one nurse who had been caring for a young patient with an intractable severe headache. The nurse recalled her efforts over the previous few days when she sought to:

Try to look at whole picture as to what’s been happening, the day before or the day prior . . . looking at every angle and every possibility as to what can be maybe causing it. Her oral intake was quite minimal . . . she wasn’t looking dehydrated . . . but it may have all been adding to the headache as well. (N05)

These data emphasised the underlying complexity of patients’ severe pain problems. Moreover, it was only when nurses’ first preference of a pharmacological solution was unavailable that they fully used the comprehensive assessment and holistic approaches associated with effective comfort provision.

Summary of stage two: Finding alternative ways to comfort.

To summarise, nurses looked for alternative ways to comfort patients whose severe pain persisted because pharmacological strategies were ineffective. In this second stage of the basic social psychological process, nurses sought to empower themselves with approaches that facilitated their independence and problem-solving. Primarily, strategies included increasing physical and emotional support by being

there to soothe patients' distress, and supplementing medication with nonpharmacological measures, such as heat, positioning and distraction.

Building connections and finding alternative ways to comfort were the first two stages of the basic social psychological process of seeking empowerment to provide comfort. Nurses built connections to ally themselves with people who could offer the time to care and could offer access to effective medication. When a pharmacological cure for patients' severe pain seemed unlikely, nurses then used these connections to increase support by being there for patients, and they increased problem-solving to find alternative ways to offer comfort.

When connections with patients and colleagues, and alternative comfort measures empowered nurses to provide comfort, they tended to experience the relaxation and satisfaction of empowerment. However, when these strategies proved ineffective nurses' distress, frustration and dissatisfaction escalated. It was apparent that as nurses' feelings of disempowerment persisted, causing them to come closer to exhaustion, the threat to their well-being increased. In this situation, nurses were found to enter the third stage of the basic social psychological process, entitled *quelling emotional turmoil*. This stage revolved around managing the psychological fallout of witnessing patients' ongoing suffering with severe pain and feeling unable to assist.

Stage Three: Quelling Emotional Turmoil

In the final stage of the basic social psychological process, nurses attempted to shield themselves from unpleasant and potentially harmful feelings of disempowerment. While they continued to build connections with patients and colleagues, as well as find alternative ways to offer comfort, in this stage nurses also incorporated strategies to alleviate their own significant discomfort. They described using actions and interactions to decrease the stress of helplessly watching patients suffer with pain, or of feeling manipulated by opioid-tolerant patients who seemed to make repeated baseless demands for analgesia. The primary aim was protection from disempowerment. However minimising stressful emotions also enabled nurses' cognitive and emotional resources to be available for use in renewed efforts towards empowerment.

Whereas building connections and finding alternative ways to comfort tended to use and consolidate nurses' connectedness with patients, the third stage of quelling emotional turmoil involved degrees of disengagement. Nurses' feelings of distress and frustration tended to dissipate when they removed themselves from the spectre of patients' suffering. Accordingly, some described disengaging temporarily from patients' pain problems in order to regroup, refresh and reinvigorate problem-solving:

Talk to other nurses about it and get it off your chest to deal with it . . . as soon as you talk to someone else about it . . . you . . . feel a bit better . . . [and can say] "ok, back in there try again." (N10)

However, disengagement could become prolonged if patients' anguish persisted and nurses sought only to protect themselves from their own escalating anxiety and sense of ineffectiveness. Nurses described using three strategies to quell emotions. These were (a) venting, which dispelled emotions; (b) reappraisal, which allowed nurses to see themselves as less disempowered; and (c) disengaging, which distanced nurses from patients' suffering. Figure 11 illustrates how nurses used these strategies to quell emotional turmoil.

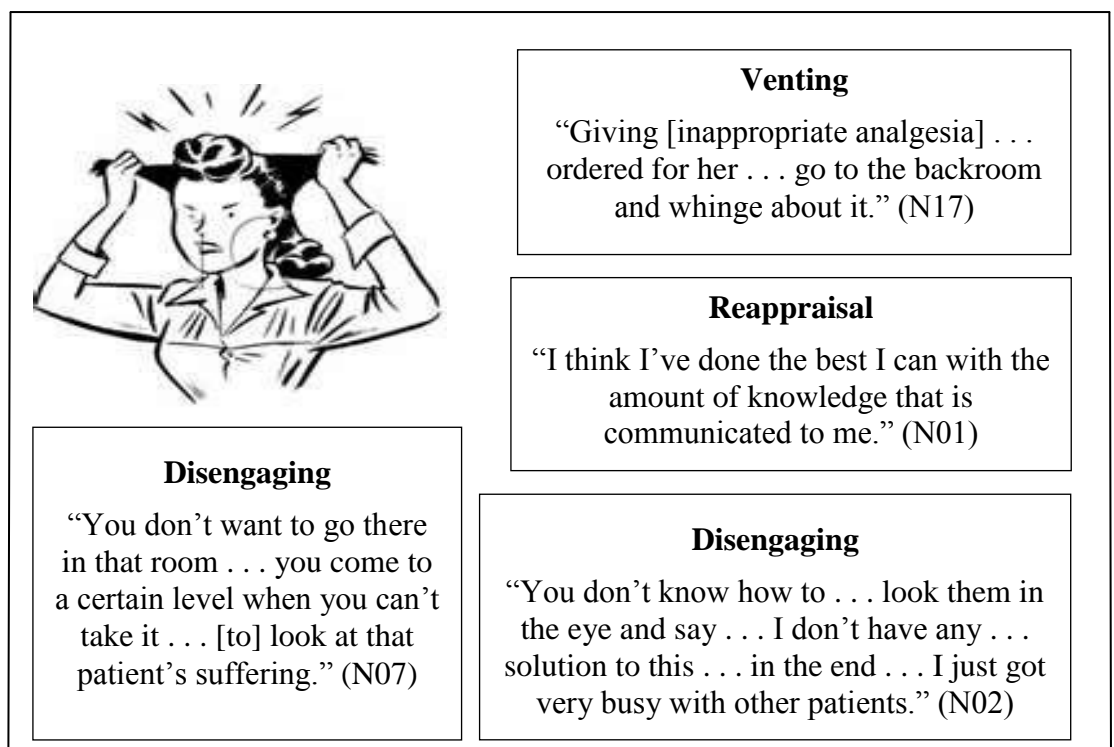


Figure 11. Illustration of quelling emotional turmoil subcategories

The hierarchical relationship between the actions and interactions employed by nurses to quell their own emotions is represented in Figure 12. A detailed description of each strategy supported by examples from the data then follows.

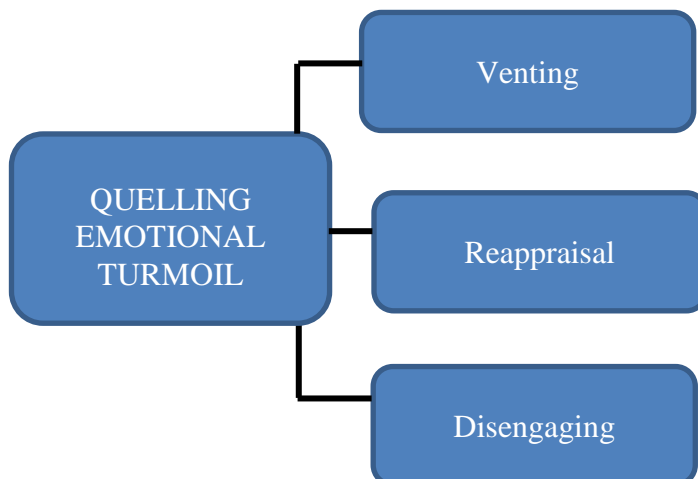


Figure 12. Nurses' strategies to quell their own emotional turmoil.

Venting.

The findings indicated that the longer nurses witnessed patients' distress with severe pain and felt unable to help, the more uncomfortable their feelings of disempowerment became. In response, nurses sought to reduce their stress to manageable levels. A common approach was to acknowledge and describe how they felt to colleagues. Venting negative feelings assisted these feelings to dissipate. When asked how they dealt with anxiety and frustration, nurses replied: "talk to other staff, verbalise your feelings. Tell them how frustrated you are" (N14), and "talk to your colleagues about it . . . sometimes have a joke about it . . . try and lighten the mood" (N24).

Nurses who described venting their feelings stated that they retreated to a space, real or esoteric, in which they could regroup with colleagues. For example, one recalled feeling manipulated by a patient with chronic pain who she thought had made baseless demands for analgesia. She described responding to her consequent feeling of powerlessness by "giving [the analgesia] . . . ordered for her and . . . go[ing] to the backroom and whinge about it" (N17).

While nurses were largely unaware of their low levels of empathy for opioid-tolerant patients, the findings indicated that venting helped many manage the feelings of powerlessness they felt when caring for apparently comfortable patients who repeatedly requested analgesics. As was described in Chapter Four, nurses tended not to engage with patients' pain experiences when these were not evident, and they could feel compelled to give seemingly unnecessary medication. There was little indication that nurses sought to overcome low levels of empathy by either building connections or finding alternative ways to comfort because they were inclined not to recognise these patients' pain experiences. Although one nurse attempted to negotiate the struggle for control by sharing knowledge and compromising, other nurses moved directly to the third stage of the basic social psychological process to manage their frustration and feelings of manipulation.

Venting negative emotions removed nurses, albeit temporarily, from the bedside. For some, there was comfort in the camaraderie of like-minded colleagues. One suggested that she drew strength from solidarity with other nurses when faced with powerlessness:

You can't prove someone has no pain . . . not even the pain team can prove that, unless it's over a period of time and you can see a pattern . . . whinge about it . . . that's what everyone does . . . as a nurse . . . if any of us come across a patient or has looked after a patient . . . [that] we share the same sort of sentiment about . . . the same sort of feelings. . . more or less we have a common understanding that "look this patient don't [*sic*] really have pain."
(N17)

Although venting helped nurses overcome the sense of having been manipulated by patients they felt were not in pain, these data suggested that communication between nurses contributed to negative labelling of opioid-tolerant patients. As described in Chapter Four, some nurses felt inadequate even before meeting such patients because previous experience had primed them for difficulty and stress. The above quotation demonstrated that venting was important for nurses managing stress, but also reinforces the earlier suggestion that such prior experiences could be nurses' own or those of their colleagues.

Venting assisted nurses to manage powerlessness when they felt manipulated by opioid-tolerant patients. However, this strategy was also useful for nurses who

were feeling powerless to help patients who seemed to be distressed with severe pain. For example, a junior nurse working on the orthopaedic ward observed:

I probably vented . . . just talk to someone about it . . . just to tell someone else who would understand . . . what it's like, and you're so frustrated and you can't do anything, and they understand 'cause they work on the same ward . . . it definitely helps . . . they can go "you did all you could do" . . . it's good to talk to someone and that's all you can do. (N18)

It was apparent that nurses preferred to vent negative feelings to colleagues who understood the challenges they faced. The above quotation revealed that these interactions provided opportunity for nurses to receive positive feedback. The suggestion from this young nurse was that such encouragement prompted her to view herself as slightly more empowered.

The strategy of venting enabled nurses to manage escalating disempowerment by providing an outlet for unpleasant and damaging emotions. As the quotation above demonstrated, another approach was to reappraise situations as less disempowering, which tended to reduce feelings of distress and frustration. Reappraisal allowed nurses to see themselves as effective comfort providers. The data proposed that they achieved this by moderating their thoughts and behaviours through self-talk and by keeping up appearances.

Reappraisal.

The findings indicated that nurses sought to avoid feelings of disempowerment by reappraising themselves as empowered. Many described reframing stressful situations so that they appeared empowered both to themselves and to others. *Self-talk* was a commonly-used strategy through which nurses could envision themselves as effective practitioners. For example: "you've just got to tell yourself that you're doing your best . . . you're doing all you possibly can" (N05), "I just realised I had to deal with it . . . I thought to myself 'well . . . I've done what I can . . . now we're just waiting'" (N12), and "you just console yourself with the fact that if you get the best outcome for the patient then your own frustrations . . . you can let go . . . after the event" (N15).

Nurses' accounts revealed that self-talk involved a degree of reflection. They described stepping back from stressful situations in order to consider the context of interactions with patients and colleagues. In doing so, nurses were able to take a dispassionate view of the situation:

Take some deep breaths and try and think clearly and not become emotional about it because . . . if you think rationally . . . you know you are doing all the right things and that the hurt that you feel is just emotional . . . when you break it down and just look at it . . . if you did anything differently you would be wrong . . . you're doing the right thing, that you've got accountability and responsibility of the patient. (N29)

These data suggested nurses' reflections took them away from the immediacy of the bedside, either physically or mentally, which brought the limitations of the practice environment into perspective. The following comments illustrate how nurses' self-talk moderated the way they thought about themselves when considering these constraints: "I think I did the right thing. I mean I couldn't do any more than I did" (N18), "I think I've done the best I can with the amount of knowledge that is communicated to me" (N01), and "when I look back at it . . . I tried everything I could" (N02). These more positive thoughts provided nurses with temporary refuge from feelings of disempowerment, and allowed them to regroup emotionally. For example, one nurse stated:

There's nothing worse than feeling like you're leaving the patient in pain but then I took comfort in that I was giving the maximum [analgesia] that I could and that I was doing everything that I had available to me. (N29)

Reappraisal using self-talk enabled nurses to think of themselves as effective rather than disempowered. Another approach was for nurses to moderate their behaviour to *keep up appearances* so they felt effective in the eyes of others. A vivid example follows, in which one nurse who had earlier described using heat as ineffective to relieve pain described offering her patient a heat pack purely to quell her own feeling of helplessness:

He'd already had his maximum dose of analgesia. I couldn't give him any more. I was waiting for the doctor to call back. He didn't want me to hold his hand . . . but if I could do things like [ask] "do you want a flannel on your head? . . . Or a heat pack?" It's doing something seems better than doing nothing . . . Helping yourself probably as well. So you don't feel guilty

because you are literally actually not doing anything . . . to ease his pain at that point. You are doing nothing because you can't do anything . . . (long pause) . . . I'm doing as much as I can in that situation. I'm doing my job to the best of my ability. (N26)

To an extent, keeping up appearances was similar to the strategy of staying calm. Nurses moderated their behaviour to deescalate increasing anxiety to comfort patients and to keep control of interactions. The difference here was that keeping up appearances directly addressed nurses' sense of ineffectiveness by creating a comforting semblance of effectiveness. It was also thought that patients could feel confidence in the apparent competence of their nurses. In the following examples, both parties drew comfort from these actions:

You've got to provide them with a solution and it puts them at ease somewhat, maybe not necessarily reducing the pain . . . They have the perception that you're doing something for them and it eases their pain. He had this perception of me doing something . . . that worked . . . It's not that we cure the pain but that we actually do something for it. (N17)

[I would] stroke his head or just sit and rub his arm and talk to him . . . I don't know if that gave me more comfort than him . . . sometimes it's a bit hard to know whether it's helping you, making you feel like you are doing something when nothing else seems to work or whether you actually are helping him. (N24)

The strategy of keeping up appearances tended to keep nurses at the bedside because they reappraised stressful situations through their interactions with others.

These data proposed that nurses used self-talk or kept up appearances in order to reappraise themselves as empowered and reduce the stress of feeling disempowered. In doing so, they temporarily disengaged from patients to regroup and reengage with the pain problem with renewed vigour. Such strategies minimised the distress and frustration that were caused by nurses feeling helpless or manipulated, and enabled nurses to conserve their cognitive and emotional reserves. However, over time these reserves became depleted. Nurses found their capacity to feel effective eroded as they watched patients suffer with severe pain and were unable to offer assistance. The findings indicated that nurses' disengagement from patients and their pain problems increased, leading some to absent themselves from the bedside. For nurses included in this study, disengaging was found to be the

“worst case scenario” that was a final strategy used to terminate intense and prolonged feelings of disempowerment.

Disengaging.

Disengaging was found to be a powerful strategy used by nurses to protect themselves either from the distress of witnessing patients’ unrelenting suffering with severe pain, or from the frustration of feeling manipulated. Nurses’ descriptions demonstrated that they disengaged from patients’ pain experiences when other strategies of building connections and finding alternative ways to comfort failed to quell their emotional turmoil. Until this point, disengagement was temporary, facilitating strategies of venting emotions or reappraising stressful situations. However, the strategy of disengaging involved nurses permanently withdrawing from interactions with patients and relinquishing responsibility for solving their patients’ pain problems.

The data proposed that nurses tended to use disengaging as a final strategy to resolve feelings of helplessness when too much empathy caused them personal distress. They also disengaged when too little empathy left them feeling manipulated. As has been described, nurses were largely unaware of their faltering empathic responses toward opioid-tolerant patients. Few described attempts to build connections or find alternative ways to comfort these patients whose pain was not always acknowledged. These data suggested that nurses sought to deal directly with the emotional fallout of anticipating or experiencing difficulty by distancing themselves from the problem.

Disengaging was effective because it diverted nurses’ focus from the event that was causing them distress, anxiety or frustration. As with the other strategies in this third stage of seeking empowerment to provide comfort, disengaging protected nurses and preserved their physical, emotional and cognitive resources. A natural disengagement occurred at the end of the shift. For example, one junior nurse recalled a recent shift during which she had been caring for a patient who had severe pain:

There’s this poor man who’s not written up for enough [analgesia], bent over, grimacing I was so . . . frazzled. I was so glad to leave that day . . . I had

to go out shopping for bridesmaids dresses so forgot all about it straight away . . . if I'd just gone home normally I would have sat there and thought "thank God that's over. I am so glad to get out of that place." (N23)

This nurse's senior colleague demonstrated that she had learnt to use strategies that were aimed at emphasising a physical, emotional and cognitive distance from work-related distress, anxiety and frustration:

You kind of have to take it home with you and deal with it really. Like I go for a walk at the end of the day, most days and just getting out in the fresh air and think through things and I just try and leave it . . . behind. (N24)

There was evidence that nurses who found themselves unable to cope with escalating feelings of disempowerment during their shifts used strategies to create a protective distance. Two experienced nurses each confessed, during their interviews, to reaching a point at which physical removal from the bedside was the only way to alleviate their ongoing feelings of distress and failure. The senior nurse quoted above made a similar admission when she spoke informally after her interview, and the comments of a fourth nurse evoked a sense that she emotionally disengaged when she felt manipulated by opioid-tolerant patients.

It was apparent that disengaging was a measure of last resort that protected nurses who were becoming exhausted by ongoing distress, frustration and dissatisfaction. One senior nurse described how she eventually sought to absent herself from patients' bedsides when this seemed the only way to reduce the stress of watching their anguish:

It's really a challenge to look after such patients and sometimes . . . you get drained out and . . . you don't want to go there in that room . . . you just don't want to go . . . you come to a certain level when you can't take it . . . [to] look at that patient's suffering. (N07)

This finding supports research that explores empathy. This research has suggested that when an observer's empathy for another individual who is in pain becomes personal distress, the focus becomes the observer's own stress rather than the needs of the person who is in pain (Jackson et al., 2006). At this point, empathic responses underpin avoidance behaviours that are aimed to protect oneself, rather than cooperating with and helping others (de Vignemont & Singer, 2006).

In the current study, another nurse revealed she had experienced situations in which disengaging from a distressed patient was the only way to circumvent her ongoing powerlessness and sense of failure. She avoided the stress of interacting with a suffering patient by busying herself with others. As she stated:

It was horrible . . . you don't know how to tackle the problem. You don't know how to . . . look them in the eye and say "I don't know what to do. I don't have any . . . solution to this" . . . [you say] "oh well just hold on, hold on an hour," and they held on and the consultant came up and . . . [you say] "they will change the pump. Just wait, wait an hour until it starts working" and they did and . . . in the end, there was nothing . . . and I just . . . got very busy with the other patients. (N02)

The nurse quoted above referred to the difficulty of looking patients in the eye when she was without solutions for their pain. During an informal conversation with another senior nurse following her interview, this nurse similarly described a tendency to avoid eye contact when feeling powerless to help patients. Her perspective was captured in the interview field notes:

16/10/2008

This SDN [Staff Development Nurse] has been a nurse on the ward for eight years and an SDN for three of those. She spoke candidly about the emotional strain of caring for a patient in severe pain and the value of the emotional connection She also spoke of [her] feelings of inadequacy and strongly made points about nursing as both personally and professionally valuable and personal and professional consequences She talked about being in a four-bed room and [stated that] if she knew that a patient was in lots of pain and couldn't be helped that she would try not to look at the patient, not make eye contact if she had to go into the room to care for another patients. (Field note Interview N24)

These data support findings from other research that nurses seek to create distance from patients and pain problems when feeling powerless to help. Researchers have used various terms to describe nurses' responses; however a commonality of purpose is apparent, which is to divert the nurse's attention away from patients' suffering with pain. For example, Dutch district nurses (n=21) who were interviewed by de Schepper et al (1997) were found to distance themselves when they were unable to reconcile their personal ideals about providing complete pain relief with the reality of patients' intractable pain (de Schepper et al., 1997). Nurses distanced themselves mentally, through reflection that led to renewed

engagement with the patient, or by delegating care to another health professional. Australian burns unit nurses (n=32) also described delegating care when unable to accept the need to inflict pain during their treatments (Nagy, 1999). Distancing themselves from the pain was found to be these nurses' most commonly-used coping strategy. This distancing was done, either physically, by delegating or taking a break, or mentally, by focusing on the task, rather than the person. Other less commonly reported strategies included seeking support by connecting with patients and colleagues, and reconstructing the nurse's role by accepting that caring could mean causing pain.

More recently, through examining six clinical vignettes, a study found that oncology/hospice nurses (n=35), who had extensive experience caring for patients in pain, demonstrated a greater tendency to minimise patients' pain compared to generalist district nurses (n=37) (Wilson & McSherry, 2006). The suggestion was that minimising pain diminished the enormity of patients' suffering in nurses' eyes. Swedish research described the "passive role" (p. 2027) taken by district nurses (n=20) when unable to meet the expectations of providing pain relief for chronic pain patients (Blomberg et al., 2008). In this study, nurses' passivity meant allowing others (patients, family or doctors) to alert them to patients' pain problems and having little involvement in the solutions.

Additionally, two Swedish phenomenological studies of nurses' experiences of pain management briefly referred to participants who eschewed stressful interactions with patients. The first study analysed nurses' (n=14) written narratives, which revealed some participants' "withdrawal from caring behaviours" (p. 31) and consequent sense of defeat when dealing with challenges (Söderhamm & Idvall, 2003). Later, in the second study involving 10 hospital nurses, one nurse admitted to "avoiding contact" (p. 2902) to cope with patients who made constant requests for pain medication (Blondal & Halldorsdottir, 2009). However, neither study expanded any further on when, why or how nurses used and experienced such strategies. In brief, whether nurses' strategies were labelled in the literature as distancing, delegating, minimising, taking a passive role, withdrawing, or avoiding, the aim always revolved around removing themselves from stressful interactions.

In the current study, the data indicated that nurses also tried to remove themselves by physically disengaging and absenting themselves, or emotionally disengaging and avoiding eye contact when confronted by their apparent powerlessness to alleviate patients' distress with pain. There was a further finding that some nurses disengaged emotionally from opioid-tolerant patients when difficult interactions left them feeling manipulated, anxious and frustrated. Disengaging in these circumstances involved mentally opting out of the responsibility to solve the pain problem. One nurse demonstrated how, when supporting patients who seemed to resist her care, divesting the emotional burden relieved her anger and sense of futility:

I think some people find it difficult to look after them but . . . I know that they're being manipulative in that they want to get as many drugs as they can. They possibly don't have as bad a pain as they're saying but it doesn't really bother me . . . because I . . . understand and we're not going to . . . dry them out here. They do have a wound . . . they don't come here for rehab[ilitation] . . . at the end of the day I'm not going to stand there and spend half an hour discussing with someone why I don't think they really need 20mg of Oxynorm [opioid]. I'm just not going to. I just don't have the time. I know that nothing I can say is going to turn their life around and make them go "oh yeah you're right. I'll just have Panadol. I don't have pain" . . . not that I give up . . . they don't bother me. I don't feel angry towards them . . . I just understand where they are just coming from . . . so I'm not going to waste time . . . standing around having arguments with them . . . because then they're harder to manage. Sounds a very defeatist attitude but . . . we're just here to heal. (N26)

This nurse also suggested that attempts to physically disengage from opioid-tolerant patients often failed in the face of their persistent attempts to interact with nurses.

She observed:

Chronic . . . [pain] patients . . . you know when you go in there you are going to get stuck. You leave them till last . . . I find it's simply [impossible] to avoid your patients. The ones that are time-consuming and a bit pushy . . . you can't 'cause they're on the bell. They see you walk past. They want your attention. (N26)

This evidence indicated that opioid-tolerant patients who tried to assert themselves may have secured nurses' physical attendance but could have received little or none of the emotional support associated with holistic approaches to care.

Summary of stage three: Quelling emotional turmoil.

Quelling emotional turmoil was the third stage of the basic social psychological process of seeking empowerment to provide comfort. Earlier stages revolved around nurses empowering themselves through building connections with patients and colleagues and then finding alternative ways to offer comfort. However, when distress, frustration and dissatisfaction persisted nurses incorporated strategies to shield themselves from disempowerment. In this final stage, nurses aimed to calm their own emotional turmoil and preserve energy by focusing away from patients' severe pain and suffering.

The data indicated that quelling emotional turmoil involved degrees of disengagement, which allowed nurses to retreat to a space, either real or esoteric to regroup. Many described leaving the bedside to vent their concerns and frustrations to colleagues. Releasing stressful emotions preserved cognitive and emotional resources that usually empowered nurses for renewed interactions and continued effort towards comfort provision.

An alternative approach was to reappraise situations, allowing nurses to see themselves as more empowered. Reappraising involved nurses mentally stepping away from the emotion and looking dispassionately at their apparent inability to provide comfort for patients whose severe pain persisted. Reflection brought limitations of the practice environment into perspective, and self-talk allowed nurses to moderate the way they thought when considering these constraints. Another approach was to keep up appearances and create a semblance of effectiveness that seemed to comfort both patient and nurse.

A few nurses included in this study admitted that when their distress and frustration persisted, disengagement from patients became more prolonged as they sought to distance themselves from suffering and the subsequent sense of ineffectiveness. The strategy of disengaging tended to terminate nurses' interactions with patients as they removed themselves physically and emotionally from the sources of their stress.

Quelling emotional turmoil was generally the final stage of the process used by nurses whose high levels of empathy for suffering patients caused them personal distress. In contrast, nurses who often felt little empathy for opioid-tolerant patients,

and anticipated difficulties with these patients, could progress immediately to quelling emotional turmoil to manage their anxiety and frustration.

Summary of Chapter Five

This chapter has described the basic social psychological process of seeking empowerment to provide comfort used by nurses to avoid the core problem of feelings of disempowerment experienced when their patients' pain problems persisted. Consisting of three stages, this process involved actions and interactions through which nurses attempted to empower themselves to provide comfort or to protect themselves from the ongoing distress, frustration and exhaustion of disempowerment. These stages were (a) building connections, (b) finding alternative ways to comfort, and (c) quelling emotional turmoil. Nurses were shown to progress through these stages as their experiences of disempowerment escalated.

Nurses' use of strategies to build connections with patients and colleagues in order to overcome lack of access to effective medication, problematic collaboration and insufficient time to care were presented. Building connections involved prioritising patients, initiating contact, and negotiating differences in order to enable sufficient time to provide care, and to allow nurses to consolidate alliances with those around them. The previous section also described the second stage of finding alternative ways to comfort through which nurses sought to empower themselves to overcome lack of access to effective medication. Strategies included being there physically and emotionally for patients, and using nonpharmacological comfort measures. It was argued that nurses' independent practice and increased problem-solving were central to this second stage of the process.

The third stage of the basic social psychological process was named quelling emotional turmoil. In this stage, nurses sought to protect themselves from emotional fallout when feelings of disempowerment persisted. The previous section described nurses' temporary disengagement from patients' pain problems to facilitate venting to colleagues and reappraisal of stressful situations. It was proposed that temporarily disengaging conserved nurses' resources and allowed them to regroup and redirect their efforts towards building connections and finding alternative ways to comfort. The previous section also described the final strategy of disengaging, in which nurses

ceased interacting with suffering or manipulative patients in order to protect themselves from escalating feelings of disempowerment.

The thesis to this point has described the background to the study, the research methods and the study findings. Chapter One provided an overview of current literature in the area of pain management and the effect of patients' pain on nurses. Chapter Two described the grounded theory method and its application to this research. Chapter Three presented the context of regard for well-being, discussing the phenomenon of nurses caring for patients experiencing severe pain, the positive experience of nurse empowerment, the meaning of severe pain and patient comfort, and the characteristics of nurses' effective comfort provision. Chapter Four described the core problem encountered by all nurse participants of feelings of disempowerment when they felt unable to provide comfort for patients who were experiencing severe pain. This section also outlined the four intervening conditions that influenced nurses' experience of the core problem, which concerned nurses' levels of empathy, access to effective medication, collaboration with patients and colleagues, and time to care. Chapter Five has defined the basic social psychological process used by nurses to avoid or resolve the core problem. Together these findings constitute the substantive theory of seeking empowerment to provide comfort, which was generated from the analysis of data collected in this study. In Chapter Six, an overview of the developed substantive theory is provided and the theory is discussed in relation to relevant literature. Chapter Seven details the conclusions of this research and provides recommendations for clinical practice and further research.

CHAPTER SIX

Discussion

Introduction

This study used the grounded theory method to investigate the effect on nurses working in medical and surgical wards of an acute hospital when caring for patients experiencing severe pain. Glaser (1978) describes the goal of grounded theory to “generate a theory that is relevant and accounts for a pattern of behaviour which is relevant and problematic for those involved” (p. 93). Findings of the current study described nurses’ emotional responses, actions and interactions when caring for patients experiencing severe pain, as well as the contexts, conditions and factors enhancing or inhibiting effective pain management in the acute hospital. This chapter describes the substantive theory developed to explain the nature and process of caring for patients experiencing episodes of severe pain from the nurse’s perspective.

Overview of the Substantive Theory: Seeking Empowerment to Provide Comfort

The substantive theory of seeking empowerment to provide comfort developed from this grounded theory study explained the nurse’s interpretation of caring for patients who experience severe pain. Implications for nurses and their practice were also described. Rather than examining discrete aspects of nurses’ pain management practice, using the grounded theory method has elucidated a comprehensive picture of the context, conditions, consequences and processes influencing nurses in this practice environment. Figure 13 provides an overview of the substantive theory of seeking empowerment to provide comfort.

Seeking Empowerment to Provide Comfort

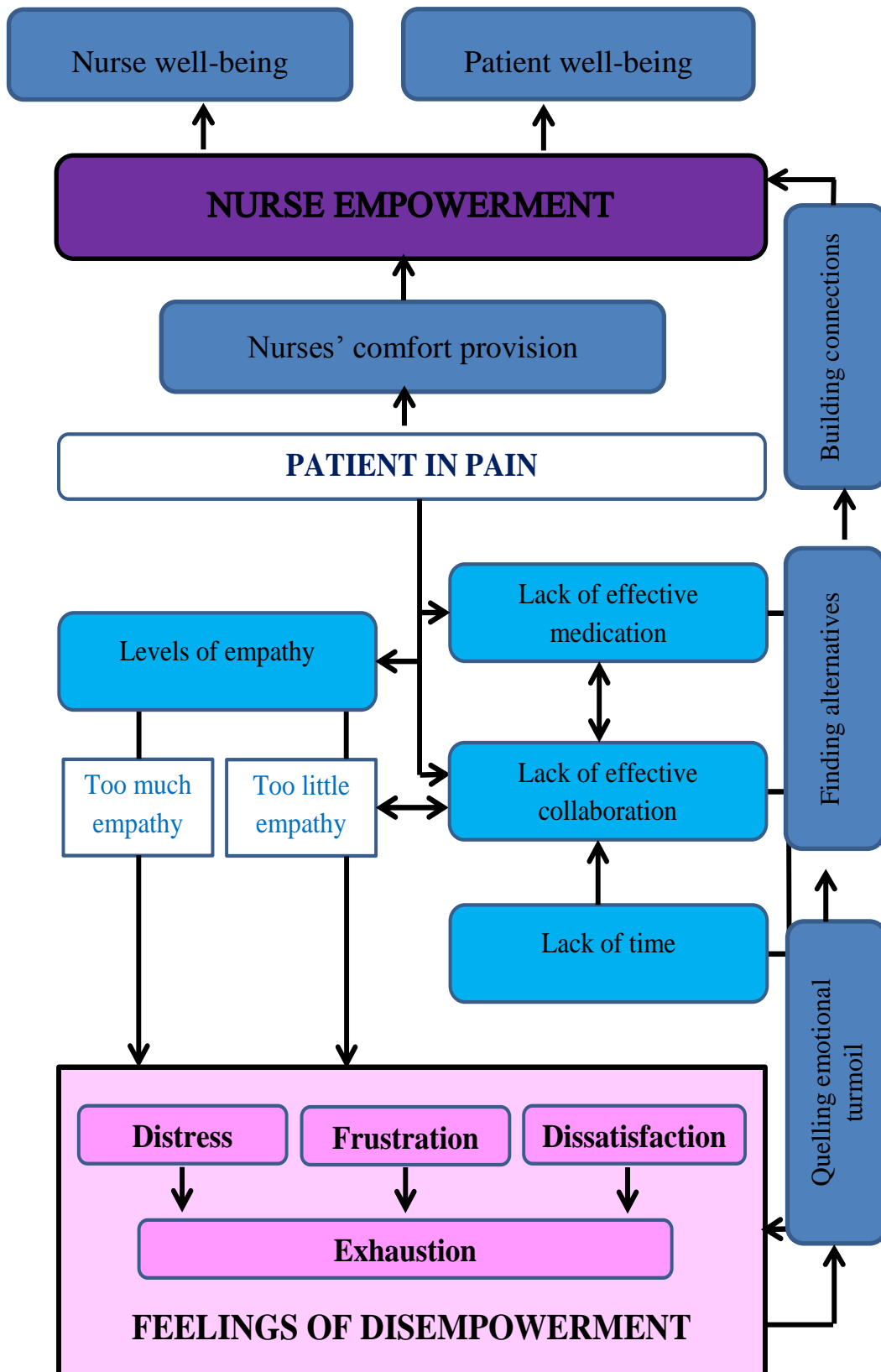


Figure 13. The substantive theory of seeing empowerment to provide comfort.

The substantive theory identified a central context of nurses' shared regard for well-being, in which the phenomenon of caring for patients who experienced severe pain occurred. Findings indicated that nurses included in this study saw patients' experiences and their own effectiveness through a prism of well-being. Nurses' regard for well-being shaped their understanding of comfort, severe pain and the nursing role, as well as their responses to feeling disempowered from fulfilling that role. Nurses referred to patient well-being to conceptualise severe pain and the nature of effective comfort provision.

A focus on physical and emotional wellness and the belief that comfort was instrumental to recovery drove nurses' efforts to comprehensively assess pain and care holistically when patients experienced severe pain. In turn, the way in which nurses perceived their effectiveness in providing comfort affected their own well-being. Patients' obvious suffering directly affected nurses as they empathically shared the emotional distress. Moreover, patients' anguish provided nurses with evidence of their own inability to help, which caused nurses to feel distress, frustration, dissatisfaction and, ultimately, exhaustion. The findings indicated that these experiences threatened nurses' well-being and that nurses subsequently invested effort towards empowering themselves for comfort provision to promote their own wellness.

Empowerment emerged as the core category that integrated the substantive theory developed in this study. As both an outcome and a process, empowerment was the psychological state nurses experienced when they felt able to provide comfort, and the means by which they sought to overcome constraints in the practice environment and to enhance wellness. Empowerment was a positive outcome for nurses that sustained their efforts to soothe patients' distress and promote healing. Nurses took pleasure in patients' improvement as their own concerns eased and they saw themselves as being effective in the nursing role.

In contrast, when nurses felt disempowered, they described helplessness, distress, frustration and dissatisfaction. Disempowerment was clearly a significant experience for the nurses included in this study. Watching patients suffer with pain was an intensely human experience. Nurses' empathic responses caused them to become emotionally engaged in the pain experience, and led them to readily assume

responsibility for protecting patients' well-being. Therefore, the consequences for nurses when patients' anguish persisted were similarly emotional and could be exhausting. Disempowerment was a stressful, anxiety-producing psychological state that related to feeling powerless, and consumed nurses' emotional, cognitive and physical resources.

In this study, disempowerment related to nurses' perceived inability to provide care that alleviated the distress and incapacitation of suffering patients. These nurses' descriptions revealed a shared understanding that effective comfort provision comprised of comprehensive assessment and holistic care. Care of this nature was likely to improve patient outcomes and provide evidence of nurses' success. However, at times the reality of the acute hospital meant that nurses were unable to provide care to match these ideals. Consequent *feelings of disempowerment* threatened nurses' well-being and constituted the core problem in this substantive theory.

The theory developed in this study identified four intervening conditions in the acute hospital that affected nurses' ability to provide comprehensive, holistic care for patients who experienced severe pain. These conditions included nurses': (a) levels of empathy, (b) access to effective medication, (c) collaboration with patients and colleagues, and (d) time to care. Each condition varied and influenced the level of empowerment or disempowerment nurses felt at a given time.

This substantive theory proposed that the first of these intervening conditions, nurses' *levels of empathy*, involved their innate responses to patients in pain. Empathy was a crucial concept in this theory. Nurses' empathic responses engaged them in patients' pain problems and mediated comfort provision. Accordingly, in this theory, nurses' empathy was the foundation for their connectedness with patients.

While largely unaware of their empathic responses, the data indicated that nurses' feelings of empathy for patients varied depending upon their own personal experiences and the behaviours they encountered in patients. While nurses required sufficient empathy to initiate and sustain collaborative relationships, too much empathy could cause the nurses to have personal distress because of patients' suffering. However, too little empathy caused nurses to disregard patients' self-reports of pain. The latter was most common when nurses cared for opioid-tolerant

patients who appeared comfortable, but asked for analgesics. In both circumstances, nurses tended to feel disempowered because they felt helpless or manipulated.

The second intervening condition in the substantive theory related to nurses' *access to effective medication*. Nurses conceptualised pharmacological strategies as the most effective method to alleviate severe physical pain. Therefore, they saw analgesic administration to be central to holistic comfort provision. Increased access to effective medication empowered nurses to administer sufficient and timely analgesia, which led to experiences of nurse empowerment as patients' pain and distress eased. Factors determining nurses' ability to use analgesics included knowledge of patients and pain management, availability of an effective prescription, and patients' willingness to report pain and accept analgesics. Without these resources, many nurses felt helpless to address patients' distress and incapacitation.

Nurses' *collaboration with patients and colleagues* was the third intervening condition described in the substantive theory. Collaboration was defined as communication and cooperation between nurses, patients and colleagues that enabled them to develop feasible pain relief. The theory explained that the degree to which nurses collaborated with those around them depended upon shared perspectives of pain management. Working together enabled nurses to understand patients' pain experiences, tailor treatment, secure effective prescriptions and participate in clinical decision-making. Key determinates were the availability and cooperativeness of medical staff, patients' apparent willingness to accept care and other nurses' readiness to provide knowledge and support.

In the developed theory, collaboration with patients empowered nurses to handle the subjectivity of pain and develop acceptable comfort strategies. It was through collaborative interactions that nurses learnt about patients' pain experiences and tailored pain relief. Nurses' empathic responses initiated helping behaviours and nurtured connectedness between them. These connections facilitated nurses' ability to support patients via physical and emotional means to alleviate the distress of severe pain. Moreover, nurses were able to use and develop these collaborative relationships to negotiate concerns about analgesics and to secure resources for pain relief, including time to provide care, a willing patient and alternative ways to offer comfort. The theory explained how nurses interpreted patients' compliant behaviours

as evidence of their trust and acceptance, which facilitated feelings of empowerment. The contrasting situation, in which nurses saw patients' difficult behaviours as resistance to the care they offered, was also described.

This substantive theory postulated that differing perspectives of analgesic benefit and risk could underpin struggles for control between nurses and opioid-tolerant patients in the acute hospital. Although nurses understood that these patients had learnt to tolerate discomfort and analgesics, they tended to see them as people who were not in pain and who inappropriately requested analgesics. This was because nurses' empathic responses towards these apparently comfortable, yet demanding, patients often faltered, limiting their engagement in the pain problem. Meanwhile opioid-tolerant patients focused on the prospect of analgesic benefit and sought liberal pain relief. A tussle for control could arise when patients wanted medication for pain while nurses tried to protect them from seemingly excessive and risky analgesics. The struggle could intensify when patients were experienced in managing their own medication and nurses remembered previous struggles, their own or those of other nurses, and anticipated conflict. The data indicated that such tussles undermined collaborative relationships, leaving nurse feeling disempowered.

Time to care was the last of the four intervening conditions that influenced nurses' experiences of empowerment or disempowerment in this substantive theory. This related to constraints in the practice environment around nurses' workloads and the reactive nature of care. The theory explained that multiple patient loads, patient high acuity and interruptions influenced the amount of time nurses had available to attend physically and emotionally to each person in their care. Caring for a single patient empowered nurses to comprehensively assess pain and provide holistic care. In contrast, the conflicting demands of patients and colleagues tended to prevent nurses from spending time with distressed patients in severe pain.

This substantive theory explained the basic social psychological process of seeking empowerment to provide comfort, used by nurses to avoid or resolve their feelings of disempowerment. As the name suggests, a quest for empowerment was at the heart of this process, as nurses sought to provide positive outcomes and enhance wellness for themselves and their patients. Strategies revolved around nurses empowering themselves either to secure resources and drive collaborative

relationships, or to shield themselves from disempowerment. The theory proposed three stages in the basic social psychological process: (a) building connections, (b) finding alternative ways to comfort, and (c) quelling emotional turmoil.

The developed theory postulated that nurses moved through the three stages of the process when feelings of disempowerment escalated. The first stage, *building connections*, proposed that nurses sought to develop relationships with people who had the power to implement measures that would alleviate patients' suffering. The premise was that nurses attempted to empower themselves with connections that secured them necessary resources, such as effective analgesic prescriptions, appropriate knowledge, and time to care. Strategies were aimed to facilitate a shared understanding of pain management to increase collaboration with patients and colleagues. Central features of building connections were actions and interactions through which nurses (a) prioritised patients, (b) initiated contact, and (3) negotiated differences.

However, when severe pain persisted nurses looked to empower themselves by using these connections to *find alternative ways to comfort*. This was the second stage of the basic social psychological process. Increased problem-solving and independent practice defined this stage. A striking feature was nurses' attempts to comfort through "care" rather than "cure." Central elements were nurses' attempts to be physically and emotionally present for patients and, where possible, use nonpharmacological comfort measures. The developed theory explained how nurses sought to empower themselves through these means to ease both patients' anxiety and their own distress.

The final stage of the basic social psychological process involved a shift in nurses' focus as they directed less effort towards empowering themselves and more towards negating the effects of disempowerment. Labelled *quelling emotional turmoil*, the defining feature of this stage was that nurses disengaged from patients, to varying degrees, in order to conserve their personal resources. The theory explained that temporary disengagement meant retreating to a space, real or esoteric, in which nurses regrouped in order to sustain effort towards empowerment. Bursts of disengagement facilitated strategies, such as venting and reappraisal, that were aimed at minimising negative emotions. However, as escalating feelings of

disempowerment threatened to exhaust nurses, disengagement eventually became prolonged as they sought only to protect their own well-being.

This substantive theory proposed a link between nurses' feelings of disempowerment and a coping response. Initially, nurses acted and interacted to build connections and find alternative ways in order to cope with barriers to effective comfort provision and sustain efforts towards comfort provision. However, as their feelings of disempowerment escalated, nurses focused increasingly on coping with the emotional fallout. While temporary disengagement conserved nurses' personal resources for sustained effort towards empowerment, eventually they disengaged for prolonged periods to avoid distress, frustration, dissatisfaction and exhaustion.

To summarise, this substantive theory of seeking empowerment to provide comfort explains one aspect of nurses' care in the acute hospital: the provision of comfort for patients experiencing severe pain. Although this study focused on a discrete area of nurses' practice, major tenets of the generated theory are located in the broader domains of nurse caring, comfort, empowerment, and stress and coping. A search of literature pertaining to key emergent categories helped to develop the final theory. Other research investigating nurses' pain management was also sought to validate findings of the current study. Where relevant, this literature has been integrated into Chapters Three, Four and Five. An overview of related literature and comparison of the substantive theory to other developed theories follows.

The Substantive Theory of Seeking Empowerment to Provide Comfort and Related Literature

The substantive theory of seeking empowerment to provide comfort is limited, at present, in terms of generalisations to other populations, although the literature offers considerable support for the emergent categories. A search of published evidence revealed that the major concepts of comfort, empowerment, nurse caring, and stress and coping have been described previously. Aspects of nurses' pain management practice and the influence of patients' pain and the acute hospital on nurses and their practice have also been explored. However, no theory was located that was exactly the same as seeking empowerment to provide comfort.

Existing theories describing comfort (Kolcaba, 1994), psychological empowerment (Spreitzer, 1995), structural empowerment (Kanter, 1977, 1993), nurse caring (Parse, 1992; Swanson, 1991; Watson, 2001), and stress and coping (Lazarus & Folkman, 1984) provide significant support and explanation for the findings of the study. The literature search however, failed to locate any theory specifically linking nurses' feelings of disempowerment to a stress and coping response when caring for patients experiencing severe pain.

The following discussion will relate the substantive theory to the pertinent literature. An overview of the findings of this study to current knowledge of nurses' pain management will be presented. Literature pertaining to the core category of empowerment identified in the current study will be discussed. Specifically, empowerment as a positive outcome for nurses in this study will be compared to a prominent theory of psychological empowerment. Empowerment as a process, in particular nurses' attempts to build connections with patients and colleagues, will then be considered through the current understanding of structural empowerment. The centrality of nurses' collaborative relationships with patients will be explored in the context of major theories of comfort and caring in nursing and subthemes of empathy, connectedness and nurses' presence. Brief discussions of literature pertaining to patient empowerment and aspects of the acute hospital will be included. Finally, the basic social psychological process will be compared to an established theory of stress, appraisal and coping.

The substantive theory and literature relating to nurses' pain management.

The substantive theory developed in this study builds on previous work by integrating aspects of nurses' pain management to elucidate the influences in the practice environment and their emotional responses. Findings in this study support Australian and international qualitative research exploring nurses' pain management and the influence of the hospital environment (Blomberg et al., 2008; Blondal & Halldorsdottir, 2009; Bolster & Manias, 2010; Bucknall et al., 2007; Manias, 2003b; Manias et al., 2002; Manias et al., 2005; Rejeh et al., 2009). Where applicable,

literature pertaining to aspects of the developed theory has been integrated into the findings presented in earlier chapters. An overview will be presented now.

The findings of this study support the contention that nurses' pain management is fundamental to and integrated into daily patient care (Rejeh et al., 2009; Richards & Hubbert, 2007). Nurses saw pain as distressing, incapacitating, and incongruent with comfort. Pain relief was central to comfort provision, as has been recognised in the literature (Carr & Thomas, 1997). Moreover, nurses acknowledged a connection between physical and emotional comfort similar to that described by Williams and Irurita (2004) who found "pleasant positive feelings" (p. 809) positively affected patients' physical status.

The developed theory also offers considerable support for the findings of two recent Scandinavian studies exploring the effect on nurses who seek to provide comfort for their patients. In the first of these studies, the grounded theory method was used to explore Swedish district nurses' (n=20) care of chronic pain patients (Blomberg et al., 2008). While this paper did not describe a core problem or basic social psychological process, conditions in the practice environment were identified as affecting nurses' ability to relieve pain. Similarly to the current study, patients' ability to express pain and nurses' collaboration with the multidisciplinary team facilitated effective comfort provision (Blomberg et al., 2008). Despite this study being conducted with nurses who worked in community settings with chronic pain patients, parallels between their experiences and those of the nurses included in the current study were evident. For example, Swedish nurses' "active" (p. 2027) responses of communication, interaction, encouragement, problem-solving and advocacy, which led to feelings of competence and satisfaction, resonated with nurses' attempts to build connections and consequent nurse empowerment described in the current study. Additionally, the Swedish nurses' tendency to take a "passive" (p. 2027) role when feeling powerless, which meant taking no involvement in care and referring patients to other health practitioners (Blomberg et al., 2008), could be equated to disengaging in the current study.

Findings of the current study also provided considerable support for the phenomenological exploration of the experiences of Icelandic nurses (n=10) who cared for patients in pain in acute medical and surgical hospital wards (Blondal &

Halldorsdottir, 2009). These Icelandic nurses described similar experiences of distress and helplessness to their counterparts in the current study when unable to relieve pain. Additionally, both groups of nurses espoused goals for pain relief informed by a natural sense of duty, and assumed responsibility for solving their patients' pain problems. The nurses included in the study by Blondal and Halldorsdottir (2009) described impediments to their collaborative relationships with patients that resonated with those experienced by nurses in the current study. They recalled difficulty communicating about pain, and found themselves relying on patients' verbal and nonverbal expressions to try to assess stoic patients or those unable to use pain scores. Additionally, they spoke of putting themselves in patients' places, suggesting they sought to facilitate a shared understanding of the pain experience (Blondal & Halldorsdottir, 2009).

The finding that Icelandic nurses encountered significant challenge when managing analgesia for "individuals with addictions" (p. 2093) resonated strongly with the current study (Blondal & Halldorsdottir, 2009). Mirroring nurses in the current study, the Icelandic nurses described particular difficulties when pain aetiology was unclear or when the patient kept requesting analgesia. Findings indicated a similar tendency to that of nurses in the current study to doubt the honesty of such patients. However, for these Icelandic nurses this was experienced as a moral dilemma (Blondal & Halldorsdottir, 2009).

Lastly, Blondal and Halldorsdottir (2009) described impediments to nurses' collaborative relationships with colleagues related to perceptions of physicians as "gatekeepers" (p. 2901), which crystallised their frustration at their lack of prescribing power. These nurses similarly described the satisfaction of feeling heard by doctors and using nonpharmacological comfort measures to decrease their dependence on others. This study of Icelandic hospital nurses also described similar constraints in the practice environment on nurses' effective comfort provision to those identified in the current study, including lack of time and inadequate analgesic prescription (Blondal & Halldorsdottir, 2009).

Despite contextual differences, this depiction of Icelandic nurses' experience of caring for patients with pain provides considerable support for the findings of the current study. Using different qualitative methodologies, these studies have similarly

demonstrated that nurses naturally assume responsibility to address pain and encounter constraints related to patients, medical staff and a lack of resources. Striking similarities were also noted in the experiences of nurses included in both studies, particularly in their distress and helplessness at patients' ongoing suffering with pain or questioning of patients with addictions.

The developed theory builds upon observational studies exploring pain management in the practice of nurses in Australian hospitals. Exploration of the nurses' perspective further examines how this practice setting might shape nurses' responses, behaviours and clinical practices observed in earlier work. The findings indicating that competing demands contribute to the reactive nature of nurses' work supports findings from observations of Victorian hospital nurses (Manias et al., 2002). The current study further suggests that such demands, interruptions and the subsequent necessity to prioritise comfort provision can lead nurses to experience powerlessness and frustration.

The findings of the current study also support previous research that suggested nurses' lack of pain assessment is a barrier to their effective comfort provision. Nurses included in this study acknowledged that the subjectivity of pain and pain management meant they needed to comprehensively assess patients in order to tailor treatment. Nevertheless, no nurse was observed undertaking a detailed exploration of patients' pain. Similarly to the findings of Bucknall et al. (2007), assessment activities tended to be incidental to other clinical activities and involve only simple questioning. Moreover, in their interviews, nurses demonstrated a tendency to weigh their observations of patients' pain behaviours against patients' self-reports when making assessments. Most described integrating objective and subjective evidence to determine pain intensity. If the evidence conflicted, discrepancies were often resolved by discounting patients' verbal descriptions. This finding tends to support the observation of 316 pain-related activities involving 52 nurses in two Australian hospital surgical units, which indicated that pain assessments were less likely to occur when patients experienced chronic pain (Manias et al., 2004).

The substantive theory of seeking empowerment to provide comfort explains the nature of nurses' comfort provision for patients experiencing severe pain, and

how aspects of the acute hospital constrain effective practice. The developed theory supports extensive evidence that nurses encounter a lack of cooperation from physicians and inadequate prescriptions, limited authority, lack of time and negative attitudes to pain and pain management (Berry & Dahl, 2000; Brockopp et al., 1998; Bucknall et al., 2007; Layman Young et al., 2006; Manias et al., 2005; Rejeh et al., 2009; Schafheutle et al., 2001; Van Niekerk & Martin, 2003; Willson, 2000). Moreover, nurses in the current study described obstacles to communication, sufficient time and holistic care depicted elsewhere as important for pain management (Manias & Williams, 2007; Richards & Hubbert, 2007).

Collaboration was a prominent theme in the findings of the current study. Collaborative relationships with colleagues gave nurses input into analgesic decision-making and allowed them the direction, authority and knowledge required to implement effective comfort strategies. These findings support early work suggesting a collaborative, multidisciplinary approach to pain management helps nurses overcome feelings of helplessness when unable to meet expectations of pain relief (Clements & Cummings, 1991). Although not systematically evaluated, a collaborative team approach including nurses was purported to have “restored their power base” (p. 84) when nurses felt manipulated by patients with chronic pain. Although published 20 years ago, the nurses’ feelings of manipulation and their need for colleagues’ support still resonate with the findings of the current study.

In the substantive theory developed in the current research, collaboration with medical staff provided nurses with direction and authority to administer timely and sufficient analgesia. This explained the effect of doctors’ unavailability or perceived uncooperativeness on nurses’ feelings of disempowerment, particularly when they felt excluded from discussions or unable to secure an effective prescription. This finding tends to support an earlier suggestion that these situations challenge nurse “self-efficacy” (p. 405), leading to feelings of helplessness (Willson, 2000).

Knowledge of pain management was an important resource for nurses’ effective comfort provision in the developed theory. Nurses included in the current study equated knowledge with power. Knowing about pain management empowered them to negotiate complex analgesic administration and individualise pharmacological strategies. In general, these nurses reported receiving only minimal

pain education. Twelve nurses had received nothing specific after graduation, while 20 had attended only in-service study days. One senior nurse had temporarily acted in a position within the Acute Pain Service. Rather, these nurses tended to accumulate an understanding of pain management through clinical experience.

It was evident that a body of nursing knowledge resided in the acute hospital. Senior nurses drew strength from the collective knowledge of their peers and junior nurses relied heavily on their more experienced colleagues' counsel. These findings tend to support an investigation of Hong Kong nurses (n=143), which reported that years of clinical experience rather than academic education correlated with an increased knowledge and attitudes about pain management (Lui et al., 2008).

Requests from younger nurses in this study for analgesic plans and guidelines contribute to suggestions that readily applicable guidelines for nurses' pain practice are not available (Manias & Williams, 2007). While experienced nurses in the current study felt confident of their abilities, junior nurses wanted more information to support decision-making. However, evidence in the literature about nurses' knowledge levels and the best way to impart meaningful information is conflicting.

Poor theoretical knowledge in nurses has been described in a number of studies (Dihle et al., 2006; Lui et al., 2008; Sloman et al., 2005; Watt-Watson et al., 2001). One study found no association between nurses' critical knowledge deficits and patients' increased pain or with less analgesic administration (Watt-Watson et al., 2001). Moreover, some research has suggested that educational programmes have little effect on nurses' attitudes to pain assessment tools or analgesic administration (Boer et al., 1997; Grinstein-Cohen et al., 2009; Layman Young et al., 2006; Michaels, Hubbart, Carroll & Hudson-Barr, 2007; Willson, 2000). In contrast, one small study reported an improvement in pain management practice of nurses working on a surgical unit in the USA after mandatory ward-based education sessions (Tapp & Kropp, 2005).

In the study hospital, a programme was undertaken to implement Pain Resource Nurses in acute care wards (Williams et al., 2011). This approach consolidated collaborative relationships between nurses by providing team members with advanced knowledge and expertise who could assist their colleagues. The success of this programme supports suggestions that context specific education can

improve pain outcomes for patients (Grinstein-Cohen et al., 2009; Willson, 2000). In the current study, junior nurses' stated need for unit-specific education indicates that initiatives to incorporate education into clinical practice may be beneficial.

In this current study, nurses' attempts to empower themselves with strategies that did not require medical prescriptions were evident. In particular, increased emotional support, positioning, distraction and use of heat were important. Nurses clearly felt that such approaches were useful comfort measures. Nevertheless, none considered them first-line treatments for pain relief, and many found that lack of time and equipment in the acute hospital limited their use. Such constraints may explain why, apart from the three experienced surgical nurses included in Richards and Hubberts' (2007) phenomenological study who first relied on nondrug approaches, nurses have been found to use nonpharmacological strategies only rarely (Clarke et al., 1996; Dihle et al., 2006; Manias, 2003b).

In summary, the substantive theory generated in the current study builds upon current pain management literature by providing an integrated picture of the clinical reality encountered by nurses who care for hospitalised patients who experience severe pain. While the developed theory explains the effect on nurses in this area of their practice, the major tenets of the theory are located in the broader contexts of: empowerment; nurse caring and subthemes of comfort, empathy, and constraints in the acute hospital; and stress and coping. The substantive theory will now be compared to existing theories and pertinent literature in these areas.

The substantive theory and literature relating to empowerment.

Empowerment emerged as the core category in this substantive theory as an outcome for nurses who felt able to provide comfort for patients who experienced severe pain, and a process through which nurses sought to avoid feelings of disempowerment. This section will discuss the literature exploring empowerment in relation to caring, and two prominent theories. Literature pertaining to nurses' empowerment of patients will be discussed separately in relation to their potential struggles for control.

Empowerment has been described as a "contested" (Piper, 2010, p. 174) concept in the caring literature. Although widely used, the term has varied meanings

depending on context, being both a process and an outcome and relating to individuals and the environment (Chambers & Thompson, 2009; Ellis-Stoll & Popkess-Vawter, 1998; Jones & Meleis, 1993; Kuokkanen & Leino-Kilpi, 2000; Piper, 2010; Skelton, 1994). Considering the ambiguities that abound, the concept of empowerment is selectively considered in this study. Figure 14 presents a diagrammatic overview of how concepts of empowerment are situated in the caring literature.

One useful review of empowerment explained the three theoretical perspectives pertinent to nursing (Kuokkanen & Leino-Kilpi, 2000). These were social psychological theory, organisational theory and critical social theory. Empowerment in social psychological theory is relevant to the current study and the outcome of nurse empowerment as a positive state for those who feel able to provide comfort. The theory of empowerment in organisational contexts is useful to consider the intervening conditions identified in the acute hospital and nurses' attempts to overcome these by building connections. Lastly, empowerment from the perspectives of critical social theory pertains to nurses' relationships with patients and concepts of shared control.

Spreitzer's theory of psychological empowerment.

The concept of psychological empowerment concerns subjective experience and has been used as a framework to investigate employees' perceptions and experiences of work (Engstrom, Wadensten & Haggstrom, 2010). One model applied to nurses was developed from a business background by Spreitzer (1995). This theory invites comparison with the substantive theory developed in the current study to support and explain nurses' subjective experiences of empowerment. Spreitzer (1995) proposed empowerment as a psychological state with four dimensions, which were (a) meaning, (b) competence, (c) self-determination, and (d) impact. Meaning related to matching the value of work to individuals' ideals; competence referred to belief in the ability to perform the job; self-determination was a sense of control over work; and impact meant the individual had influence over important outcomes at work (Laschinger, Finegan, Shamian & Wilk, 2001; Spreitzer, 1995).

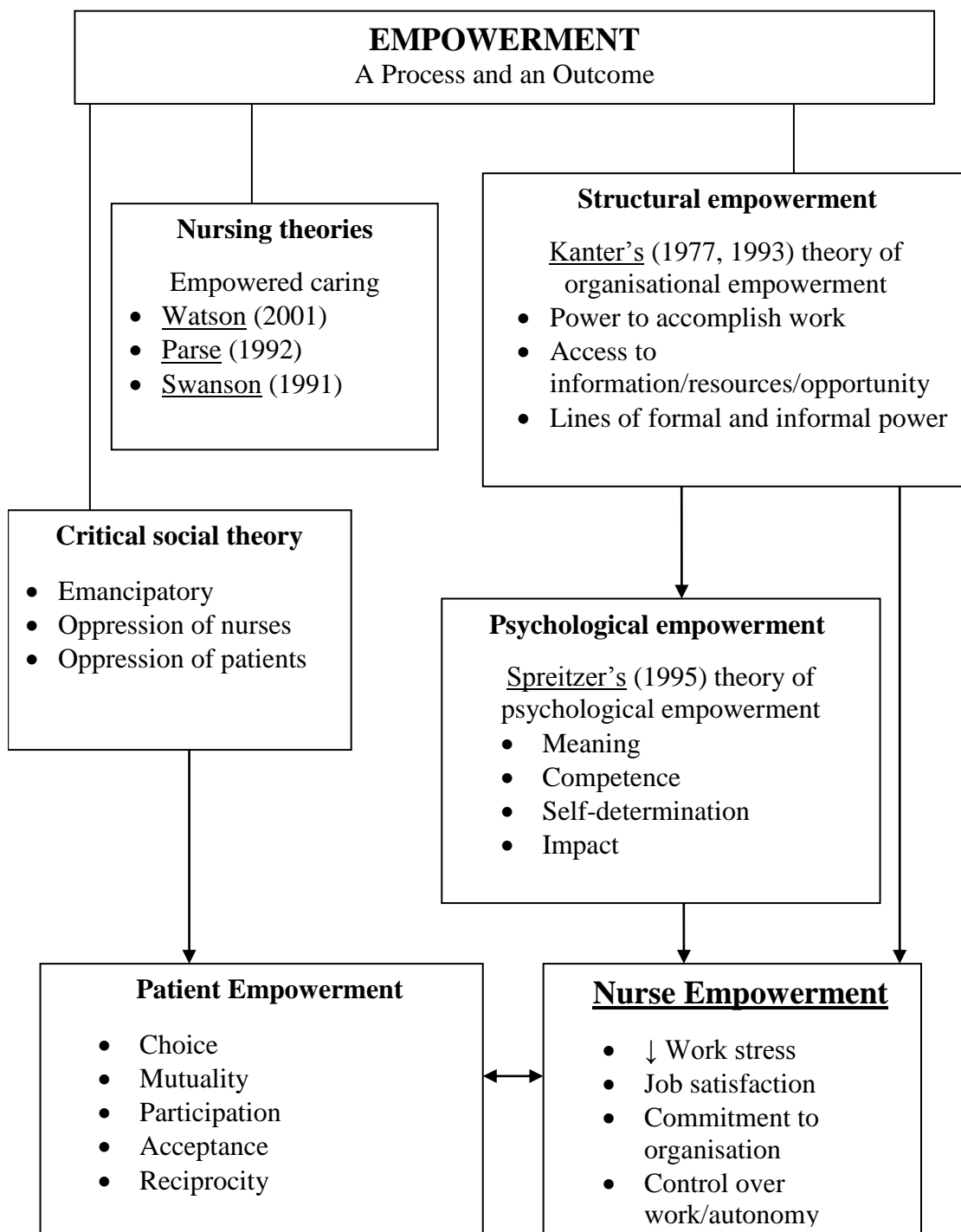


Figure 14. Themes of empowerment in the literature.

Spreitzer's (1995) model was underpinned by the following assumptions of empowerment: (a) empowerment is not a personality trait but dependent on the work environment; (b) empowerment is specific to a particular sphere of work; and (c) people can be more or less empowered. Empowerment has been related to individuals' access to information and has been positively linked to self-esteem, innovative behaviour and job satisfaction in health care settings (Engstrom et al., 2010; Spreitzer, 1995).

The findings of the current study lend support for this model. Nurses constructed the nursing role on the personal value that they should respond to the human suffering of patients experiencing severe pain. The enjoyment, relaxation and satisfaction of nurse empowerment stemmed from perceptions of their ability to provide care that accorded with their personal ideals. Moreover, nurse empowerment was a subjective experience drawn from patients' comfort, which was evidence of their own effectiveness and competence. The substantive theory holds with Spreitzer's (1995) model, in that nurses experienced more or less empowerment depending on intervening conditions in the acute hospital. Nurse empowerment was a positive psychological outcome related, in part, to the knowledge and information resources available. While nurses' characteristics affected the intervening conditions identified in the substantive theory, their feelings of empowerment or disempowerment were derived from experiences at work rather than from the traits of individual nurses.

Comparison of the substantive theory to Spreitzer's (1995) model helps to explain outcomes for nurses of empowerment and disempowerment. Comparing the substantive theory to an established theory of structural empowerment explains the influence of intervening conditions in the acute hospital and nurses' attempts to empower themselves by building connections. Structural empowerment has been linked to nurses' ability to make a difference (Kramer et al., 2008).

Kanter's theory of structural empowerment.

Structural empowerment is concerned with work effectiveness, and provides for "well-being at both the individual and organisational level" (p. 240) by strengthening collaborative networks (Kuokkanen & Leino-Kilpi, 2000). The

concept emerged when a seminal work on organisational behaviour shifted the focus of empowerment from the individual to the work environment (Kanter, 1977). Since then Kanter's theory of structural empowerment has been applied extensively to nursing practice (Laschinger et al., 2010). Originally developed to explain empowerment of individuals in organisations, this theory firmly located power in access to resources as crucial for undertaking work competently (Chandler, 1991).

In Kanter's view, power relates to autonomy, the ability to do and the access to required resources (Kanter, 1993). In contrast, powerlessness stems from being accountable for outcomes without access to resources or control over one's fate (Kanter, 1993). These themes of control, ability and access resonate with the findings of the current study in which nurses' feelings of disempowerment often linked to lack of tools for comfort provision such as effective prescriptions, knowledge, a willing patient and time to care.

Laschinger et al. (2010) described two primary structures of empowerment in Kanter's model (1977, 1993). These were (a) the structure of opportunity relating to conditions that provide for advancement, knowledge and skill development, and (b) the structure of power where individuals have information, support and resources (Laschinger et al., 2010). Access to these structures of empowerment was through systems of formal and informal power. Kanter's notion of formal power referred to flexibility and discretion in decision-making, while informal power rested in alliances with others in the organisation to achieve goals (Laschinger et al., 2010). Kanter predicted that employees would experience powerlessness, frustration, hopelessness and disengagement when they lacked resources, information, support and opportunity (Laschinger et al., 2010). In contrast, those provided with power and opportunity have control to do their work, which facilitates well-being.

Findings of the current study provide support for Kanter's theory (1977, 1993) and demonstrate how this model might apply when nurses care for patients who experience severe pain in the acute hospital. Firstly, the substantive theory tends to support Kanter's predicted link between lack of access to resources and consequent powerlessness. Additionally, Kanter's structure of power, which entails access to resources, information and support, reinforces findings in the current study that nurses who had the necessary tools to use effective medication and the resource

of sufficient time to care experienced nurse empowerment. Lastly, the concepts of formal and informal power in Kanter's theory (1977, 1993) relate to nurses' collaborative relationships with patients and colleagues.

In the substantive theory, lines of formal power were the structures that empowered nurses to assess, plan and make analgesic decisions, such as effective prescriptions and time to care. Lines of informal power were nurses' relationships with patients and colleagues that afforded them the authority, knowledge and cooperation in pain management to implement feasible comfort strategies. Kanter's ideas of lines of informal power offer considerable support for the first stage of basic social psychological process identified in the substantive theory; building connections.

Laschinger's body of work has extensively applied Kanter's theory (1977, 1993) to nursing (Armstrong, Laschinger & Wong, 2009; Laschinger, 1996). Using Kanter's framework, Laschinger linked nurses' perceived access to structural empowerment to organisational commitment, perceived autonomy, perceived justice and respect, job satisfaction, effectiveness, engagement in work and lower levels of job burnout (Hatcher & Laschinger, 1996; Laschinger & Finegan, 2005b; Laschinger & Havens, 1996; Sabiston & Laschinger, 1995; Wilson & Laschinger, 1994). Moreover, Laschinger demonstrated that empowered nurses were able to deliver care that accorded with their professional values (Laschinger & Finegan, 2005a; Laschinger & Havens, 1996). In turn, structural empowerment has strongly influenced job satisfaction and commitment for Canadian, American and Chinese nurses (Laschinger, Leiter, Day & Gilin, 2009; Nedd, 2006; Ning, Zhong, Libo & Li, 2009).

In 2001, Kanter's model was expanded to incorporate Spreitzer's concept of psychological empowerment when it was hypothesised that psychological empowerment was the natural outcome of structural empowerment (Laschinger et al., 2001). Studies using this integrated framework have linked nurses' experience of empowerment to lessened job strain, increased job satisfaction and perceived respect, while those who experienced less meaning, low control and lack of time in their work were subject to increased work stress (Faulkner & Laschinger, 2008; Li, Chen & Kou, 2008).

Recommendations stemming from studies using Kanter's framework (1977, 1993) focus on nurses' organisational participation, promotion of collaborative multidisciplinary relationships to strengthen informal power, and participation in clinical decision-making (Armstrong et al., 2009; Faulkner & Laschinger, 2008; Laschinger & Havens, 1996; Nedd, 2006; Wilson & Laschinger, 1994). Suggestions include involving nurses in committees; increased communication through unit and nursing forums; rewards for good work; allocation of necessary resources; and decreased documentation to enable more free time.

Findings from the current study support requests to promote nurses' participation, collaborative relationships and access to resources to facilitate nurse empowerment. The current study supports other work that has suggested that nurses felt most empowered by structures of informal power, which have been significantly related to positive working relationships (Faulkner & Laschinger, 2008; Laschinger & Finegan, 2005a, 2005b; Laschinger & Havens, 1996). Nurses in the current study gave little indication that increased organisational participation would decrease feelings of disempowerment. Rather, the substantive theory emphasises the need to strengthen nurses' collaborative relationships with patients, medical staff, specialised pain teams and other nurses.

Through using qualitative methodology, the current study has inductively developed a substantive theory that provides considerable support for Laschinger's (2001) deductively derived model of structural and psychological empowerment. Recently, Laschinger (2010) linked nurses' control over conditions at work to their health and well-being. Resources, information and support in the workplace were associated with improved functioning, while a lack of access led to experiences of powerlessness, frustration, hopelessness and disengagement (Laschinger et al., 2010). The substantive theory of seeking empowerment to provide comfort is congruent with this model. Moreover, the developed theory builds on Laschinger's work by linking two components: (a) lack of structural empowerment in the acute hospital, and (b) nurses' subjective experiences of disempowerment, to (c) a basic social psychosocial process.

The concept of empowerment, which was both a psychological outcome for nurses who felt able to provide comfort and also a process used to resolve the core

problem, integrated the substantive theory developed in the current study. Nurses' empowerment of their patients also emerged as a theme. In this regard, empowerment related to nurses' collaborations with patients as they sought to build connections and find alternative ways to comfort.

Critical social theory and patient empowerment.

Critical social theory is largely concerned with power as a source of domination and with the emancipation of oppressed groups (Holmstrom & Roing, 2010; Kuokkanen & Leino-Kilpi, 2000). In the nursing context, empowerment from an emancipatory standpoint has underpinned nursing education and has bolstered nurses' relationships with other health professionals (Kuokkanen & Leino-Kilpi, 2000; Ryles, 1999). Critical social theory also insists on nurses' empowerment of patients as active and equal participants in their own care (Anderson, 1996). This stance has nurses facilitating patients' personal control through shared decision-making, rather than nurses dominating as experts over passive patients (Falk Rafael, 1996).

The substantive theory developed in the current study proposed that nurses felt more able to provide comfort when they collaborated with patients who experienced severe pain. Collaboration between nurse and patient involved cooperation, trust and informed decision-making. The literature suggests that this approach accords with a process of patient empowerment through nurturing relationships based on mutuality and the patients' active participation (Aujoulet, d'Hoore & Deccache, 2007; Falk-Rafael, 2001; Piper, 2010; Takemura & Kanda, 2003; Tveiten & Meyer, 2009). Notions of patient empowerment in health have developed through critical social theory and emancipation of oppressed groups (Holmstrom & Roing, 2010). One definition has patient empowerment as a "philosophy which views human beings as having the right and ability to choose by and for themselves" (Aujoulet et al., 2007, p. 15).

Patient empowerment embodies concepts of choice, responsibility and skill development, and attributes include communication involving active listening; individualised knowledge; access to resources; trust; respect; education; and support (Holmstrom & Roing, 2010; Piper, 2010; Rodwell, 1996). These themes reflect the

value that nurses in the current study ascribed to communication, cooperation and patient participation. However, a striking finding was that nurses were not always able to collaborate with patients in these ways, particularly when caring for opioid-tolerant patients. The tussle for control described in Chapter Four, which could arise when nurses cared for opioid-tolerant patients, was a case in point. Although nurses understood that these patients had a high tolerance for medication, they often viewed their requests for analgesics as excessive. Protecting the well-being of such patients, therefore, revolved around restricting doses of the painkillers that they viewed as inappropriate. Meanwhile, the patients focused on obtaining liberal medication to relieve pain. With differing goals for comfort provision, a tussle for control of their interactions could arise as each party tried to achieve their preferred outcome. The literature offers insight into this finding.

It emerges that many health professionals remain prescriptive despite embracing the idea of empowering patients. One proposition is that busy, pressured staff feel unable to allow patients enough time to truly own their decision-making (Aujoulet et al., 2007). Another suggestion is that patient empowerment must start with patients' concerns being taken seriously, a difficult undertaking when nurse and patient views contrast (Tveiten & Meyer, 2009). In the current study, nurses who felt little empathy for opioid-tolerant patients showed they tended to dismiss self-reports of pain. In this regard, nurses clearly found it difficult to take patients' concerns about pain and requests for analgesia into account.

The literature may offer further insight into nurses' responses to these patients. A number of studies have described a reciprocal effect whereby empowered nurses were more likely to empower their patients (Aujoulet et al., 2007; Falk-Rafael, 2001; Laschinger et al., 2010). Findings from an Australian qualitative study (Henderson, 2000) suggested the reverse might also hold; that disempowered nurses tend to disempower patients. In that study of hospital nurses (n=33), those who felt constrained by medical staff neglected to invite patients to participate in their own care, and used technical procedures to maintain control. Although not specifically related to nurses' pain management, this notion of reciprocity might explain why nurses in the current study, who felt manipulated and frustrated, resisted ceding control to opioid-tolerant patients who they saw as demanding and inappropriate.

In the substantive theory, collaboration with patients facilitated comfort provision as the goal of nurses' care for patients who experienced severe pain. The following section discusses literature pertaining to *comfort* and *caring*; and subthemes of *empathy*, *connectedness*, *mutuality*, and *aspects of the acute hospital*.

The substantive theory and literature relating to comfort and caring.

The literature search located four prominent theories conceptualising comfort and nurse caring. The substantive theory will first be compared to an existing theory of comfort (Kolcaba, 1994) and will then be compared to three well-established theories of nurse caring (Parse, 1992; Swanson, 1991; Watson, 2001). Finally, the developed theory will be related to relevant literature describing elements of nurse caring and aspects of the acute hospital.

Kolcaba's theory of comfort.

A search of the literature revealed inextricable links between concepts of pain, comfort and nursing care. One paper acknowledged that early research tended to describe pain as a "subcomponent" of comfort (Malinowski & Stampler, 2002, p. 600). Modern enquiry about the concept of comfort began in the 1980s, when caring and comfort were differentiated (Morse, 1983). While caring was described as motivation for nurses' actions, comfort entailed touching, talking, and, to a lesser extent, listening to those who were sick or in pain. Kolcaba (1994) began her analysis of the concept of comfort when she undertook doctoral studies and drew upon the work of earlier nursing theorists, including Watson (2001) who viewed comfort as a significant part of the science of caring (Dowd, 2002; Kolcaba & Kolcaba, 1991). This work culminated in Kolcaba's (1994) theory of holistic comfort for nursing, which was underpinned by three assumptions:

- 1) Human beings have holistic responses to complex stimuli.
- 2) Comfort is a desirable holistic outcome in the discipline of nursing.
- 3) Human beings strive to meet, or to have met, their basic comfort needs (Kolcaba, 1994).

Kolcaba theorised that when patients are in stressful situations, nurses assess their total comfort needs and provide strengthening interventions to meet needs (Kolcaba,

1994; Kolcaba & Steiner, 2000). She explored the relief of pain in patients' perspectives of comfort and argued that her theoretical perspective of holistic comfort broadens and helps to explain theories of pain (Kolcaba & Steiner, 2000).

In 2001, Kolcaba published her midrange theory of comfort, which was orientated toward nursing theories based upon human need, where patients are viewed according to what they require for sustenance or growth (Kolcaba, 2001). This theory held that numerous discomforts include pain, and that the strengthening aspect of comfort moves patients toward well-being (Kolcaba, 2001; Wilson & Kolcaba, 2004). Kolcaba's comfort theory has been applied in paediatric and perioperative nursing settings and for end-of-life care (Kolcaba & DiMarco, 2005; Novak, Kolcaba, Steiner & Dowd, 2001; Wilson & Kolcaba, 2004). Encompassing domains such as care, holism, symptom management, healing environment and identification of needs, comfort theory was selected to enhance the practice environment at one New England hospital (Kolcaba, Tilton & Drouin, 2006).

Aspects of the substantive theory of seeking empowerment to provide comfort support Kolcaba's theory of comfort. The context of nurses having a regard of well-being in the substantive theory fits with the notion of comfort as multidimensional with physical, psychospiritual, sociocultural aspects. Moreover, both the substantive theory and Kolcaba's (1994) theory hold that nurses' comfort provision moves patients towards wellness. Kolcaba's sense of comfort as a state of ease rather than total absence of discomfort, fits with the perspectives of nurses in the current study that comfort provision was not about the elimination of pain, but rather about providing sufficient relief from discomfort to ease anguish and restore function. Lastly, both theories emphasise holistic care and hold that comfort provision meets patient need.

Nurses in the current study provided comfort for their patients through collaborative relationships, which emerged as central to their care for patients experiencing severe pain. A search of the literature located three well-established theories of caring in nursing that invited comparison with the substantive theory developed in this study. The following section considers each theory in turn.

Watson's theory of human caring.

Watson began in 1979 to develop her theory of human caring, which has human care as the essence of nursing practice (Neil, 2002; Watson, 2001). Reviews of her theory have identified a moral imperative, whereby human dignity is protected and enhanced by helping people to find meaning in illness, pain and existence (Dyson, 1996; Pryds Jensen, Bäck-Pettersson & Segesten, 1993). The central idea is that caring is more “healthogenic” (p. 151) than curing (Neil, 2002). While curing means an absence of disease, health is embedded in the harmony of mind, body and soul.

In essence, Watson's theory elucidates a caring process based on humanistic values that assist people through a human relationship and a corrective protective environment (Drach-Zahavy, 2009; McCance, McKenna & Boore, 1999; Rafael, 2000; Sourial, 1996). Furthermore, as Rafael explains, Watson regards the patient as the agent of change in the caring process, with the nurse as facilitator (Rafael, 2000). Ten “carative” (p. 37) factors define the caring process through which patients attain and maintain health, or die a peaceful death (Rafael, 2000). The first three of these factors encompass humanistic and altruistic values, provision of holistic care through an effective nurse-patient relationship, and being fully present to others (Neil, 2002; Rafael, 2000; Watson, 2001). They relate to the preparation of the nurse, and presuppose knowledge, clinical competence and a commitment to the protection and enhancement of human dignity (Sourial, 1996).

The fourth factor identifies a “helping-trust” (p. 149) relationship that is crucial to caring (Neil, 2002). This involves honesty, authenticity, empathy and effective verbal and nonverbal communication; values that are inherent for the relationships and skills required for nursing (McCance et al., 1999). The eighth carative factor concerns the influence that the mental, physical, social and spiritual environment has on health, healing and well-being, including comfort (Neil, 2002). Other factors refer to sharing feelings, a problem-solving approach, facilitating learning that shifts responsibility to the patient, meeting needs, and helping to develop understanding of experiences; both of the self and of others.

The substantive theory developed in the current study supports much of Watson's (2001) theory . Nurses sought to provide effective comfort provision

through collaborative relationships with patients, which was congruent with Watson's vision of helping trust relationships based on holistic care and nurses' authentic, empathic presence. Health, healing and well-being are integral in both theories and both have prominent themes of empathy, holism and nurses being there for patients. Moreover, both theories differentiate between cure and care. However, a major difference is that Watson's theory states that care rather than cure is paramount, while the substantive theory developed in the current study states that nurses tend to fall back on care to provide comfort when the default option of pharmacological cure is not available.

Parse's theory of nursing: human becoming.

Rosemarie Rizzo Parse first published her theory of Man-Living-Health in 1981. She later revised the theory; renaming it as her theory of human becoming (Parse, 1992), and then the Human Becoming School of Thought in 1998 (Daly, 2000). To develop her theory, Parse drew upon the work of nurse theorist Martha Rogers' Science of Unitary Human Beings and philosophical thought from the existential-phenomenological movement (Daly, 2000; Mitchell, 2002). In doing so, she brought together concepts of human beings as energy fields in constant mutual process with environment fields and a focus on individual existence where humans are free, responsible for personal choices and constantly evolving through interpretation.

Accordingly Parse's Human Becoming School of Thought was based on three principles reflecting notions of human choice, rhythmical and paradoxical patterns of relating with the universe, and the process of moving forward in life through struggle with contradictory aspects (Daly, 2000; Mitchell, 2002). The first principle concerns how people construct meaning through "linguaging", "valuing" and "imaging." The second concerns the way people relate with others in rhythmical patterns that have contradictory aspects of "revealing-concealing", "enabling-limiting" and "connecting-separating." The last suggests that humans are constantly moving forward in life that involves struggle and a rhythm of pushing-resisting through "powering", "originating" and "transforming" (Daly, 2000).

From this theoretical perspective, Parse's goals of nursing practice are to enhance quality of life from the patient's perspective and preserve dignity (Parse, 1992). The nurse does not control the patient, but is rather present as the patient makes decisions from his or her perspective (Parse, 1987). In developing her theory, Parse sought to move nursing away from the medical model towards practice that values patients as experts on their own life and health (Parse, 1992).

The substantive theory of seeking empowerment to provide comfort supports Parse's work by grounding nurses' comfort provision in holistic, participatory care where being there for patients carries an inherent value. The substantive theory also supports Parse's vision of the nurse who creatively tends to the whole person through communication, collaboration and inclusion. These qualities defined comforting nurse-patient interactions in the substantive theory, becoming more prominent as nurses sought to empower themselves by building connections and finding alternative ways to comfort.

Finally the substantive theory is considered in relation to Swanson's middle range theory of caring (Swanson, 1991). This established theory proposes an understanding of caring that is central in nursing but not unique to nursing. Five characteristics of caring provide the major tenets of the theory. Swanson (1991) found parallels between these characteristics and Watson's (2001) ten factors, which she suggested provided "cross-validation" (p. 165) for each other. In recent years, Swanson's theory of caring has provided the framework for professional practice models implemented to guide excellent nursing practice in two health services in the USA (Berger, Conway & Beaton, 2012; Latta & Davis-Kirsch, 2011).

Swanson's theory of caring.

Swanson sought to develop an inductively derived theory of caring during the 1980s when she found herself unable to find definitive answers to questions about the nature of caring (Swanson, 1991). She sought to determine whether caring is a process, an intent that drives behaviour, or a perception only recognisable from the viewpoint of those being cared for. In response, she conducted three studies with parents and health professionals from perinatal settings, all of whom had cared for

very low birthweight babies. The aim was to develop a definition of caring and identify its characteristics.

Qualitative methods, including interviewing and participant observation were used to explore the experiences of (a) mothers (n=20) who had recently miscarried (Swanson-Kauffman, 1986, 1988b), (b) practitioners and parents (n=19) who cared for babies in a neonatal intensive care unit (NICU) (Swanson, 1990), and (c) young mothers (n=8) involved in a public health nursing network (n=8) (Swanson-Kauffman, 1988a). Participants from the NICU included six nurses, one ethicist, one allied health practitioner, four doctors and seven parents. The sampling ensured that data were contributed by people who were cared for, as well as people who cared for others in personal and professional roles.

Over the course of the three studies, five characteristics of caring were inductively proposed, refined and confirmed (Swanson, 1991). These characteristics were labelled: (a) knowing, (b) being with, (c) doing for, (d) enabling and (e) maintaining belief. In Swanson's theory, *knowing* revolved around understanding how an event has meaning for another. The carer acknowledges the person being cared for as significant and uses thorough assessment to elicit experiences. Concepts of engagement, between carers and recipients of care, as well as carers' recognition of the prior experience of those they care for, were important.

The second characteristic of *being with* meant the carer being emotionally present for the person being cared for (Swanson, 1991). It was the carer's emotional openness and availability for the recipient of care that set the category of being with apart from the category of knowing in this theory. Swanson also identified parallels with the earlier work of Noddings (1984), who referred to carers' regard for the well-being of others, when explaining her conceptual understanding of being with in caring.

The characteristic of *doing for* revolved around meeting the needs of others and was described as carers doing for others things that they would do themselves if they could (Swanson, 1991). *Enabling* meant helping the passage of another through one of life's transitions, and involved the carer using expert knowledge to help others to find solutions and alternative perspectives to deal with their concerns. Lastly, *maintaining belief* was about holding others in esteem and believing in their

capability to reach fulfilment. Of the five identified characteristics of caring, maintaining belief was the only one not confirmed after completion of the three studies. In the context of nursing, maintaining belief referred to nurses helping their patients to attain or regain meaning in their experiences. Swanson concluded that such fulfilment for some people may not be possible considering the challenges they face.

Refinement and confirmation of these five characteristics generated the proposed definition of caring as “a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Swanson, 1991, p. 165). The theory developed in the current study provides significant support for Swanson’s (1991) theory in the substantive area of nurses’ care for patients in pain management. Nurses in the current study demonstrated that they responded empathically to people who suffered from severe pain and assumed responsibility to alleviate their distress and promote recovery. There was no obligation on patients to care for nurses in the same way. In the substantive theory, assuming responsibility for solving pain problems led to nurses doing for their patients; meeting their needs and using expert knowledge to do so.

Swanson’s (1991) theoretical characteristics of knowing and being with resonate strongly with the substantive theory developed in the current study. In the current study, comprehensive assessment provided the means for nurses to understand their patients’ pain experiences, including its meaning, and their subsequent needs. Knowledge of the patient facilitated collaborative relationships and was a platform for decision-making. Being with patients was a prominent theme in the substantive theory. Nurses’ physical and emotional presence was integral to effective comfort provision and a crucial strategy when nurses looked to find alternative ways to comfort their suffering patients.

The findings from the current study suggested that nurses sought to know and be with patients who they perceived were suffering with pain. However, they tended to disregard the experiences of opioid-tolerant patients and, when feeling particularly manipulated and frustrated, avoid attending to them. In light of Swanson’s (1991) theory, this evidence from the current study suggests some nurses may provide deficient care for these patients, which warrants further investigation. The findings of

the current research indicate that when nurses encounter insufficient time to care in the acute hospital, some characteristics of their comfort provision become less prominent. Without sufficient time, nurses found it difficult to know and be with their patients, although they continued to do for them and became more task oriented in order to meet needs.

Relating findings of the current study to theories developed by Watson (2001), Parse (1992) and Swanson (1991) highlight how difficult it can be for nurses in the acute hospital to provide holistic, participatory, empathic, and attentive care. The substantive theory identified that intervening conditions, such as lack of time, prevented nurses from being truly present for patients. The findings identified a divide between cure and care that was not easy to put aside in the busy hospital where nurses were responsible for multiple acutely ill patients. Therefore, a prominent finding of the current study was that it was only when pharmacological cure failed, that escalating feelings of disempowerment prompted nurses to more fully develop the interpersonal processes encapsulated in these theories.

Comparison of the substantive theory to these theories demonstrates congruence with core values of nurse caring, but highlights tensions between this theoretical view and the reality of the current practice environment. To examine this finding in more depth, further literature exploring the nature of nurse caring and an overview of constraints in the acute hospital are summarised.

The attributes of nurse caring.

Caring has been not been clearly defined in the nursing literature (Brilowski & Wender, 2005; Finfgeld-Connett, 2008a; Henderson, 2000; Mackintosh, 2000; Pearcey, 2010; Rolfe, 2009). However, certain themes appear consistently to describe caring in nursing as a profoundly human-to-human experience grounded in a trusting and authentic interpersonal relationship, feelings of empathy and compassion (Barker, 2000; Finfgeld-Connett, 2008a; Pearcey, 2010). Ethically, nurse caring is founded upon principles of fidelity, justice and beneficence, which is the provision of benefits (Laganá, 2000). Moreover, in a caring relationship, it is respect and understanding that “lead the nurse to engage with the patient’s experience of health” (Laganá, 2000, p. 17).

Building on the well-established theories of nurse caring described earlier, the literature insists that an interpersonal nurse-patient relationship based on trust and intimacy is central to caring in nursing (Berg et al., 2006; Brilowski & Wender, 2005; Carter et al., 2008; Finfgeld-Connett, 2008a; Laganá, 2000; McQueen, 2000; Neil, 2002; Pearcey, 2010; Turkel, 2001; Turkel & Ray, 2000). This relationship is understood to be contextual, holistic and humanistic as a partnership between nurse and patient, and congruent with patient-centred care (Dyson, 1997; McQueen, 2000).

Nurse caring is thought to unfold when a patient's vulnerability, fearfulness and worry are out of control (Finfgeld-Connett, 2008b). The substantive theory offers support for this notion. Severe pain was conceptualised as a multidimensional experience that was physically and emotionally distressing. Nurses recognised the vulnerability of hospitalised patients in pain and demonstrated that they supplemented analgesics with reassurance, information and a comforting human presence. These strategies figured more prominently when patients' severe pain persisted and nurses sought alternative ways to comfort.

Attributes of the nurse-patient relationship arising consistently in the literature include empathy, connectedness, trust, respect, attentiveness, genuine concern, competence and commitment (Brilowski & Wender, 2005; Carter et al., 2008; Finfgeld-Connett, 2008a; Fredriksson, 1999; Halldórsdóttir & Hamrin, 1997; Hartrick, 1997; McQueen, 2000). Of these, *empathy*, *presence* and *mutuality* emerge as defining characteristics in the literature and prominent themes in the substantive theory developed in the current study.

Empathy: The foundation for the nurse-patient relationship.

The role of empathy in engaging nurses in patients' pain problems and prompting comfort provision has been described. A brief overview of literature emphasising empathy as the foundation for nurse caring and essential for collaboration follows. In summary, many authors contend that a nurse-patient relationship grounded in compassion and empathy is central to caring (Barker, 2000; Brilowski & Wender, 2005; Finfgeld-Connett, 2008a; Halldórsdóttir & Hamrin, 1997; McQueen, 2000; Teng, Hsiao & Chou, 2010). Compassion has been described as participation in another's experience and a demonstration of respect for human life

and autonomy that is congruent with the altruistic-humanistic values of Watson's theory (Pryds Jensen et al., 1993). Similarly, nurses' empathy, which helps them see others in themselves, provides motivation for caring and emotional connection to cultivate the nurse-patient relationship (Dyson, 1997; Finfgeld-Connett, 2008a; Hartrick, 1997; Ryles, 1999). A recent concept analysis established that nurse-related factors necessary for empathy included an ability to communicate and a conscious desire to do so, and a reciprocal relationship (Campbell-Yeo et al., 2008).

As has been described, the findings of the current study support notions of empathy as a foundation for a caring nurse-patient relationship. Empathy was a major tenet of the substantive theory in which nurses' levels of empathy were an intervening condition. Nurses' empathic feelings were found to vary. Too much empathy for suffering patients caused nurses to feel distress and helplessness, while too little empathy for opioid-tolerant patients tended to leave nurses feeling manipulated. Empathy was important for nurses' connectedness with patients in the substantive theory. Elements found to strengthen these connections included spending time, being present, touching and listening; all of which have been described in the nursing literature (Carter et al., 2008; Fredriksson, 1999).

Presence: Being there for patients.

A prominent theme in the substantive theory was nurses' belief that being there for patients who were experiencing severe pain was inherently comforting. In particular, nurses described being there as they sought alternative ways to offer comfort. This finding from the current study supports evidence in the literature that nurses' presence enhances connectedness in the nurse-patient relationship (Brilowski & Wender, 2005; Finfgeld-Connett, 2006; Woodward, 1997). Being present for patients entails nurses' physical attendance, communication and touch to convey empathy and compassion. This nurtures the caring relationship, particularly when patients feel vulnerable (Alliex & Irurita, 2004). Other authors have referred to nurses' presence for patients as both physical and emotional, which requires interpersonal sensitivity, empathy and attentiveness (Finfgeld-Connett, 2008a; McQueen, 2000). Nurses included in the current study described being there for patients in similar terms, depicting a physical and emotional presence that transcended verbal communication.

The concept of reciprocity when nurses are present for their patients also figures in the nursing literature. Resting on “engaged availability” (p. 170) reciprocity refers to nurses being actively invited into the patient’s experience and able to reciprocally engage (Finfgeld-Connett, 2006). Themes of reciprocity and engagement reflect findings from the current study; firstly that nurses engaged with patients’ pain problems; and secondly that caring was participatory, which meant that patients made choices to accept or refuse the care offered by nurses. Their descriptions of collaborating with patients to provide comfort links to a further attribute of nurse caring found in the literature, which is mutuality in relationships.

Mutuality: Collaborative nurse-patient relationships.

Notions of reciprocity link to an understanding that the nurse-patient relationship is a mutual process in which both parties are respected, autonomous and collaborating towards shared goals (Dyson, 1997; Hartrick, 1997; McQueen, 2000). Nurse and patient each influence the development of their relationship (Berg et al., 2006; Finfgeld-Connett, 2008b; McQueen, 2000; Turkel, 2001). The substantive theory developed in the current study offers support for suggestions of mutuality in nurses’ care. Nurses felt able to provide comfort when they agreed on goals and strategies for pain relief. Trust, rapport and a sense of shared control characterised collaboration, through which nurses and patients communicated and cooperated effectively. In contrast, nurses experienced feelings of disempowerment when patients seemed to resist the care they offered. In particular, tussles for control could arise when nurses and opioid-tolerant patients sought different outcomes from their interactions in terms of analgesic administration.

Caring behaviours.

A number of authors suggest that the nurse-patient relationship brings with it a responsibility to contribute to patients’ well-being by meeting needs (Brilowski & Wender, 2005; Corbin, 2008; Dyson, 1997; Halldórsdóttir & Hamrin, 1997). The assumption of responsibility for solving pain problems to protect patient well-being and promote recovery by nurses in the current study supports this contention. Moreover, the use of comfort measures such as administering analgesia, initiating,

encouraging, and informing supports Finfgeld-Connett's (2008a) notion that caring involves nurses doing, advocating for and empowering their patients.

Lastly, nurses' knowledge of their patients has been described as integral to caring. A qualitative study of nurses working in medical and surgical wards (n=24) in Japan identified that nurses knowing their patients was the basis for ethical and technical decision-making, and individualised care (Takemura & Kanda, 2003). The substantive theory offers supports for this idea by explaining how nurses' knowledge of their patients enabled them to understand pain problems and flexibly negotiate complex analgesic administration.

Elements of nurse caring, such as empathy, presence and mutuality, described in the literature resonate strongly with the collaborative nurse-patient relationships through which nurses provided comfort in the substantive theory. Perusal of the literature also reveals antecedents and consequences of nurse caring, which have some relevance to the intervening conditions and core problem described in the developed theory.

Antecedents to nurse caring.

Antecedents have been defined as those events that must occur before caring can take place (McCance, McKenna & Boore, 1997). Concepts of reciprocity and mutuality suggest that antecedents to caring relate to nurse, patient and the practice setting (Finfgeld-Connett, 2008b).

Nurses are thought to require a capacity to (a) understand self, appreciate others and offer empathetic connection; (b) an attitude of commitment; (c) regard for the patient; and (d) an intent to spend time with the patient (Finfgeld-Connett, 2006, 2008a, 2008b). In addition to this, nurses profess the need for courage to maintain calm, cope with stress, manage conflict and advocate in a crisis (Pryds Jensen et al., 1993). Knowledge and skills facilitate competent and dextrous nursing activities, while knowing the patient emphasises humanistic care and diminishes the intrusive influence of technology on caring relationships (Alliex & Irurita, 2004; Finfgeld-Connett, 2008b; Takemura & Kanda, 2003).

Mutuality in nurse-patient relationships requires patients to be open to caring. This means that difficulties can arise when recipients are angry, aggressive or

demanding (Finfgeld-Connett, 2008a). The substantive theory offers support for this proposition by linking nurses' feelings of disempowerment to patients' behaviours and apparent acceptance or rejection of the care they offered. Most pronounced were nurses' sense of manipulation and tendency to disengage when caring for resistive opioid-tolerant patients.

From another perspective, the literature provides evidence of the need for an environment conducive to caring, which provides adequate resources, sufficient time, education, role modelling and an emphasis on the value of care (Brilowski & Wender, 2005; Finfgeld-Connett, 2008a, 2008b). These themes resonate strongly with the findings of the current study. For example, hospital nurses in the USA described how access to a body of nursing knowledge and peer support enabled them to care for their patients (Carter et al., 2008). When such factors relating to nurse, patient and the practice environment are in place to facilitate caring, the literature describes positive consequences for patients and nurses. In the substantive theory, these outcomes are described in terms of nurses' experiences of empowerment.

Consequences of nurse caring.

When conditions for caring were in place, consequences in terms of benefits for patients and nurses have been described. Patients experience improved health and healing (Finfgeld-Connett, 2006; Turkel & Ray, 2000). Reciprocity in the nurse-patient relationship brings empowerment, decreased stress, increased comfort, self-esteem, revitalisation and satisfaction for nurses (Barker, 2000; Brilowski & Wender, 2005; Finfgeld-Connett, 2006, 2008a, 2008b; Turkel, 2001). Additionally, there is a suggestion that nurses' mental health improves when those who have a high orientation towards caring can provide patient-centred care (Drach-Zahavy, 2009). Despite the benefits to all, aspects of the acute hospital have been found to constrain nurses' caring relationships with patients.

Aspects of the acute hospital.

Although Watson (2001) regards nurse caring as a moral idea and intrinsically related to healing, Neil (2002) believes that caring "at the human level" (p. 151) is increasingly under threat in the healthcare system. In particular, pressure from a

growing and ageing population has seen hospitals become high-dependency environments in which increasing patient acuity and decreasing length of stay have implications for nurses' ability to provide ideal care (Corbin, 2008; Fatovich, Hughes & McCarthy, 2009; McQueen, 2000; To et al., 2010).

Accordingly, a paradox in acute care is apparent in which nurses must care for older, sicker patients yet have less resources to do so (Turkel, 2001). One UK study demonstrated the effect of such constraints on young nurses (n=26) in a contemporary hospital environment (Maben, Latter & Macleod Clark, 2006). As new graduates, these nurses described ideals of "making a difference" (p. 468) through patient-centred, holistic care, but they encountered time pressures and staff shortages similar to those faced by nurses in the current study. Factors including cost containment, workload and increasing emphasis on technology, have been found to underpin constraints on nurses who provide care in acute hospitals (Allix & Irurita, 2004; Berg et al., 2006; Pearcey, 2010).

Almost twenty years ago, Australian authors described a technological health system that had increasing pressure to reduce costs, despite the need to treat older and sicker patients (Duffield & Lumby, 1994). The need for nurses to balance conflicting demands of cost containment and delivery of quality care was described. Rather than abating, it appears these pressures have compounded as increased documentation, changes to the skill mix, restructuring and downsizing have progressively involved nurses in tasks that take them away from the bedside (Duffield et al., 2008).

The evidence indicates that heavy workloads are a particular impediment for nurses' delivery of emotional care and relationships with patients (Berg et al., 2006; Pearcey, 2010). Without sufficient time to care, nurses have to focus on being, knowing and doing for their patients all at once (Turkel, 2001). Moreover, the value nurses ascribe to caring means that time constraints can lead them to experience feelings of struggle, frustration and fear for their patients (Turkel, 2001).

The influence of insufficient time to care on nurses' relationships with their patients was captured in observational research in an Australian hospital (Henderson et al., 2007). In this study, nurse-patient interactions occurring in a four-bed room in a medical and surgical ward over 12 four-hour periods were observed. Interactions

were classified as “getting to know you”, which involved greetings and welcomes; “translating”, in which nurses informed, instructed and explained; and “expert compassion” (p. 150), in which nurses facilitated closeness (Henderson et al., 2007). This third interaction occurred least often. This study made evident the demands on nurses’ time and the extent to which these demands shortened nurses’ interactions with patients.

The substantive theory developed in the current study offers support for the hypothesis that insufficient time related to heavy workloads impinges upon nurses’ relationships with patients. Moreover, the developed theory identified lack of time as an intervening condition in the acute hospital, that led to nurses feeling disempowered from providing comfort for patients who experienced severe pain. Particularly evident were nurses’ distress and frustration when unable to be there for suffering patients, as was their discomfort when feeling reliant on analgesic medication as a “quick fix.”

The influence of the acute hospital practice environment, which seemed to demand that nurses focus on clinical treatments at the expense of being there for patients, also emerged in the current study. While their physical and emotional presence was considered a powerful comfort measure, nurses consistently described distress and frustration at their inability to stay with patients who suffered from pain. The literature suggests that nurses in the current study were not alone in feeling constrained in this way. A number of authors have suggested that the invisibility of emotional connectedness and the emphasis placed on productivity in a depersonalised technological environment devalues the caring relationship (Barker, 2000; Carter et al., 2008; Corbin, 2008; Duffield et al., 2008; Flatley & Bridges, 2008; McQueen, 2000; Pearcey, 2010).

A Western Australian study of hospital nurses described how their acute awareness of technology and instrumentation tended to stymie relationships with patients (Alliex & Irurita, 2004). This led these authors to argue that science has increasingly subsumed the art of nursing. Although not specifically related to pain management, that grounded theory study identified a process used by nurses to manage their feelings of being stymied, which had several similar features to the substantive theory developed in the current study. In the earlier study, nurses

attempted to navigate nurse-patient interactions over time (Alliex & Irurita, 2004). The strategy of maximising was identified, in which nurses tried to reduce the influence of technology by maintaining a presence with patients through “popping in” and “giving time” (Alliex & Irurita, 2004, p. 36). This strategy of maximising reflected descriptions from nurses in the current study of being there and of checking in frequently with patients who continued to experience severe pain. Additionally, maximising involved nurses verbally distracting patients from the influence of technology (Alliex & Irurita, 2004), which was similar to nurses’ use of distraction in the current study. In both studies, these strategies seemed to embody nurses’ attempts to assert the caring relationship and provide human connectedness to alleviate hospitalised patients’ stress and anxiety.

The substantive theory of seeking empowerment to provide comfort developed in the current research supports the literature that defines nurses’ care as a mutual interpersonal relationship grounded in empathy, in which nurses are physically and emotionally present for their patients. Nurses in the current study viewed comfort provision as participatory, holistic and collaborative. Moreover, the findings indicated that nurses’ feelings of empathy nurtured a connectedness between them. This connection underpinned nurses’ attempts to provide a caring presence for distressed patients, which was increasingly important when pain treatments were ineffective. The literature has also described aspects of the acute hospital that have affected nurses’ ability to connect with and be present for patients. The developed theory identified and summarised factors, such as heavy workloads and the multiple demands on nurses, as being causes of this lack of time to care.

A major tenet of the substantive theory of seeking empowerment to provide comfort was that nurses used a basic social psychological process to avoid the core problem of feelings of disempowerment. The theory postulated that the distress, frustration, dissatisfaction and exhaustion experienced by nurses who felt disempowered were threats to their well-being. They responded with actions and interactions aimed to empower themselves in order to provide comfort or manage the emotional fallout of disempowerment. A search of the literature revealed that aspects of stress in nursing have been previously described. The literature also revealed a well-established theory of stress and coping (Lazarus & Folkman, 1984) that invites comparison with the substantive theory.

The substantive theory and literature relating to stress and coping.

Nurses included in the current study clearly demonstrated that feelings of disempowerment were particularly stressful. The emotional experience of disempowerment related to feeling unable to provide comfort for suffering patients, or feeling manipulated by opioid-tolerant patients. Findings indicated that this experience constituted sufficient threat to nurses' well-being to trigger a basic social psychological process. Sources of stress in nurses have been explored in the literature, and the basic social psychological process identified in this study suggests nurses responded with coping strategies that had implications for them and their patients.

Stress in the nursing literature.

Recently, a systematic review identified stress as a significant issue for Australian nurses (Lim, Bogossian & Ahern, 2010). The negative effect stress has on well-being and the implications for staff retention and quality of care were recognised. Sources of stress for hospital-based nurses in Australia include workload, experiences of aggression, role ambiguity, death and dying, conflict with physicians, and shift work (Chang et al., 2006; Healy & McKay, 2000; Hegney, Eley, Plank, Buikstra & Parker, 2006; Lim et al., 2010). These are in accordance with stressors identified in international literature, which include workload and time pressure; collegial relationships, poor management, emotional demands of caring, shift work, and lack of reward (Garrosa, Rainho, Moreno-Jiménez & Monteiro, 2010; McVicar, 2003). This literature offers further support for the findings of the current study, in which nurses' heavy workloads and consequent lack of time to care emerged as a significant source of frustration for nurses who were trying to be there for suffering patients.

Another issue highlighted as a stressor in the literature is the "emotional labour" (p. 638) required of nurses who enter into a caring relationship (McVicar, 2003). In the current study, nurses described the distress of watching anguished patients when they were unable to help. The substantive theory explained that nurses' feelings of empathy engaged them with patients' pain problems and nurtured connectedness between them. However, while these connections facilitated holistic

comfort provision, it was evident that this engagement affected nurses emotionally if patients continued to suffer.

From a different perspective, research has identified the issue of role stress as a significant stressor for nurses. Role stress occurs when a person's expectation of a specific role differs from the reality of the role in practice (Chang et al., 2006; Lambert, Lambert & Ito, 2004). For nurses, role stress has been related to lack of control and resources, such as collaborative relationships with doctors, and time to care (Chang et al., 2006). For example, Chinese nurses (n=2,060) were shown to be at high risk of stress from the ambiguities and demands of their roles and the difficulties of the nurse-patient relationship (Wu, Chi, Chen, Wang & Jin, 2010). In contrast, nurses who felt in control and socially supported had a lower incidence of exhaustion (Garrosa et al., 2010; Wu et al., 2010).

The concept of role stress described in the literature resonates with notions of psychological empowerment in the current study. Disparity between expected and actual roles relates to the dimensions of meaning and impact in Spreitzer's (1995) theory of psychological empowerment. In the current study, nurses found meaning in the perceived nursing role of providing comfort for patients who suffered with severe pain. Their distress and frustration experienced when conditions in the acute hospital prevented fulfilment of this role were evidence that disempowerment was a significant source of stress for these nurses. Furthermore, there are suggestions in the literature that such workplace stress causes nurses to have poorer mental and physical health (Lim et al., 2010). This supports the proposal in the substantive theory that feelings of disempowerment threaten nurse well-being. Based on this, nurses' use of a basic social psychological process to avoid the stressful experience of disempowerment suggests use of a coping response.

Coping in the nursing literature.

An early paper described nurses' use of avoidance to manage feelings of powerlessness and frustration when unable to provide comfort for patients (Clements & Cummings, 1991). Later, Swedish district nurses described effective and ineffective strategies to cope with their sense of powerlessness when patients' pain persisted (de Schepper et al., 1997). Effective strategies included sharing their

feelings to strengthen nurse-patient relationships, and seeking out improved knowledge and skills. In contrast, ineffective strategies involved nurses avoiding patients as they tried to distance themselves from sources of stress. A study of nurses (n=10) practising in a Western Australian hospital found that they used a similar approach to manage dissatisfaction and stress experienced when unable to deliver quality nursing care (Williams, 1998). These nurses commonly struggled to overcome a lack of time that tended to constrain their ability to meet patients' psychosocial needs. Stress arose when nurses felt they could provide only basic care, which was considered ineffective. In response, they were found to protect themselves by using a strategy of "self-focusing" (p. 812) whereby they became indifferent to patients and eschewed interaction.

Findings of the current study indicated nurses used similar strategies to overcome feelings of disempowerment. They described building connections with patients and using these connections to find alternative ways to comfort. Similarly to the ineffective approaches described by de Schepper et al. (1997), nurses in the current study also described disengaging from patients to distance themselves from suffering and their own sense of ineffectiveness. These strategies suggest the basic social psychological process of seeking empowerment to provide comfort was a coping response to the stress of disempowerment. Perusal of the literature located a prominent theory of stress, appraisal and coping that invites comparison with the substantive theory developed in the current study.

Lazarus and Folkman's theory of stress, appraisal and coping.

In 1984, Lazarus and Folkman published their seminal work "Theory of Stress, Appraisal and Coping" to explain cognitive approaches to stress, coping and adaptation (Lazarus & Folkman, 1984). This theory conceptualises stress and coping as products of a relationship between a person and the environment. Stress arises when an individual cognitively appraises the environment and decides that the demands exceed his or her resources. Coping is the process by which the person manages the stressful event and the emotions generated.

According to Lazarus and Folkman's (1984) classic theory, cognitive appraisal of a stressful encounter involves judgment as to whether the event involves

(a) harm already sustained, (b) threat of anticipated harm, or (c) challenge from which there is possibility of gain. These judgments are not on a continuum, but can occur simultaneously. Whether an encounter is appraised as stressful also depends on the meaning a person ascribes to it, and the potential for threat in the environment. Control is a prominent concept. A person's belief about having personal control over the environment and his or her response to the stressful encounter is central. The theory postulates that situations seen as controllable are less stress inducing.

Lazarus and Folkman (1984) described the coping process as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as exceeding the resources of the person” (p. 141). Coping is theorised to serve two functions: (a) manage the problem (problem-focused coping), and (b) manage the emotional response to the problem (emotion-focused coping). This theory predicts that problem-focused coping is more likely when stressors seem amenable to change. Strategies revolve around defining the problem and finding a solution. In contrast, emotion-focused coping regulates distress when it appears that nothing can modify the harmful or threatening environment. Strategies involve either reappraising the situation as less threatening by looking at the big picture, or setting emotions aside by taking a break, venting or seeking support. Both forms of coping can occur simultaneously and are often seen together in naturalistic settings (Lazarus & Folkman, 1984).

The substantive theory of seeking empowerment to provide comfort developed in the current study offers significant support for Lazarus and Folkman's (1984) theory and demonstrates how this theory might apply to nurses caring for patients experiencing severe pain in the acute hospital. The substantive theory explained that nurses' feelings of disempowerment were created by experiences of watching patients suffer with severe pain while feeling unable to help. These feelings arose when nurses found themselves unable to access resources such as effective medication, medical direction, appropriate knowledge, collegial support or time to care. Moreover, many nurses described distress and frustration when they were unable to be there for suffering patients.

The substantive theory proposed that nurses became stressed when they implicitly appraised the demand of watching anguished patients in pain and found

themselves without the capacity to help. The consequent discomfort and potential exhaustion of feeling disempowered threatened nurses' well-being and triggered the basic social psychological process.

As predicted by Lazarus and Folkman's (1984) theory, the process of seeking empowerment to provide comfort entailed both problem-focused and emotion-focused strategies. The initial stages of building connections and finding alternative ways to comfort were clearly problem-focused. During these stages, nurses strengthened collaboration with those around them who had the power to help them secure the resources, knowledge and support they needed to feel empowered.

The final stage of quelling emotional turmoil focused on managing the emotional fallout of disempowerment. Strategies in this third stage of the basic social psychological process were largely congruent with Lazarus and Folkman's (1984) theoretical notions of venting and reappraisal. Temporary disengagement allowed nurses to take a break from the stress of disempowerment. However, the prolonged disengagement described in the substantive theory concurred with Lazarus and Folkman's strategy of avoidance. Additionally, as their theory predicted, the problem-focused strategies of building connections and finding alternative ways to comfort occurred alongside the emotion-focused strategies of quelling emotional turmoil. An example of this was when nurses disengaged temporarily to vent or reappraise, then reengaged to build connections and find alternative ways to offer comfort with renewed vigour.

Evidence in the literature suggests that nurses' use of problem-focused coping strategies may produce better mental health outcomes, while strategies aimed at managing emotional fallout are associated with poorer psychological health and well-being (Healy & McKay, 2000; Lim et al., 2010; McVicar, 2003). However, these apparent poor outcomes of emotion-focused coping may depend on the strategies employed. For example, using reappraisal appears to protect nurses' well-being in the long term, while the use of avoidance tends to correlate with poorer outcomes (Chang et al., 2006; Healy & McKay, 2000; Lambert et al., 2004; Sasaki, Kitaoka-Higashiguchi, Morikawa & Nakagawa, 2009).

Overall, a comparison of the substantive theory of seeking empowerment to provide comfort, to the theory of stress, appraisal and coping developed by Lazarus

and Folkman (1984) clearly demonstrated nurses' coping responses to the stress of feeling disempowered. The theory developed in the current study supported Lazarus and Folkman's predictions that individuals use problem-focused and emotion-focused coping, often simultaneously, when confronted by situations that seem to overwhelm their resources. The substantive theory demonstrates how Lazarus and Folkman's (1984) classic theory of stress, appraisal and coping applies in relation to nurses who care for patients in pain in an acute hospital.

Summary of the substantive theory related to relevant theories.

Perusal of the literature revealed that the current study is one of a few to present an integrated picture of the clinical reality for nurses caring for patients experiencing severe pain in an acute hospital. By examining the nurse's perspective, this study revealed the emotional effect upon nurses, their coping responses and the personal and professional implications. These findings build on a body of research that investigates discrete aspects of nurses' pain management, and observational work exploring the pain management practice of nurses working in Australian hospitals.

Comparisons of the substantive theory with a number of prominent theories supported the major tenets and validated empowerment as the integrating theme. Kolcaba's (1994) theory of comfort validated the notion that nurses' goal of comfort provision was central to their care of patients who were experiencing severe pain. Moreover, Spreitzer's (1995) theory of psychological empowerment helped to explain empowerment and disempowerment as subjective outcomes for nurses. Current perspectives of structural empowerment validated the influence of intervening conditions identified in this acute hospital. In particular, this substantive theory lent support for Kanter's (1977) theoretical notions of the structures of power and the lines of formal and informal power. The current study has used qualitative methods to demonstrate considerable support for Laschinger's (1996; Laschinger & Finegan, 2005a; 2010; 2009) body of work that explores structural and psychological empowerment in acute hospital nursing through a deductive, quantitative approach.

The substantive theory also provides support for current perspectives of nurse caring and a number of previously identified constraints in acute hospital settings. In

turn, evidence in the literature validates the importance of nurses' collaborative relationships with patients and the importance of empathy, participation, mutuality and presence in order for nurses to provide comfort. Comparison with three well-established theories of caring developed by Watson (2001), Parse (1992) and Swanson (1991) elucidated a tension between the ideal of humanistic practice and the reality of contemporary hospitals.

Lastly, comparison of the substantive theory of seeking empowerment to provide comfort to a classic theory of stress, appraisal and coping (Lazarus & Folkman, 1984) offers significant support for the notions of problem-focused and emotion-focused coping. Considerable parallels between the substantive theory and Lazarus and Folkman's (1984) theory demonstrated that the basic social psychological process identified in the current research was a coping response employed by nurses to manage the stress of feeling disempowered. This study is the first to articulate the link between nurses' lack of psychological and structural empowerment and a coping response in the area of hospital pain management.

Summary of Chapter Six

Chapter Six described the substantive theory of seeking empowerment to provide comfort that was generated in this grounded theory study. This substantive theory explained the emotional effect on nurses of caring for patients who experienced severe pain in one acute hospital. Empowerment was identified as the core category in this grounded theory study, and integrated the substantive theory. It emerged that nurses' main concern was feelings of disempowerment and their subsequent quest for empowerment accounted for how this main concern was resolved. A core problem, entitled *feelings of disempowerment*, was identified and it was discovered that the intervening conditions that were influencing nurses' experience of the core problem were fourfold. These included nurses' *levels of empathy, access to effective medication, collaboration with patients and colleagues, and time to care*. A basic social psychological process, through which nurses sought to avoid the core problem, was labelled *seeking empowerment to provide comfort*. This process consisted of three stages: *building connections, finding alternative ways to comfort, and quelling emotional turmoil*.

This chapter has presented an overview of the substantive theory developed in this research and related the findings to relevant literature. Comparison of the substantive theory with formal theories of empowerment; comfort; nurse caring; and stress, appraisal and coping explained, validated and developed the main tenets. The substantive theory builds upon these formal theories and demonstrates how a number of theoretical perspectives apply in the context of nurses' pain management in the acute hospital setting. This understanding provides direction for the recommendations stemming from this study. These are discussed in Chapter Seven.

CHAPTER SEVEN

Conclusions and Recommendations

Introduction

Using the grounded theory method, the phenomenon of caring for patients who were experiencing severe pain from the nurse's perspective was described, explained and analysed. This investigation provided access to the nurse's world and captured the reality of caring for patients suffering from pain, related to a variety of medical and surgical conditions. Nurses' emotional responses to pain management in the acute hospital setting were revealed. The substantive theory of *seeking empowerment to provide comfort* explained nurses' actions and interactions as they sought to avoid the shared problem of *feelings of disempowerment* and associated distress, frustration, dissatisfaction and exhaustion. Although considerable support for the major tenets is evident, this theory has not been described previously in the literature.

The findings of this study broaden the scope of knowledge about how nurses deal with the clinical problem of pain encountered in everyday acute hospital practice. The substantive theory developed is limited to the context of nurses who care for patients who experience severe pain and are hospitalised in Western Australia. It is acknowledged that nurses working at other Australian hospitals, or internationally, may experience caring for patients who experience severe pain differently. Nevertheless, perusal of the literature identified many similarities between the findings of this study and investigations conducted in Australia and other countries. Moreover, the theoretical understanding of process developed in the current study lends itself to application in other settings (Artinian, 2009; Cooney, 2011; Glaser, 2001).

The findings of this study suggest that:

- ❖ Nurses who work in medical and surgical hospital wards may encounter patients who experience significant pain from a variety of aetiologies.
- ❖ Nurses are emotionally affected by the evident suffering of their patients and are often left distressed, frustrated, dissatisfied and exhausted by feelings of disempowerment when patients' severe pain persists.
- ❖ Potential struggles for control with opioid-tolerant patients who are perceived to inappropriately request analgesics can leave nurses feeling manipulated and frustrated.
- ❖ Nurses' levels of empathy for patients in pain appear to vary and apparently influence their willingness to accept patients' self-reports and prioritise pain management, eliciting consequent experiences of helplessness or manipulation.
- ❖ Nurses who are unable to access effective analgesic medication or collaborate with patients and colleagues, or who lack sufficient time to care, tend to experience feelings of disempowerment that damage their well-being.
- ❖ Nurses attempt to avoid feelings of disempowerment by empowering themselves to provide comfort through building connections with patients and colleagues, finding alternative ways to comfort, and quelling their own emotional turmoil.
- ❖ Eventually, nurses will protect themselves from escalating feelings of disempowerment by disengaging from patients whose suffering with pain persists, or from opioid-tolerant patients who repeatedly demand analgesics.

This in-depth study has revealed that there are implications for both nurses' well-being and patient comfort.

Further research is warranted to determine whether issues found to affect nurses in the current study extend to other health care settings. The substantive theory developed in this research is yet to be tested and proposed links between

nurses' empathic responses, feelings of disempowerment, and use of a stress and coping response require verification. The suggestion of a potential tussle for control between nurses and patients who are opioid-tolerant needs additional investigation. Further development of new knowledge about nurses' use of alternative comfort measures to avoid emotional distress when patients' pain persists is also required. Nevertheless, the findings of this study provide direction for interventions to support nurses and their pain management practice in acute hospital settings. This chapter will present implications for clinical practice based on these study findings and outline indications for further research. A summary of recommendations from the research and a concluding statement will follow.

Implications for clinical practice

A striking finding of the current study was the intensity of nurses' emotional distress, powerlessness and frustration when unable to alleviate their patients' suffering with severe pain. The depth to which nurses were personally affected by witnessing patients' anguish when they felt unable to help was evident during the interviews in the vivid retelling of experiences not only from days before but also from weeks, months or even years previously. While those nurses who alleviated their patients' pain derived enjoyment and satisfaction; nurses who found themselves powerless to arrest their patients' suffering were left stressed, anxious, and, ultimately, exhausted.

Knowledge developed from this study indicates that the phenomenon of nurses' caring for patients who suffer with pain is a deeply human experience that transcends the professional nursing role. While nurses viewed severe pain as nontherapeutic and a threat to patients' well-being, the substantive theory explained that they shared the emotional distress of the severe pain experience and risked damage to their own well-being when unable to protect those in their care.

This study has revealed how deficiencies in nurses' *levels of empathy, access to effective medication, collaboration with patients and colleagues*, and *insufficient time to care* in the acute hospital contributed to nurses' feelings of disempowerment when patients' severe pain persisted. Nurses sought to empower themselves to provide comfort by *building connections, finding alternative ways to comfort* and

quelling emotional turmoil. This understanding provides direction for interventions to address factors that disempower nurses from providing comfort in the acute hospital setting and to bolster nurses' attempts to empower themselves in this practice environment.

The imperative to empower nurses to provide comfort for patients who experience severe pain in the acute hospital, is strengthened by similar evidence from international studies that patients' ongoing severe pain has significant negative emotional consequences for nurses (Blomberg et al., 2008; Clements & Cummings, 1991; de Schepper et al., 1997; Walker, 1994). In particular, the descriptions of nurses in the current study reflect the experiences of Icelandic nurses (n=10) and their "profound distress and frustration" (p. 2902) when watching patients suffer from unrelieved pain (Blondal & Halldorsdottir, 2009). Such previous research tends to validate the findings of the current investigation. In turn, this study adds to the body of knowledge about how nurses are affected by patients' experiences of severe pain and their responses.

Evidence that nurses seek to quell their emotional turmoil by eventually disengaging from suffering patients, builds upon earlier studies suggesting there are implications for nurses' practice and their patients when severe pain is not relieved (Blomberg et al., 2008; de Schepper et al., 1997; Nagy, 1999; Wilson & McSherry, 2006). Other studies have described nurses' strategies of disengaging from patients who experience pain, which were similar to those described in the current study but termed differently as distancing, minimising, or taking a passive role. Whilst nurses may protect themselves through such means however, the implication for patients may be isolation and increased discomfort when nurses are not there for them.

The findings of the current study therefore emphasise a pressing need to support nurses whose patients suffer with severe pain, and their efforts to provide comfort. The major implication of this research is that interventions to facilitate nurses' access to physical and emotional comfort measures are crucial to protect them and their patients from distress. Strategies to bolster nurses' connections with colleagues and patients who can secure them access to effective medication, overcome problematic collaboration and free up time to care, would seem essential. Moreover, strategies to increase nurses' ability to find alternative ways to offer

comfort by being there for patients and by supplementing analgesics with nonpharmacological approaches in the acute hospital are indicated.

The designation of persistent severe pain as a “critical incident” in the acute hospital, which triggers the deployment of medical and senior nursing personnel to the bedside, would seem vital to support distressed patients and nurses. The current situation could also be improved by the development of rapid response protocols that recognise severe pain as a clinical priority and equip nurses with communication channels through which to source timely input from specialised clinicians. Expedited processes to connect nurses with medical staff in the hospital who can provide direction for treatment and authority to administer appropriate analgesic medication are also indicated. Similarly, increased on-call access to pain team nurses who hold advanced knowledge of pain management and can support nurses to negotiate complex pain problems would also be beneficial. Within the ward, establishment of a system of alerts which prompt nurses to report patients’ increasing or persisting pain to senior staff, such as the shift coordinator or CNS may facilitate younger nurses’ access to the body of nursing knowledge and collegial support residing in the acute hospital.

Knowledge gained from this study indicates that enhanced communication systems are required to empower hospital nurses to initiate contact with and collaborate with colleagues who have the resources they need to address patients’ suffering with pain. In particular, increased support from hospital pain management staff may benefit nurses who practice after hours or in medical wards when, the findings indicated, nurses may have fewer options for treatment. Initiatives to provide nurses with timely access to specialised staff are analogous to strengthening the lines of informal power described in Kanter’s (1977, 1993) theory of structural empowerment. In that model (Kanter, 1977, 1993), alliances with others afford individuals the ability to achieve their goals. Findings from the current study suggest that processes which facilitate strong associations with colleagues who are expert in pain management would seem essential to support nurses as they strive to provide comfort for patients who suffer with pain.

While the findings of this research indicate an imperative to expedite nurses’ communication with colleagues, initiatives to improve collaboration with the

recipients of nurses' care, their patients, are also warranted. The substantive theory developed in this study held that nurse's caring for patients' in severe pain was participatory. A patient who was willing to report pain and accept medication, and who shared nurses' goals and strategies for pain relief was essential if analgesic medication was to be used effectively. However, patients' concerns about analgesic risk or preferences not to bother busy nurses seemed to underlie a commonly reported tendency to refrain from reporting pain. This evidence suggests the provision of written information to educate patients about medications and the importance of early intervention to address pain would be beneficial.

Additionally, measures that enable nurses to get to know and communicate with patients would seem essential if they are to address their fears and tailor acceptable pain relief. Rostering and patient allocation that allow nurses to build connections with patients over contiguous shifts may prove a feasible solution. Such initiatives could be supplemented with a system whereby nurses are allocated a "buddy" during each shift. In this system, each nurse would be paired with a colleague who could be called upon to attend to other patients, thereby freeing the nurses to spend time with a patient in pain.

Evidence from this study raises particular concerns about the difficulty nurses encounter when caring for opioid-tolerant patients who experience pain in the acute hospital setting. Clear indications that nurses differed in the way they responded to patients in severe acute pain and patients who also had a history of chronic pain or substance abuse emerged in the early stages of data analysis. As data collection became more focused, nurses' feelings of disempowerment crystallised as they described a sense of being manipulated by patients who seemed to demand inappropriate medication.

Nurses' tendency to dismiss self-reports of pain from these patients was evident in the data. Their consequent questioning of such patients' motives and frustration when dealing with repeated requests for pain relief reflect those described by nurses in several earlier studies (Blomberg et al., 2008; Blondal & Halldorsdottir, 2009; Clements & Cummings, 1991). Findings from the current study build on this previous research with evidence suggesting that a reluctance to share control with opioid-tolerant patients underlies nurses' feelings of manipulation and frustration.

Furthermore, nurses' apparent tendency to quell these feelings by disengaging emotionally during their interactions suggests there are implications for patients who have a history of prolonged opioid use and experience pain during their hospitalisation.

The current study presents new knowledge that nurses struggle to control their interactions with opioid-tolerant patients in the acute hospital. This notion of a tussle for control has not been described previously in literature pertaining to nurses' pain management. The substantive theory developed in the current study links nurses' struggle to the contrasting perceptions that nurses and opioid-tolerant patients may hold of analgesic risk and benefit. Theoretically, nurses in this situation focus on the perceived risks of giving medication to apparently comfortable people, while their patients seek analgesic benefits from large, frequent doses of painkillers. The nurses' perceived role becomes one of protecting patients from the adverse effects of excessive medication. Patients' knowledge and experience are not valued but rather tend to undermine nurses in this situation and nurses' consequent anxiety and expectations of failure were evident. Moreover, the potential for nurses to feel manipulated may increase when patients engage in separate interactions with medical staff.

Whilst further research is required to test the theoretical notion of a tussle for control between nurses and opioid-tolerant patients in the acute hospital, the findings of this study suggest there is a need to improve care planning processes when such patients are hospitalised with pain. The development of an individualised, multidisciplinary plan for pain management, drawn up through collaboration between patient, medical staff, nurses and allied health professionals and adhered to by all parties, would seem a useful first step. A clearly articulated plan with negotiated goals and strategies for pain relief would provide support for nurses who implement analgesic prescriptions at the bedside.

Comparison of the substantive theory with Lazarus and Folkman's (1984), classic theory of stress, appraisal and coping revealed that nurses in the current study were using a problem-focused approach to cope with feelings of disempowerment. The current study provides further new knowledge that nurses seek to overcome the problem of disempowerment by offering patients alternative comfort measures when

analgesic medication, proves ineffective. Nurses' attempts to be there for distressed patients and to integrate nonpharmacological pain relief to potentiate the beneficial effects of medication were evidence of increased problem-solving. These findings emphasise the importance of supporting nurses' independent practice in the acute hospital, particularly in light of evidence that nurses' use of problem-focused coping strategies is associated with improved mental health (Healy & McKay, 2000; Lim et al., 2010).

A major issue for nurses, who seek to comfort patients with their physical and emotional presence or through nonpharmacological means, is a lack of resources in the acute hospital. Most prominent was a lack of time to care. A prominent finding of this research was that staffing constraints and the need to care for multiple, high acuity patients in the acute hospital eroded the time nurses could spend with patients who were suffering with severe pain. Lack of time was found to prevent nurses from comforting patients by being there and by using a holistic, proactive approach to pain relief. These findings strengthen evidence from earlier studies that competing demands on nurses in acute settings tend to interrupt and fragment their pain management practice (Bolster & Manias, 2010; Manias et al., 2002). With predicted trends for increasing patient acuity and decreased length of stay in acute hospitals (To et al., 2010), the pressure on nurses to defer "care" in favour of "cure" is likely to increase.

Accordingly, there is a compelling need to protect nurses' time to care for patients who are distressed and incapacitated with severe pain. Initiatives described earlier such as a critical incident protocol, which prioritises the clinical problem of persisting severe pain, and the allocation of nurse buddies to mobilise collegial support would serve in part, to increase nurses' capacity to be present for suffering patients. However, this research also emphasises the need for the nursing profession to develop innovative solutions to address the problem of nurses' increasing workloads. Measures that allow nurses uninterrupted chunks of time would increase their ability not only to stay with patients in pain but also to supplement analgesics with comfortable positioning, reassurance and distraction.

Lastly, the nurses included in this study clearly indicated that in their world of caring for patients who experience severe pain "knowledge is power" (N08). The

study findings revealed that nurses required a good understanding of analgesics if they were to access effective medication and negotiate complex pain management. However, of the 33 nurses who participated in this research, 12 had received no pain management education since registering as a nurse. Another 20 nurses had attended hospital in-service study days, while only one senior nurse who had acted as the Clinical Nurse Consultant in Acute Pain, had undertaken in-depth education. While there is conflicting opinion in the literature over the effectiveness of education sessions (Grinstein-Cohen et al., 2009; Michaels et al., 2007; Tapp & Kropp, 2005), junior nurses in the current study requested the provision of education about pharmacological pain relief to support their decision-making.

The findings of this study suggest that information delivered at ward level, which is focused on clinical pain problems and analgesic management pertinent to each area, would most effectively equip nurses to flexibly tailor pain relief. Modes of content delivery may include self-directed learning packages, e-learning programs or ward-based interactive sessions using case studies involving relevant clinical problems. A complementary program providing ward-based Pain Resource Nurses who have advanced pain management skills to support their colleagues at the bedside is also merited. As evidence, Pain Resource Nurses (Williams et al., 2011) who shared their knowledge and were available to assist nurses encountering difficult pain problems have been successfully used and positively evaluated in the study hospital.

While the findings of this study provide direction for interventions to support nurses who practice in acute hospital settings, the research raises several questions that warrant further exploration.

Indications for further research

The theory developed in this study is applicable to the substantive area of nurses' care for patients who experience severe pain in this acute hospital. It would be valuable to conduct the study with other groups of nurses who are experiencing the same phenomenon, caring for patients experiencing severe pain, in other hospitals, or in aged care or community settings. Newly emergent theories could then be compared to *seeking empowerment to provide comfort* to validate and further develop the theory for application.

The findings of this study build on accumulating evidence about the role of empathy in pain management. The findings furthermore, articulate a new understanding of nurses' empathic responses to patients in pain. Although largely unaware of these responses, nurses demonstrated that the empathy they felt for patients in pain varied and that these variations had implications for both parties. This research postulates a link between nurses' levels of empathy, their responses to patients' reports of pain and their consequent experiences of powerlessness. Empathy was theorised as engagement with the emotional aspects of patients' severe pain experiences, which increased or decreased depending on nurses' prior experiences or patients' physical and behavioural pain cues. Theoretically, high levels of empathic engagement with patients' pain powered nurses' comfort provision, but potentially left them personally distressed and, ultimately, exhausted if patients' pain persisted. In contrast, low levels of empathic engagement, particularly for opioid-tolerant patients, caused nurses to dismiss patients and feel manipulated when required to give pain relief. The theoretical understanding of empathy in this context proposed that both extremes, either very high or very low levels of empathy caused powerlessness in nurses, although this was experienced differently; either as helplessness or manipulation respectively. Evidence in the data that some nurses sought to disengage from patients to quell these feelings is concerning.

Further research to verify the theoretical proposition that levels of nurses' empathy influenced their pain-related interactions with patients is indicated. While an investigation conducted in four Canadian cardiovascular surgical units found no correlation between nurses' (n=94) level of empathy and the analgesia their patients (n=225) received (Watt-Watson et al., 2000), nurses in the current study clearly found it difficult to prioritise pain management for patients who had a history of chronic pain or substance abuse. It would be valuable to use quantitative methods to determine whether nurses' levels of empathy differ according to patients' diagnosis or history and how these correlate with the amount of pain reported and analgesic medication received by patients in each group.

Qualitative exploration of the phenomenon of nurses' care for patients who experience severe pain in an acute hospital from the perspective of patients with a history of prolonged opioid use, would also be useful. Such research may shed light on suggestions from the current research that nurses and opioid-tolerant patients can

struggle for control during hospitalisation. This struggle has not been described before in the literature exploring nurses' pain management. An understanding of hospitalised patients' experiences would help to establish whether and how such struggles arise. If grounded theory methodology were used to explore opioid-tolerant patients' experiences of pain management in the acute hospital, data from nurses included in the current study could be integrated into the emergent theory to potentially explain the process of interactions between nurse and patient in the context of patients' prolonged opioid use.

Knowledge of opioid-tolerant patients' experiences would also provide direction for education to promote nurses' understanding of such patients' needs, strategies to improve communication, and options for analgesic treatments while hospitalised. Additionally, this path of enquiry may provide direction for strategies to enhance the autonomy of patients with chronic pain who are admitted to acute hospitals and facilitate improved relationships with the nurses who care for them.

The substantive theory, seeking empowerment to provide comfort, proposed a link between nurses' feelings of disempowerment and use of a stress and coping response. Further research is required to verify and test the strength of this theorised relationship and nurses' employment of both problem-focused and emotion-focused coping strategies to avoid distress and exhaustion when caring for patients in pain. In particular, nurses' use of alternative comfort measures to avoid emotional distress when pharmacological treatments fail to alleviate the suffering of patients in pain, merits attention. This is new knowledge that may be developed by investigating how nurses attempt to comfort suffering patients in other areas of the hospital. Exploring nurses' comfort provision in various hospital contexts would extend the findings of the current study by discerning elements of nurses' care and the practice environment that minimise the distress of patients and the nurses who care for them.

Lastly, the findings of the current study described a paradox in nurses' attitudes to pain assessment that has been described previously and warrants further exploration. While nurses recognised the subjectivity of pain and the necessity of comprehensive pain assessment to tailor pain relief, they did not describe or were observed assessing pain in any depth. Additionally, many nurses discounted patients' subjective self-reports when these were not validated by observed behaviours.

Although nurses' pain assessment practices were not measured quantitatively in this study, the evidence tends to support widespread evidence in the literature that nurses' deficient pain assessments affect pain management. A further in-depth exploration of nurses' responses to patients' self-reports of pain would build on the current research. Knowledge developed in the present study could be used to guide semi-structured interviews with nurses who manage pain in other hospital and community settings. Additionally, data collected from nurses in the current study could be integrated into the analysis, to develop an understanding of how nurses respond to patients who report pain and illuminate the factors that enhance or inhibit their acceptance of self-reports.

Whilst the substantive theory, seeking empowerment to provide comfort, developed in this study has yet to be tested in practice, the findings add to current knowledge about how patients' pain affects nurses. The implications of the study findings for clinical nursing practice, and research have been outlined. A summary of recommendations follows.

Recommendations for Clinical Practice

- ❖ Enhance communication systems to expedite nurses' timely contact with medical, senior nursing and specialised pain management clinicians through:
 - Development of "critical pain incident" protocols to facilitate rapid deployment of medical and senior nursing support to the bedside.
 - Increased on-call access to specialised pain management nurses.
 - Development of nursing alerts that prompt nurses' notification of patients' persisting pain to senior ward staff.

- ❖ Promote nurse-patient communication about pain and pain management through:
 - Provision of written information to patients about reporting pain and pharmacological and nonpharmacological pain relief.

- Rostering and patient allocation where feasible to facilitate nurses' care of patients over contiguous shifts.
 - Allocation of shift buddies who can assist with the patient load to allow nurses to spend time with patients in pain.
 - Use of individualised, multidisciplinary care plans drawn up in consultation with patient, nurse and doctor for the management of opioid-tolerant patients.
- ❖ Provide pain management educational support:
- Delivery of unit-specific content, which may include self-directed learning packages, e-learning or ward-based case study sessions.
 - Appointment of Pain Resource Nurses in clinical areas.

Recommendations for Further Research

- ❖ Exploration and application of the substantive theory of *seeking empowerment to provide comfort* in other acute care settings and contexts.
- ❖ Investigation of the proposed link between nurses' levels of empathy and pain management outcomes in different patient groups.
- ❖ Exploration of nurses' care for patients who are experiencing severe pain in the acute hospital setting from the perspective of patients with a history of prolonged opioid use.
- ❖ Further develop knowledge about nurses' use of alternative comfort measures to minimise their emotional distress when caring for suffering patients in other hospital settings and contexts.
- ❖ More focused exploration of nurses' responses to patients' self-reports of pain in other hospital and community settings.

Concluding Statement

This study aimed to investigate the effects on nurses of caring for patients who suffered from severe pain in acute hospital wards. Literature pertaining to this topic indicated that such care was often problematic and to the detriment of both nurses and their patients. This study provides an integrated picture of the clinical reality for nurses who care for patients experiencing severe pain in acute medical and surgical wards in an Australian hospital. In doing so, this study has revealed the depth of nurses' feelings of powerlessness and distress when they felt unable to protect those in their care from suffering with severe pain. Conditions in this practice environment that caused nurses to feel disempowered and the stress and coping response employed by nurses who seek to empower themselves in these situations, were also revealed. These findings provide direction for the development of interventions to support nurses in clinical practice, and future research.

Above all else, this research emphasised the intensely human experience of caring for someone in pain, which transcends the clinical setting and notions of the workplace and the professional. The nurses included in this study showed that to connect with another person through suffering can bring reward or dissatisfaction, pleasure or pain. The findings of this research provide compelling evidence that supporting nurses who care for patients who are experiencing severe pain, and facilitating comfort provision in acute hospitals, enhance outcomes for both nurses and patients.

REFERENCES

- Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research*, 9, 407-411. doi: 10.1177/104973239900900309
- Alliex, S., & Irurita, V. (2004). Caring in a technological environment: How is it possible? *Contemporary Nurse*, 17(1-2), 32-43.
- Anderson, J. M. (1996). Empowering patients: Issues and strategies. *Social Science and Medicine*, 43, 697-705. doi: 10.1016/0277-9536(96)00153-0
- Armstrong, K., Laschinger, H., & Wong, C. (2009). Workplace empowerment and magnet hospital characteristics as predictors of patient safety climate. *Journal of Nursing Care Quality*, 24, 55-62. doi: 10.1097/NCQ.0b013e31818f5506
- Artinian, B. M. (2009). An overview of Glaserian grounded theory. In B. M. Artinian, T. Giske & P. H. Cone (Eds.), *Glaserian grounded theory in nursing research: Trusting Emergence* (pp. 3-17). New York, NY: Springer Publishing Company.
- Ashley, J. L. (2008). Pain management: Nurses in jeopardy. *Oncology Nursing Forum*, 35(5), E70-E75. doi: 10.1188/08.ONF.E70-E75
- Aujoulet, I., d'Hoore, W., & Deccache, A. (2007). Patient empowerment in theory and practice: Polysemy or cacophony? *Patient Education and Counseling*, 66, 13-20. doi: 10.1016/j.pec.2006.09.008
- Australian Bureau of Statistics. (2012) Retrieved June 25, 2012, 2012, from http://www.censusdata.abs.gov.au/census_services/getproduct/census//quicksat/5?opendocument&navpos=220
- Barbour, R. S., & Schostak, K. (2005). Interviewing and focus groups. In B. Somekh & C. Lewin (Eds.), *Research methods in the social sciences* (pp. 41-48). London, England: Sage Publications Ltd.
- Barker, P. (2000). Reflections on caring as a virtue ethic within an evidence-based culture. *International Journal of Nursing Studies*, 37, 329-336. doi: 10.1016/S0020-7489(00)00012-2
- Bartunek, J. M., & Spreitzer, G. M. (2006). The interdisciplinary career of a popular construct used in management: Empowerment in the late 20th century. *Journal of Management Inquiry*, 15, 255-273. doi: 10.1177/1056492606291201
- Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics* (5th ed.). New York, NY: Oxford University Press.
- Bédard, D., Purden, M. A., Sauvé-Larose, N., Certosini, C., & Schein, C. (2006). The pain experience of post surgical patients following the implementation of an evidence-based approach. *Pain Management Nursing*, 7, 80-92. doi: 10.1016/j.pmn.2006.06.001
- Bell, L., & Duffy, A. (2009). Pain assessment and management in surgical nursing: A literature review. *British Journal of Nursing*, 18, 153-156. Retrieved from <http://www.britishjournalofnursing.com/>

- Bendelow, G. A. (2006). Pain, suffering and risk. *Health, Risk & Society*, 8, 59-70. doi: 10.1080/13698570500532298
- Berg, L., Skott, C., & Danielson, E. (2006). An interpretive phenomenological method for illuminating the meaning of the caring relationship. *Scandinavian Journal of Caring Sciences*, 20, 42-50. Retrieved from <http://au.wiley.com/WileyCDA/WileyTitle/productCd-SCS.html>
- Berger, J. T., Conway, S., & Beaton, K. J. (2012). Developing and implementing a nursing professional practice model in a large health system. *Journal of Nursing Administration*, 42, 170-175. doi: 10.1097/NNA.0b013e31824809f5
- Berman, A., Snyder, S. J., Kozier, B., Erb, G., Levett-Jones, T., Dwyer, T., . . . Stanley, D. (2010). *Kozier and Erb's fundamentals of nursing* (1st Australian edition ed.): Pearson Australia.
- Berry, P. H., & Dahl, J. L. (2000). The new JCAHO pain standards: Implications for pain management nurses. *Pain Management Nursing*, 1, 3-12. doi: 10.1053/bm.2000.5833
- Birks, M., Chapman, Y., & Francis, K. (2006). Moving grounded theory into the 21st century: Part 1 - an evolutionary tale. *Singapore Nursing Journal*, 33(4), 4-10.
- Blomberg, A.-M., Hylander, I., & Törnkvist, L. (2008). District nurses' involvement in pain care: a theoretical model. *Journal of Clinical Nursing*, 17, 2022-2031. doi: 10.1111/j.1365-2702.2007.02222.x
- Blomqvist, K. (2003). Older people in persistent pain: Nursing and paramedical staff perceptions and pain management. *Journal of Advanced Nursing*, 41, 575-584. doi: 10.1046/j.1365-2648.2003.02569.x
- Blondal, K., & Halldorsdottir, S. (2009). The challenge of caring for patients in pain: From the nurse's perspective. *Journal of Clinical Nursing*, 18, 2897-2906. doi: 10.1111/j.1365-2702.2009.02794.x
- Bloor, M., & Wood, F. (2006). *Keywords in Qualitative Research: A Vocabulary of Research Concepts*. London, England: Sage Publications Ltd.
- Boer, C., Treebus, A. N., Zuurmond, W. W. A., & de Lange, J. J. (1997). Compliance in administration of prescribed analgesics. *Anaesthesia*, 52, 1177-1181. doi: 10.1111/j.1365-2044.1997.243-az0378.x
- Bogdewic, S. P. (1992). Participant observation. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research* (pp. 45-68). Newbury Park, California: Sage Publications.
- Bolster, D., & Manias, E. (2010). Person-centred interactions between nurses and patients during medication activities in an acute hospital setting: Qualitative observation and interview study. *International Journal of Nursing Studies*, 47, 154-165. doi: 10.1016/j.ijnurstu.2009.05.021
- Bonis, S. A. (2009). Knowing in nursing: A concept analysis. *Journal of Advanced Nursing*, 65, 1328-1341. doi: 10.1111/j.1365-2648.2008.04951.x

- Botti, M., Bucknall, T., & Manias, E. (2004). The problem of postoperative pain: Issues for future research. *International Journal of Nursing Practice*, *10*, 257-263. doi: 10.1111/j.1440-172x.2004.00487.x
- Botvinick, M., Jha, A. P., Bylsma, L. M., Fabian, S. A., Solomon, P. E., & Prkachin, K. M. (2005). Viewing facial expressions of pain engages cortical areas involved in the direct experience of pain. *NeuroImage*, *25*, 312-319. doi: 10.1016/j.neuroimage.2004.11.043
- Brilowski, G. A., & Wender, M. C. (2005). An evolutionary concept analysis of caring. *Journal of Advanced Nursing*, *50*, 641-650. doi: 10.1111/j.1365-2648.2005.03449.x
- Brockopp, D. Y., Brockopp, G., Warden, S., Wilson, J., Carpenter, J. S., & Vandever, B. (1998). Barriers to change: A pain management project. *International Journal of Nursing Studies*, *35*, 226-232. doi: 10.1016/S0020-7489(98)00035-2
- Brown, C. A., & Richardson, C. (2006). Nurses in the multi-professional pain team: A study of attitudes, beliefs and treatment endorsements. *European Journal of Pain*, *10*, 13-22. doi: 10.1016/j.ejpain.2005.01.007
- Bryant, B., & Knights, K. (2011). *Pharmacology for health professionals* (3rd ed.). Chatswood, NSW: Elsevier Australia.
- Bucknall, T., Manias, E., & Botti, M. (2007). Nurses' reassessment of postoperative pain after analgesic administration. *Clinical Journal of Pain*, *23*, 1-7. doi: 10.1097/01.ajp.0000210936.50186.49
- Burgess, R. G. (1984). *In the field: An introduction to field research*. London, England: George Allen & Unwin
- Burns, R. B. (2000). *Introduction to research methods* (4th ed.). Frenchs Forest, NSW: Pearson Education Australia Pty Ltd.
- Bush, H. A., & Barr, W. J. (1997). Critical care nurses' lived experiences of caring. *Heart & Lung*, *26*, 387-398. doi: 10.1016/S0147-9563(97)90025-X
- Campbell-Yeo, M., Latimer, M., & Johnston, C. (2008). The empathetic response in nurses who treat pain: Concept analysis. *Journal of Advanced Nursing*, *61*, 711-719. doi: 10.1111/j.1365-2648.2007.04562.x
- Carr, E., & Christensen, M. (2010). Introduction to advancing practice in pain management E. Carr, M. Layzell & M. Christensen (Eds.), *Advancing nursing practice in pain management* Retrieved from <http://onlinelibrary.wiley.com/book/10/1002/9781444318722>
- Carr, E. C. J. (2002). Refusing analgesics: Using continuous improvement to improve pain management on a surgical ward. *Journal of Clinical Nursing*, *11*, 743-752. doi: 10.1046/j.1365-2702.2002.00658.x
- Carr, E. C. J., & Thomas, V. J. (1997). Anticipating and experiencing post-operative pain: the patients' perspective. *Journal of Clinical Nursing*, *6*, 191-201. doi: 10.1111/j.1365-2702.1997.tb00304.x

- Carter, L. C., Nelson, J. L., Sievers, B. A., Dukek, S. L., Pipe, T. B., & Holland, D. E. (2008). Exploring a culture of caring. *Nursing Administration Quarterly*, 32, 57-63. doi: 10.1097/01.NAQ.0000305948.69311.44
- Cepeda, M. S., Africano, J. M., Polo, R., Alcalá, R., & Carr, D. B. (2003). What decline in pain intensity is meaningful to patients with acute pain? *Pain*, 105, 151-157. doi: 10.1016/S0304-3959(03)00176-3
- Chambers, D., & Thompson, S. (2009). Empowerment and its application in health promotion in acute care settings: Nurses' perceptions. *Journal of Advanced Nursing*, 65, 130-138. doi: 10.1111/j.1365-2648.2008.04851.x
- Chandler, G. E. (1991). Creating an environment to empower nurses. *Nursing Management*, 22(8), 20-23. Retrieved from <http://journals.lww.com/nursingmanagement/Pages/default.aspx>
- Chang, E. M., Daly, J. W., Hancock, K. M., Bidewell, J., Johnson, A., Lambert, V. A., & Lambert, C. E. (2006). The relationships among workplace stressors, coping methods, demographic characteristics, and health in Australian nurses. *Journal of Professional Nursing*, 22, 30-38. doi: 10.1016/j.profnurs.2005.12002
- Chang, S. H., Maney, K. M., Mehta, V., & Langford, R. M. (2010). Pain assessment and management in medical wards: An area of unmet need. *Postgraduate Medical Journal*, 86, 279-284. doi: 10.1136/pgmj.2008.076497
- Charmaz, K. (1994). In B. G. Glaser (Ed.), *Basics of grounded theory analysis*. Mill Valley, California: Sociology Press.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: Sage Publications Inc.
- Charmaz, K. (2009). Shifting the grounds: constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz & A. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-191). Walnut Creek: Left Coast Press.
- Chenitz, W. C. (1986). Getting started: The research proposal for a grounded theory study. In W. C. Chanitz & J. M. Swanson (Eds.), *From practice to grounded theory*. California: Addison-Wesley Publishing Company.
- Chung, J., & Lui, J. (2003). Postoperative pain management: Study of patients' level of pain and satisfaction with healthcare providers' responsiveness to their reports of pain. *Nursing and Health Sciences*, 5, 13-22. doi: 10.1046/j.1442-2018.2003.00130.x
- Clarke, A. (2009). From grounded theory to situational analysis. In J. M. Morse (Ed.), *Developing grounded theory: The second generation* (pp. 194-235). Walnut Creek: Left Coast Press.
- Clarke, E. B., French, B., Bilodeau, M. L., Capasso, V. C., Edwards, A., & Empoliti, J. (1996). Pain management knowledge, attitudes and clinical practice: The impact of nurses' characteristics and education *Journal of Pain and Symptom Management*, 11, 18-31. doi: 10.1016/0885-3924(95)00134-4

- Clements, S., & Cummings, S. (1991). Helplessness and powerlessness: Caring for clients in pain. *Holistic Nursing Practice*, 6(1), 76-85. Retrieved from <http://journals.lww.com/hnpjjournal/pages/default.aspx>
- Cooney, A. (2010). Choosing between Glaser and Strauss: an example. *Nurse Researcher*, 17(4), 18-28.
- Cooney, A. (2011). Rigour and grounded theory. *Nurse Researcher*, 18(4), 17-22.
- Corbin, J. (2008). Is caring a lost art in nursing? *International Journal of Nursing Studies*, 45, 163-165. doi: 10.1016/j.ijnurstu.2007.09.003
- Corbin, J. (2009). Taking an analytic journey. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz & A. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 35-53). Walnut Creek: Left Coast Press.
- Courtenay, M., & Carey, N. (2008). The impact and effectiveness of nurse-led care in the management of acute and chronic pain: A review of the literature. *Journal of Clinical Nursing*, 17, 2001-2013. doi: 10.1111/j.1365-2702.2008.02361.x
- Coventry, L. L., Siffleet, J. M., & Williams, A. M. (2006). Review of analgesia use in the intensive care unit after heart surgery. *Critical Care and Resuscitation*, 8(2), 135-139.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed) Thousand Oaks, California: Sage Publications.
- Crooks, D. L. (2001). The importance of symbolic interactionism in grounded theory research on women's health. *Health Care for Women International*, 22, 11-27. Retrieved from <http://www.tandfonline.com/loi/uhcw20>
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Crows Nest, New South Wales: Allen & Unwin.
- Crowe, L., Chang, A., Fraser, J. A., Gaskill, D., Nash, R., & Wallace, K. (2008). Systematic review of the effectiveness of nursing interventions in reducing or relieving post-operative pain *International Journal of Evidence-Based Healthcare*, 6, 396-340. doi: 10.1111/j.1744-1609.2008.00113.x
- Daly, J. (2000). Parse's human becoming school of thought. In J. Greenwood (Ed.), *Nursing theory in Australia: Development and application* (2nd ed.). French's Forest, NSW: Pearson Education Australia.
- Davis, B. D. (2000). *Caring for people in pain*. London, England: Routledge.
- Davison, S. N. (2005). Chronic pain in end-stage renal disease. *Advances in Chronic Kidney Disease*, 12, 326-334. doi: 10.1016/j.ackd.2005.03.008
- de Schepper, A., Francke, A. L., & Abu-Saad, H. H. (1997). Feelings of powerlessness in relation to pain: Ascribed causes and reported strategies: A qualitative study among Dutch community nurses caring for cancer patients with pain. *Cancer Nursing*, 20, 422-429. Retrieved from <http://journals.lww.com/cancernursingonline/pages/default.aspx>
- de Vignemont, F., & Singer, T. (2006). The empathic brain: How, when and why? *TRENDS in Cognitive Sciences*, 10, 435-441. doi: 10.1016/j.tics.2006.08.008
- Deceglie, A. (2009, 4 January, 2009). Short by 800 nurses, *The Sunday Times*.

- Decety, J. (2011). Dissecting the neural mechanisms mediating empathy. *Emotion Review*, 3, 92-108. doi: 10.1177/1754073910374662
- Decety, J., Yang, C.-Y., & Cheng, Y. (2010). Physicians down-regulate their pain empathy response: An event-related brain potential study. *NeuroImage*, 50(4), 1676-1682. doi: 10.1016/j.neuroimage.2010.01.025
- Denzin, N. K. (2004). Symbolic Interactionism. In U. Flick, v. K. E & I. Steinke (Eds.), *A Companion to Qualitative Research* (pp. 81-87). Thousand Oaks, California: Sage Publications.
- Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 1-32). Thousand Oaks, California: Sage Publications Inc.
- Dihle, A., Bjolseth, G., & Solvi, H. (2006). The gap between saying and doing in postoperative pain management. *Journal of Clinical Nursing*, 15(4), 469-479. doi: 10.1111/j.1365-2702.2006.01272.x
- Dix, P., Sandhar, B., Murdoch, J., & MacIntyre, P. A. (2004). Pain on medical wards in a district general hospital. *British Journal of Anaesthesia*, 92, 235-237. doi: 10.1093/bja/aeh052
- Dowd, T. (2002). Katherine Kolcaba: Theory of comfort. In A. M. Tomey & M. R. Allgood (Eds.), *Nursing theorists and their work* (5th ed.). St Louis: Mosby, Inc.
- Drach-Zahavy, A. (2009). Patient-centred care and nurses' health: The role of nurses' caring orientation. *Journal of Advanced Nursing*, 65, 1463-1474. doi: 10.1111/j.1365-2648.2009.05016.x
- Drayer, R. A., Henderson, J., & Reidenberg, M. (1999). Barriers to better pain control in hospitalised patients. *Journal of Pain and Symptom Management* 17, 434-440. doi: 10.1016/S0885-3924(99)00022-6
- Dudgeon, D., Raubertas, R. F., & Rosenthal, S. N. (1993). The short-form McGill questionnaire in chronic cancer pain. *Journal of Pain and Symptom Management*, 8, 191-195. doi: 10.1016/0885-3924(93)90126-G
- Duffield, C., Gardner, G., & Catling-Paull, C. (2008). Nursing work and the use of nursing time. *Journal of Clinical Nursing*, 17, 3269-3274. doi: 10.1111/j/1365-2702.2008.02637.x
- Duffield, C., & Lumby, J. (1994). Caring nurses: The dilemma of balancing costs and quality. *Australian Health Review*, 17(2), 72-83. Retrieved from <http://www.publish.csiro.au/?nid=270>
- Dunwoody, C. J., Krenzischek, D. A., Pasero, C., Rathmell, J. P., & Polomano, R. C. (2008). Assessment, physiological monitoring, and consequences of inadequately treated acute pain. *Journal of Perianesthesia Nursing*, 23, S15-S27. doi: 10.1016/j.jopan.2007.11.007
- Dyson, J. (1996). Nurses' conceptualization of caring attitudes and behaviours. *Journal of Advanced Nursing*, 23, 1263-1269. doi: 10.1046/j.1365-2648.1996.13326.x

- Dyson, L. (1997). An ethic of caring: Conceptual and practical issues. *Nursing Inquiry*, 4, 196-201. Retrieved from <http://au.wiley.com/WileyCDA/WileyTitle/productCd-NIN.html>
- Easton, K. L., McComish, J. F., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research*, 10, 703-707. doi: 10.1177/104973200129118651
- Eggly, S., & Tzelepis, A. (2001). Relational control in difficult physician-patient encounters: Negotiating treatment for pain. *Journal of Health Communication*, 6, 323-333. doi: 10.1080/108107301317140814
- Ellis-Stoll, C. C., & Popkess-Vawter, S. (1998). A concept analysis on the process of empowerment. *Advances in Nursing Science*, 21(2), 62-68.
- Engstrom, M., Wadensten, B., & Haggstrom, E. (2010). Caregivers' job satisfaction and empowerment before and after an intervention focused on caregiver empowerment. *Journal of Nursing Management*, 18, 14-23. doi: 10.1111/j.1365-2834.2009.01047.x
- Falk-Rafael, A. R. (2001). Empowerment as a process of evolving consciousness: A model of empowerment. *Advances in Nursing Science*, 24(1), 1-16. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Falk Rafael, A. R. (1996). Power and caring: A dialectic in nursing. *Advances in Nursing Science*, 19(1), 3-17. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Fatovich, D. M., Hughes, G., & McCarthy, S. M. (2009). Access block: its' all about available beds. *Medical Journal of Australia*, 190(7), 362-363. Retrieved from <http://www.mja.com.au>
- Faulkner, J., & Laschinger, H. (2008). The effects of structural and psychological empowerment on perceived respect in acute care nurses. *Journal of Nursing Management*, 16, 214-221. doi: 10.1111/j.1365-2934.2007.00781.x
- Fealy, G. M. (1995). Professional caring: The moral dimension. *Journal of Advanced Nursing*, 22, 1135-1140. doi: 10.1111/j.1365-2648.1995.tb03115.x
- Finfgeld-Connett, D. (2006). Meta-synthesis of presence in nursing. *Journal of Advanced Nursing*, 55, 708-714. doi: 10.1111/j.1365-2648.2006.03961.x
- Finfgeld-Connett, D. (2008a). Meta-synthesis of caring in nursing. *Journal of Clinical Nursing*, 17, 196-204. doi: 10.1111/j.1365-2702.2006.01824.x
- Finfgeld-Connett, D. (2008b). Qualitative convergence of three nursing concepts: Art of nursing, presence and caring. *Journal of Advanced Nursing*, 63, 527-534. doi: 10.1111/j.1365-2648.2008.04622.x
- Flatley, M., & Bridges, J. (2008). Promoting the art of caring for older people. *International Journal of Nursing Studies*, 45, 333-334. doi: 10.1016/j.ijnurstu.2007.09.007
- Flicke, U. (2009). *An introduction to qualitative research* (4th ed.). London, England: Sage Publications.
- Fontana, A., & Frey, J. H. (2005). The interview: From neutral stance to political involvement. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of*

- qualitative research* (3rd edition ed.). Thousand Oaks, California: Sage Publications.
- Fredriksson, L. (1999). Modes of relating in a caring conversation: A research synthesis on presence, touch, and listening. *Journal of Advanced Nursing*, *30*, 1167-1176. doi: 10.1046/j.1365-2648.1999.01192.x
- Garrosa, E., Rainho, C., Moreno-Jiménez, B., & Monteiro, M. J. (2010). The relationship between job stressors, hardy personality, coping resources and burnout in a sample of nurses: A correlational study at two time points. *International Journal of Nursing Studies*, *47*, 205-215. doi: 10.1016/j.ijnurstu.2009.05.014
- Gezeljeh, T. N., & Ememi, A. (2009). Grounded theory: Methodology and philosophical perspective. *Nurse Researcher*, *17*(1), 16-23. Retrieved from <http://nurseresearcher.rcnpublishing.co.uk>
- Giske, T., & Artinian, B. M. (2009). Learning Glaserian grounded theory by doing it. In B. M. Artinian, T. Giske & P. H. Cone (Eds.), *Glaserian grounded theory in nursing research*. New York, NY: Springer Publishing Company.
- Glaser, B. G. (1978). *Theoretical sensitivity*. San Francisco, California: The Sociological Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, California: Sociology Press.
- Glaser, B. G. (2001). *The grounded theory perspective: Conceptualisation contrasted with description*. Mill Valley, California: Sociology Press.
- Glaser, B. G. (Ed.). (1992). *Basics of grounded theory analysis*. Mill Valley, California: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, Illinois: Aldine.
- Grad, F. P. (2002). The preamble of the constitution of the World Health Organization. *Bulletin of the World Health Organization*, *80*, 981-981. doi: 10.1590/S0042-96862002001200014
- Green, A. D., Tripp, D. A., Sullivan, M. J. L., & Davidson, M. (2009). The relationship between empathy and estimates of observed pain. *Pain Medicine*, *10*, 382-392. doi: 10.1111/j.1526-4637.2009.00563.x
- Gridley, L., & van den Dolder, P. A. (2001). The percentage improvement in pain scale as a measure of physiotherapy treatment effects. *Australian Journal of Physiotherapy*, *47*, 133-136. Retrieved from <http://trove.nla.gov.au>
- Grinstein-Cohen, O., Sarid, O., Attar, D., Pilpel, D., & Elhayany, A. (2009). Improvements and difficulties in postoperative pain management. *Orthopedic Nursing*, *28*(5), 232-241. doi: 10.1097/NOR.0b013e3181b579ec
- Groenkjaer, M. (2002). Critical ethnographic methodology in nursing research: Issues and solutions. *Contemporary Nurse*, *14*, 49-55. Retrieved from <http://www.contemporarynurse.com>

- Gu, X., & Han, S. (2007). Attention and reality constraints on the neural processes of empathy for pain. *NeuroImage*, *36*, 256-267. doi: 10.1016/j.neuroimage.2007.02.025
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks, California: Sage Publications, Inc.
- Halldórsdóttir, S., & Hamrin, E. (1997). Caring and uncaring encounters within nursing and health care from the patient's perspective. *Cancer Nursing*, *20*, 120-128. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed.). London, England: Routledge.
- Han, S., Fan, Y., Xu, X., Qin, J., Wiu, B., Wang, X., . . . Mao, L. (2009). Empathic neural responses to others' pain are modulated by emotional contexts. *Human Brain Mapping*, *30*, 3227-3237. doi: 10.1002/hbm.20742
- Hartrick, G. (1997). Relational capacity: The foundation for interpersonal nursing practice. *Journal of Advanced Nursing*, *26*, 523-528. doi: 10.1046/j1365-2648.1997.t01-12-00999.x
- Hatcher, S., & Laschinger, H. K. (1996). Staff nurses' perceptions of power and opportunity and level of burnout: A test of Kanter's structural theory of organisational behaviour. *Canadian Journal of Nursing Administration*, *9*(2), 74-94.
- Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis, and practice. *Journal of Counseling & Development*, *82*, 354-364. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1002/\(ISSN\)1556-6678](http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1556-6678)
- Healy, C. M., & McKay, M. F. (2000). Nursing stress: The effects of coping strategies and job satisfaction in a sample of Australian nurses. *Journal of Advanced Nursing*, *31*, 681-688. doi: 10.1046/j1365-2648.2000.01323.x
- Hegney, D., Eley, R., Plank, A., Buikstra, E., & Parker, V. (2006). Workforce issues in nursing in Queensland: 2001 and 2004. *Journal of Clinical Nursing*, *15*, 1521-1530. doi: 10.1111/j.1365-2702.01558.x
- Henderson, A., Van Eps, M. A., Pearson, K., James, C., Henderson, P., & Osborne, Y. (2007). 'Caring for' behaviours that indicate to patients that nurses 'care about' them. *Journal of Advanced Nursing*, *60*, 146-153. doi: 10.1111/j.1365-2648.2007.04382.x
- Henderson, S. (2000). Patient participation determined by nurses' attitudes towards caring. *International Journal for Human Caring*, *4*(1), 30-35.
- Hernandez, C. A. (2010). Getting grounded: using glaserian grounded theory to conduct nursing research. *Canadian Journal of Nursing Research*, *42*(1), 150-163.
- Hesse-Biber, S. N., & Leavy, P. (2006). *The practice of qualitative research*. Thousand Oaks, California: Sage Publications.

- Hickey, O. T., Burke, S. M., Hafeez, P., Moudrakouski, A. L., Hayes, I. D., & Shorten, G. D. (2010). Severity of acute pain after breast surgery is associated with the likelihood of subsequently developing persistent pain. *Clinical Journal of Pain, 26*, 556-556. doi: 10.1097/AJP.0b013e3181dee988
- Holloway, I., & Fulbrook, P. (2001). Revisiting qualitative inquiry: Interviewing in nursing and midwifery research. *Nursing Times Research, 6*, 539-550. doi: 10.1177/136140960100600111
- Holmstrom, I., & Roing, M. (2010). The relation between patient-centeredness and patient empowerment: A discussion on concepts. *Patient Education and Counseling, 79*, 167-172. doi: 10.1016/j.pec.2009.08.008
- International Association for the Study of Pain. (2012). IASP Pain Terminology Retrieved January 3, 2012, from http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Defi...isplay.cfm&ContentID=1728
- Jackson, C. (2005). The experience of a good day: A phenomenological study to explain a good day as experienced by a newly qualified RN. *International Journal of Nursing Studies, 42*, 85-95. doi: 10.1016/j.ijnurstu.2004.05.015
- Jackson, P. L., Brunet, E., Meltzoff, A. N., & Decety, J. (2006). Empathy explained through the neural mechanisms involved in imagining how I feel versus how you feel pain. *Neuropsychologia, 44*, 752-761. doi: 10.1016/j.neuropsychologia.2005.07.015
- Jackson, P. L., Meltzoff, A. N., & Decety, J. (2005). How do we perceive pain in others? A window into the neural processes involved in empathy. *NeuroImage, 24*, 771-779. doi: 10.1016/j.neuroimage.2004.09.006
- Jones, P. S., & Meleis, A. I. (1993). Health is empowerment. *Advances in Nursing Science, 15*(3), 1-14. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Jorgensen, D. L. (1989). *Participant observation: A methodology for human studies*. Newbury Park, California: Sage Publications.
- Kanter, R. M. (1977). *Men and women of the corporation*. New York, NY: Basic Books.
- Kanter, R. M. (1993). *Men and women of the corporation* (2nd ed.). New York, NY: BasicBooks.
- Kim, H. S., Schwartz-Barcott, D., Tracy, S. M., Fortin, J. D., & Sjöström, B. (2005). Strategies of pain assessment used by nurses on surgical units. *Pain Management Nursing, 6*, 3-9. doi: 10.1016/j.pmn.2004.12.001
- Kolcaba, K. (2001). Evolution of the mid range theory of comfort for outcomes research. *Nursing Outlook, 49*, 86-92. doi: 10.1067/mno.2001.110268
- Kolcaba, K., & DiMarco, M. A. (2005). Comfort theory and Its application to pediatric nursing *Pediatric Nursing, 31*, 187-194. Retrieved from <http://www.pediatricnursing.net>
- Kolcaba, K., Tilton, C., & Drouin, C. (2006). Comfort theory: A unifying framework to enhance the practice environment. *Journal of Nursing Administration, 36*,

- 538-544. Retrieved from
<http://journals.lww.com/jonajournal/pages/default.aspx>
- Kolcaba, K. Y. (1994). A theory of holistic comfort for nursing. *Journal of Advanced Nursing, 19*, 1178-1184. doi: 10.1111/j.1365-2648.1994.tb01202.x
- Kolcaba, K. Y., & Kolcaba, R. J. (1991). An analysis of the concept of comfort. *Journal of Advanced Nursing, 16*, 1301-1310. doi: 10.1111/j.1365-2648.1991.tb01558.x
- Kolcaba, K. Y., & Steiner, R. (2000). Empirical evidence for the nature of holistic comfort. *Journal of Holistic Nursing, 18*, 46-62. doi: 10.1177/089801010001800106
- Kramer, M., Schmalenberg, C., Maguire, P., Brewer, B. B., Burke, R., Chmielewski, L., . . . Waldo, M. (2008). Structures and practices enabling staff nurses to control their practice. *Western Journal of Nursing Research, 30*, 539-559. doi: 10.1177/0193945907310559
- Kris, A. E., & Dodd, M. J. (2004). Symptom experience of adult hospitalized medical-surgical patients. *Journal of Pain and Symptom Management, 28*, 451-459. doi: 10.1026/j.jpainsymman.2004.01.015
- Kuokkanen, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: Three theoretical approaches. *Journal of Advanced Nursing, 31*, 235-241. doi: 10.1111/j.1365-2648.2000.01241.x
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, California: Sage Publications.
- Kvale, S. (2007). Doing interviews Retrieved from
<http://www.uk.sagepub.com/books/Books225072>
 doi:10.4135/9781849208963
- Laganá, K. (2000). The "right" to a caring relationship: The law and ethic of care. *Journal of Perinatal & Neonatal Nursing, 14*(2), 12-24. Retrieved from
<http://journals.lww.com/jpnnjournal/pages/default.aspx>
- Lambert, V. A., Lambert, C. E., & Ito, M. (2004). Workplace stressors, ways of coping and demographic characteristics as predictors of physical and mental health of Japanese hospital nurses. *International Journal of Nursing Studies, 41*, 85-97. doi: 10.1016/S0020-7489(03)00080-4
- Laschinger, H. K. S. (1996). A theoretical approach to studying work empowerment in nursing: A review of studies testing Kanter's theory of structural power in organisations. *Nursing Administration Quarterly, 20*(2), 25-41. Retrieved from
<http://journals.lww.com/naqjournal/pages/default.aspx>
- Laschinger, H. K. S., & Finegan, J. (2005a). Empowering nurses for work engagement and health in hospital settings. *Journal of Nursing Administration, 35*, 439-449. Retrieved from
<http://journals.lww.com/jonajournal/pages/default.aspx>
- Laschinger, H. K. S., & Finegan, J. (2005b). Using empowerment to build trust and respect in the workplace: A strategy for addressing the nursing shortage. *Nursing Economics, 23*, 6-13. Retrieved from
<http://www.nursingeconomics.net>

- Laschinger, H. K. S., Finegan, J., Shamian, J., & Wilk, P. (2001). Impact of structural and psychological empowerment in job strain in nursing work settings *Journal of Nursing Administration*, *31*, 260-272. Retrieved from <http://journals.lww.com/jonajournal/pages/default.aspx>
- Laschinger, H. K. S., Gilbert, S., Smith, L. M., & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: Applying Kanter's empowerment theory to patient care. *Journal of Nursing Management*, *18*, 4-13. doi: 10.1111/j.1365-2834.2009.01046.x
- Laschinger, H. K. S., & Havens, D. S. (1996). Staff nurse work empowerment and perceived control over nursing practice: Conditions for work effectiveness. *Journal of Nursing Administration*, *26*(9), 27-35. Retrieved from <http://journals.lww.com/jonajournal/pages/default.aspx>
- Laschinger, H. K. S., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, *17*, 302-311. doi: 10.1111/j.1365-2834.2009.00999.x
- Latta, L., & Davis-Kirsch, S. (2011). Developing a robust professional practice model using a shared governance approach. *Journal of Pediatric Nursing*, *26*, 580-585. doi: 10.1016/j.pedn.2011.06.010
- Lauzon Clabo, L. M. (2008). An ethnography of pain assessment and the role of the social context on two postoperative units. *Journal of Advanced Nursing*, *61*, 531-539. doi: 10.1111/j.1365-2648.2007.04550.x
- Layman Young, J., Horton, F. M., & Davidhizar, R. (2006). Nursing attitudes and beliefs in pain assessment and management. *Journal of Advanced Nursing* *53*, 412-421. doi: 10.1111/j.1365-2648.2006.03735.x
- Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer Publishing Company.
- Li, I.-C., Chen, Y.-C., & Kou, H.-T. (2008). The relationship between work empowerment and work stress perceived by nurses at long-term care facilities in Tapei city. *Journal of Clinical Nursing* *17*, 3050-3058. doi: 10.1111/j.1365-2702.2008.02435.x
- Lim, J., Bogossian, F., & Ahern, K. (2010). Stress and coping in Australian nurses: A systematic review. *International Nursing Review*, *57*, 22-31. doi: 10.1111/j.1466-7657.2009.00765.x
- Lin, P.-C., Chiang, H.-W., Chiang, T.-T., & Chen, C.-S. (2008). Pain management: Evaluating the effectiveness of an educational programme for surgical nursing staff. *Journal of Clinical Nursing*, *17*, 2032-2041. doi: 10.1111/j.1365-2702.2007.02190.x
- Loggia, M. L., Mogil, J. S., & Bushnell, M. C. (2008). Empathy hurts: Compassion for another increases both sensory and affective components of pain perception. *Pain*, *136*, 168-176. doi: 10.1016/j.pain.2007.07.017
- Lui, L. Y. Y., So, W. K. W., & Fong, D. Y. T. (2008). Knowledge and attitudes regarding pain management among nurses in Hong Kong medical units.

- Journal of Clinical Nursing*, 17(1), 2014-2021. doi: 10.1111/j.1365-2702.2007.02183.x
- Maben, J., Latter, S., & Macleod Clark, J. (2006). The theory-practice gap: Impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing*, 55. doi: 10.1111/j.1365-2648.2006.03939.x
- Mac Lellan, K. (2004). Postoperative pain: Strategy for improving patient experiences. *Journal of Advanced Nursing*, 46, 179-185. doi: 10.1111/j.1365-2648.2003.02977.x
- Macintyre, P. E., Schug, S. A., Scott, D. A., Visser, E. J., & Walker, S. M. (2010). *Acute pain management: scientific evidence (3rd ed.)*. Melbourne: Australia & New Zealand College of Anaesthetists and Faculty of Pain Medicine.
- Mackintosh, C. (2000). Is there a place for "care" within nursing. *International Journal of Nursing Studies*, 37, 321-327. doi: 10.1016/S0020-7489(00)00011-0
- Main, C. J., Sullivan, M. J. L., & Watson, P. J. (2008). *Pain management (2nd ed.)*. Philadelphia, Pennsylvania: Elsevier Ltd.
- Malinowski, A., & Stamler, L. L. (2002). Comfort: Exploration of the concept in nursing. *Journal of Advanced Nursing*, 39, 599-606. doi: 10.1046/j.1365-2648.2002.02329.x
- Manias, E. (2003a). Medication trends and documentation of pain management following surgery. *Nursing and Health Sciences*, 5, 85-94. doi: 10.1046/j.1442-2018.2003.00140.x
- Manias, E. (2003b). Pain and anxiety management in the postoperative gastro-surgical setting. *Journal of Advanced Nursing*, 41, 585-594. doi: 10.1046/j.1365-2648.2003.02571.x
- Manias, E., Botti, M., & Bucknall, T. (2002). Observation of pain assessment and management - the complexities of clinical practice. *Journal of Clinical Nursing*, 11, 724-733. doi: 10.1046/j.1365-2702.2002.00691.x
- Manias, E., Botti, M., & Bucknall, T. (2006). Patients' decision-making strategies for managing postoperative pain *The Journal of Pain*, 7, 428-437. doi: 10.1016/j.pain.2006.01.448
- Manias, E., Bucknall, T., & Botti, M. (2004). Assessment of patient pain in the postoperative context. *Western Journal of Nursing Research*, 26, 751-769. doi: 10.1177/0193945904267699
- Manias, E., Bucknall, T., & Botti, M. (2005). Nurses' strategies for managing pain in the postoperative setting. *Pain Management Nursing*, 6, 18-29. doi: 10.1016/j.pmn.2004.12.004
- Manias, E., & Williams, A. (2007). Communication between patients with chronic kidney disease and nurses about managing pain in the acute hospital setting. *Journal of Clinical Nursing*, 16, 358-367. doi: 10.1111/j.1365-2702.2007.02075.x

- Manias, E., & Williams, A. (2008). Managing pain in chronic kidney disease: Patient participation in decision-making. *Journal of Advanced Nursing*, *61*, 201-210. doi: 10.1111/j.1365-2648.2007.04488.x
- Mann, E., & Carr, E. (2006). *Pain management*. Oxford, England: Blackwell Publishing.
- Marks, R., & Sachar, E. (1973). The undertreatment of medical inpatients with narcotic analgesia. *Annals of Internal Medicine*, *78*(2), 173-181.
- Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *British Medical Journal*, *320*, 50-52. Retrieved from <http://www.bmj.com>
- McCaffery, M., & Pasero, C. (1999). *Pain clinical manual* (2nd ed.). St Louis: Mosby, Inc
- McCance, T. V., McKenna, H. P., & Boore, J. R. P. (1997). Caring: Dealing with a difficult concept. *International Journal of Nursing Studies*, *34*, 241-248. doi: 10.1016/S0020-7489(97)00011-4
- McCance, T. V., McKenna, H. P., & Boore, J. R. P. (1999). Caring: Theoretical perspectives of relevance to nursing. *Journal of Advanced Nursing*, *30*, 1388-1395. doi: 10.1111/j.1365-2648.1999.01214.x
- McCann, T. V., & Clark, E. (2003). Grounded theory in nursing research: part 1 - methodology. *Nurse Researcher*, *11*(2), 7-18.
- McGhee, G., Marland, G. R., & Atkinson, J. (2007). Grounded theory research: literature reviewing and reflexivity. *Journal of Advanced Nursing*, *60*, 334-342. doi: 10.1111/j.1365-2648.2007.04436.x
- McQueen, A. (2000). Nurse-patient relationships and partnership in hospital care. *Journal of Clinical Nursing*, *9*, 723-731. doi: 10.1111/j.1365-2702.00422.x
- McVicar, A. (2003). Workplace stress in nursing: A literature review. *Journal of Advanced Nursing*, *44*, 633-642. doi: 10.1046/j.0309-2402.2003.02853.x
- Meldrum, M. (2005). The ladder and the clock: Cancer pain and public policy at the end of the twentieth century. *Journal of Pain and Symptom Management*, *29*, 41-54. doi: 10.1016/j.painsymman.2004.08.004
- Melia, K. (1996). Rediscovering Glaser. *Qualitative Health Research*, *6*, 368-378. doi: 10.1177/104973239600600305
- Melzack, R. (1987). The short-form McGill pain questionnaire. *Pain*, *30*, 191-197. doi: 10.1016/0304-3959(87)91074-8
- Michaels, T. K., Hubbart, E., Carroll, S. A., & Hudson-Barr, D. (2007). Evaluating an educational approach to improve pain assessment in hospitalized patients. *Journal of Nursing Care Quality*, *22*, 260-265. doi: 10.1097/01.NCQ0000277784.14310.66
- Miles, M., & Huberman, M. (1994). *Qualitative data analysis: A sourcebook of new methods* (2nd ed.). Newbury Park, California: Sage Publications Inc.
- Miller, W. L., & Crabtree, B. F. (2005). Clinical Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, California: Sage Publications Inc.

- Mills, J., Chapman, Y., Bonner, A., & Francis, K. (2007). Grounded theory: A methodological spiral from postivism to postmodernism. *Journal of Advanced Nursing*, 58, 72-79. doi: 10.1111/j.1365-2648.2007.04228.x
- MIMS Australia Pty Ltd. (2012). MIMS Online Retrieved June 15, 2012 2012, from <https://www.mimsonline.com.au>
- Mitchell, G. J. (2002). Human becoming. In A. M. Tomey & M. R. Alligood (Eds.), *Nursing theorists and their work* (5th ed.). St Louis: Mosby, Inc.
- Montgomery, P., & Bailey, P. H. (2007). Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research*, 29, 65-79. doi: 10.1177/0193945906292557
- Moore, L. A. (2010). Being empathetic: Benefits and challenges for the clinician and client. *Topics in Stroke Rehabilitation*, 17(1), 20-29. doi: 10.101310.tsr1701-20
- Morse, J. M. (1983). An ethnocentric analysis of comfort: A preliminary investigation. *Nursing Papers*, 15(1), 6-19. Retrieved from <http://digital.library.mcgill.ca/cjnr/search/browse>
- Morse, J. M. (2009). Tussles, tensions and resolutions. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz & A. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 13-22). Walnut Creek: Left Coast Press.
- Moss, E., Taverner, T., Norton, P., Lesser, P., & Cole, P. (2005). A survey of postoperative pain management in fourteen hospitals in the UK. *Acute Pain*, 7(1), 13-20. doi: 10.1016/j.acpain.2005.02.001
- Murnion, B. P., Gnjjidic, D., & Hilmer, S. N. (2010). Prescription and administration of opioids to hospital in-patients, and barriers to effective use. *Pain Medicine*, 11, 56-66. doi: 10.1111/j.1526-4637.2009.00747.x
- Nagy, S. (1998). A comparison of the effects of patients' pain on nurses working burns and neonatal intensive care units *Journal of Advanced Nursing*, 27, 335-340. doi: 10.1046/j.1365-2648.1998.00514.x
- Nagy, S. (1999). Strategies used by burns nurses to cope with the infliction of pain on patients. *Journal of Advanced Nursing*, 29, 1427-1433. doi: 10.1046/j.1365-2648.1999.01030.x
- Nash, R., Yates, P., Edwards, H., Fentiman, B., Dewar, A., & McDowell, J. (1999). Pain and the administration of analgesia: What nurses say. *Journal of Clinical Nursing*, 8, 180-189. doi: 10.1046/j.1365-2702.1999.00228.x
- National Health and Medical Research Council. (2007). National Statement for Ethical Conduct in Human Research Retrieved 23 April, 2012, 2012, from <http://www.nhmrc.gov.au/health-ethics/human-research-ethics-committees-hrecs/human-research-ethics-committees-hrecs/national>
- Nedd, N. (2006). Perceptions of empowerment and intention to stay. *Nursing Economics*, 24, 13-18. Retrieved from <http://www.nursingeconomics.net>
- Neil, R. M. (2002). Jean Watson: Philosophy and science of caring. In A. M. Tomey & M. R. Alligood (Eds.), *Nursing theorists and their work* (5th ed.). St Louis: Mosby, Inc.

- Nieswiadomy, R. (2008). *Foundations of nursing research*. New Jersey: Pearson Education Inc.
- Ning, S., Zhong, H., Libo, W., & Li, Q. (2009). The impact of nurse empowerment on job satisfaction. *Journal of Advanced Nursing*, *65*, 2642-2648. doi: 10.1111/j.1365-2648.2009.05133.x
- Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press.
- Novak, B., Kolcaba, K., Steiner, R., & Dowd, T. (2001). Measuring comfort in caregivers and patients during late end-of-life care. *American Journal of Hospice and Palliative Medicine*, *18*, 170-180. doi: 10.1177/104990910101800308
- O'Leary, C. (2007, 16 October, 2007). Shortage of 800 nurses sparks warning care may be delayed, *The West Australian*.
- O'Leary, Z. (2005). *Researching real world problems: A guide to methods of inquiry*. London, England: Sage Publications.
- Ochsner, K. N., Zaki, J., Hanelin, J., Ludlow, D. H., Knierim, K., Ramachandran, T., . . . Mackey, S. C. (2008). Your pain or mine? Common and distinct neural systems supporting the perception of pain in self and other. *SCAN*, *3*, 144-160. doi: 10.1093/scan/nsn006
- Oxford Dictionary of English. (2007) (2nd edition, revised ed.). Oxford: Oxford University Press.
- Parker, J. M. (2004). Nursing on the medical ward. *Nursing Inquiry*, *11*, 210-217. Retrieved from <http://au.wiley.com/WileyCDA/WileyTitle/productCd-NIN.html>
- Parse, R. R. (1987). *Nursing science: Major paradigms, theories and critiques*. Philadelphia, Pennsylvania: Saunders.
- Parse, R. R. (1992). Human becoming: Parse's theory of nursing. *Nursing Science Quarterly*, *5*, 35-42. doi: 10.1177/089431849200500109
- Pasero, C., Paice, J. A., & McCaffery, M. (1999). Basic mechanisms underlying the causes and effects of pain *Pain: Clinical manual* (2nd ed., pp. 15-34). St Louis: Mosby, Inc.
- Passik, S., Byers, K., & Kirsh, K. L. (2007). Empathy and the failure to treat pain. *Palliative and Supportive Care*, *5*, 167-172. doi: 10.1017/S1478951507070241
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, California: Sage Publications
- Pearcey, P. (2010). 'Caring? It's the little things we are not supposed to do anymore'. *International Journal of Nursing Practice*, *16*, 51-56. doi: 10.1111/j.1440-172X.2009.01802.x
- Pellino, T. A., Gordon, D. B., Engelke, Z. N., Busse, K. L., Collins, M. A., Silver, C. E., & Norcross, N. J. (2005). Use of nonpharmacological interventions for pain and anxiety after total hip and total knee arthroplasty. *Orthopaedic*

- Nursing*, 24, 182-190. Retrieved from <http://journals.lww.com/orthopedicnursing/pages/default.aspx>
- Piper, S. (2010). Patient empowerment: Emancipatory or technological practice? *Patient Education and Counseling*, 79, 173-177. doi: 10.1016/j.pec.2009.09.032
- Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal and utilisation* (6th ed.). Philadelphia, Pennsylvania: Lippincott, Williams & Wilkins.
- Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47, 1451-1458. doi: 10.1016/j.ijnurstu.2010.06.004
- Polit, D. F., & Beck, C. T. (2012). *Essentials of nursing research: appraising evidence for nursing practice* (9th ed.). Philadelphia, Pennsylvania: Wolters Kluwer Health/Lippincott, Williams & Wilkins
- Pryds Jensen, K., Bäck-Pettersson, S., & Segesten, K. M. (1993). The caring moment and the green-thumb phenomenon among Swedish nurses. *Nursing Science Quarterly*, 6, 98-104. Retrieved from <http://nsq.sagepub.com>
- QSR International. (2006). NVivo 7: QSR International Pty Ltd.
- Rafael, A. R. F. (2000). Watson's philosophy, science, and theory of human caring as a conceptual framework for guiding community health nursing practice. *Advances in Nursing Science*, 23(2), 34-49. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Rejeh, N., Ahmadi, F., Mohammadi, E., Kazemnejad, A., & Anoosheh, M. (2009). Nurses' experiences and perceptions of influencing barriers to postoperative pain management. *Scandinavian Journal of Caring Sciences*, 23, 274-281. doi: 10.1111/j.1471-6712.2008.00619.x
- Richards, J., & Hubbert, A. O. (2007). Experiences of expert nurses in caring for patients with postoperative pain. *Pain Management Nursing*, 8, 17-24. doi: 10.1016/j.pmn.2006.12.003
- Rodwell, C. M. (1996). An analysis of the concept of empowerment. *Journal of Advanced Nursing*, 23, 305-313. doi: 10.1111/j.1365-2648.1996.tb02672.x
- Rolfe, G. (2009). Some further questions on the nature of caring. *International Journal of Nursing Studies*, 46, 142-146. doi: 10.1016/j.ijnurstu.2008.04.010
- Rubin, H. J., & Rubin, I. S. (2004). *Qualitative interviewing: The art of hearing data* (2nd ed.). Thousand Oaks, California: Sage Publications.
- Ryles, S. M. (1999). A concept analysis of empowerment: Its relationship to mental health nursing. *Journal of Advanced Nursing*, 29, 600-607. doi: 10.1046/j.1365-2648.1999.00928.x
- Sabiston, J. A., & Laschinger, H. K. S. (1995). Staff nurse work empowerment and perceived autonomy: Testing Kanter's theory of structural power in organisations. *Journal of Nursing Administration*, 25(9), 42-50.

- Samuels, J. G., & Fetzer, S. J. (2009). Evidence-based pain management: Analyzing the practice environment and clinical expertise. *Clinical Nurse Specialist*, 23(5), 245-251. doi: 10.1097/NUR.0b)13.e3181b20745
- Sasaki, M., Kitaoka-Higashiguchi, K., Morikawa, Y., & Nakagawa, H. (2009). Relationship between stress coping and burnout in Japanese hospital nurses. *Journal of Nursing Management*, 17, 359-365. doi: 10.1111/j.1365-2834.2008.00960.x
- Sawyer, J., Haslam, L., Daines, P., & Stilos, K. (2010). Pain prevalence study in a large Canadian teaching hospital. Round 2: lessons learned? *Pain Management Nursing*, 11, 45-55. doi: 10.1026/j.pmn.2009.01.002
- Schafheutle, E. I., Cantrill, J. A., & Noyce, P. R. (2001). Why is pain management suboptimal on surgical wards? *Journal of Advanced Nursing*, 33, 728-737. doi: 10.1046/j.1365-2658.2001.01714.x
- Schneider, Z., Whitehead, D., Elliott, D., Lobiondo-Wood, G., & Haber, J. (2007). *Nursing & midwifery research: Methods and appraisal for evidence-based practice* (3rd ed.). Marrickville, NSW: Elsevier Australia.
- Shyu, Y.-I. L., Chen, M.-L., Chen, M.-C., Wu, C.-C., & Su, J.-Y. (2009). Postoperative pain and its impact on quality of life for hip-fractured older people over 12 months after hospital discharge. *Journal of Clinical Nursing*, 18, 755-764. doi: 10.1111/j.1365-2702.2008.02611.x
- Silverman, D. (2006). *Interpreting qualitative data: Methods for analyzing talk, texts and interaction*. London, England: Sage Publications.
- Skelton, R. (1994). Nursing and empowerment: Concepts and strategies. *Journal of Advanced Nursing*, 19, 415-423. doi: 10.1111/j.1365-2648.1994.tb01102.x
- Sloman, R., Rosen, G., Rom, M., & Shir, Y. (2005). Nurses' assessment of pain in surgical patients. *Journal of Advanced Nursing*, 52, 125-132. doi: 10.1111/j.1365-2648.2005.03573.x
- Söderhamm, O., & Idvall, E. (2003). Nurses' influence on quality of care in postoperative pain management: A phenomenological study. *International Journal of Nursing Practice*, 9, 26-32. Retrieved from <http://au.wiley.com/WileyCDA/WileyTitle/productCd-IJN.html>
- Sourial, S. (1996). An analysis and evaluation of Watson's theory of human care. *Journal of Advanced Nursing*, 24, 400-404. doi: 10.1046/j.1365-2648.1996.19524.x
- Spall, S. (1998). Peer debriefing in qualitative research: Emerging operational models. *Qualitative Inquiry*, 4, 280-292. doi: 10.1177/107780049800400208
- Spichiger, E., Wallhagen, M. I., & Benner, P. (2005). Nursing as a caring practice from a phenomenological perspective. *Scandinavian journal of caring sciences*, 19, 303-319. Retrieved from <http://au.wiley.com/WileyCDA/WileyTitle/productCd-SCS.html>
- Spradley, J. P. (1980). *Participant observation*. New York, NY: Holt, Rinehart and Winston.

- Spreitzer, G. M. (1995). Psychological empowerment in the workplace: Dimensions, measurement, and validation. *Academy of Management Journal*, 38, 1442-1465. Retrieved from <http://journals.aomonline.org/amj/>
- Stadler, M., Schlander, M., Braeckman, M., Nguyen, T., & Boogaerts, J. G. (2004). A cost-utility and cost-effectiveness analysis of an acute pain service. *Journal of Clinical Anesthesia*, 16, 159-167. doi: 10.1016/j.clinane.2003.06.002
- Stake, R. E. (2008). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (3rd ed., pp. 119-149). Thousand Oaks, California: Sage Publications
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis and grounded theory. *Qualitative Health Research*, 17, 1372 -1380. doi: 10.1177/1049732307307031
- Stern, P. N. (2009). In the beginning Glaser and Strauss created grounded theory. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz & A. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 23-29). Walnut Creek: Left Coast Press.
- Stewart, M. W., Knight, R. G., Palmer, D. G., & Highton, J. (1994). Differential relationships between stress and disease activity for immunologically distinct subgroups of people with rheumatoid arthritis. *Journal of Abnormal Psychology*, 103(2), 251-258.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd edition ed.). Thousand Oaks, California: Sage Publications
- Swanson-Kauffman, J. M. (1986). Caring in the instance of unexpected early pregnancy loss. *Topics in Clinical Nursing*, 8(2), 37-46.
- Swanson-Kauffman, J. M. (1988a). *Caring as a basis for nursing practice*. Paper presented at the NCAST Institute, Seattle, Washington.
- Swanson-Kauffman, J. M. (1988b). Caring needs of women who miscarried. In M. Leininger (Ed.), *Care: Discovery and uses in clinical and community nursing* (pp. 55-69). Detroit, Michigan: Wayne State University Press.
- Swanson, K. M. (1990). Providing care in the NICU: Sometimes an act of love. *Advances in Nursing Science*, 13(1), 60-73. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Swanson, K. M. (1991). Empirical development of a middle range theory of caring. *Nursing Research*, 40, 161-166. Retrieved from <http://www.journals.lww.com/nursingresearchonline/pages/default.aspx>
- Takemura, Y., & Kanda, K. (2003). How Japanese nurses provide care: A practice based on continuously knowing the patient. *Journal of Advanced Nursing*, 42, 252-259. doi: 10.1046/j.1365-2648.2003.02614.x
- Tapp, J., & Kropp, D. (2005). Evaluating pain management delivered by direct care nurses. *Journal for Nursing Care Quality* 20, 167-173. Retrieved from <http://journals.lww.com/jncqjournal/pages/default.aspx>

- Teng, C.-I., Hsiao, F.-J., & Chou, T. A. (2010). Nurse-percieved time pressure and patient-perceived care quality. *Journal of Nursing Management*, *18*, 275-284. doi: 10.1111/j.1365-2834.2010.01073.x
- To, T., Davies, O., Sincock, J., & Whitehead, C. (2010). Multidisciplinary care needs in an Australian tertiary teaching hospital. *Australian Health Review*, *34*, 234-238. Retrieved from <http://www.mja.com.au>
- Turkel, M. C. (2001). Struggling to find a balance: The paradox between caring and economics. *Nursing Administration Quarterly*, *26*(1), 67-82. Retrieved from <http://journals.lww.com/jonajournal/pages/default.aspx>
- Turkel, M. C., & Ray, M. A. (2000). Relational complexity: A theory of the nurse-patient relationship within an economic context. *Nursing Science Quarterly*, *13*, 307-313. doi: 10.1177/08943180022107843
- Tveiten, S., & Meyer, I. (2009). 'Easier said than done': Empowering dialogues with patients at the pain clinic - the health professionals' perspective. *Journal of Nursing Management*, *17*, 804-812. doi: 10.1111/j.1365-2834.2008.00921.x
- Van Niekerk, L. M., & Martin, F. (2001). Tasmanian nurses' knowledge of pain management. *International Journal of Nursing Studies*, *38*, 141-152. doi: 10.1016/S0020-7489(00)00053-5
- Van Niekerk, L. M., & Martin, F. (2003). The impact of the nurse physician relationship on barriers encountered by nurses during pain management. *Pain Management Nursing*, *4*, 3-10. doi: 10.1053/jpmn.2003.4
- Vargas-Schaffer, G. (2010). Is the WHO analgesic ladder still valid? Twenty-four years of experience. *Canadian Family Physician*, *56*, 514-517. Retrieved from www.cfp.ca
- Wadensten, B., Frojd, C., Swenne, C. L., Gordh, T., & Gunningberg, L. (2011). Why is pain stil not being assessed adequately? Results of a pain prevalence study in a university hospital in Sweden. *Journal of Clinical Nursing*, *20*, 624-634. doi: 10.1111/j.1365-2702.2010.03482.x
- Walid, M. S., Donahue, S. N., Darmohray, D. M., Hyer, L. A., & Robinson, J. S. (2008). The fifth vital sign - what does it mean? *Pain Practice*, *8*, 417-422. Retrieved from <http://au.wiley.com/WileyCDA/WileyTitle/productCd-PAPR.htmlt>
- Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative Health Research*, *16*, 547-559. doi: 10.1177/1049732305285972
- Walker, J. M. (1994). Caring for elderly people with persistent pain in the community: A qualitative perspective on the attitudes of patients and nurses. *Health and Social Care in the Community*, *2*, 221-228. doi: 10.1111/j.1365-2524.1994.tb00168.x
- Walls, P., Parahoo, K., & Fleming, P. (2010). The role and place of knowledge and literature in grounded theory. *Nurse Researcher*, *17*(4), 8-17.
- Watson, J. (2001). Jean Watson. Theory of human caring. In M. Parker (Ed.), *Nursing theories and nursing practice*. Philadelphia, Pennsylvania: F. A. Davis Company.

- Watt-Watson, J., Garfinkel, P., Gallop, R., Stevens, B., & Streiner, D. (2000). The impact of nurses' empathic responses on patients' pain management in acute care. *Nursing Research*, *49*, 191-200. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Watt-Watson, J., Stevens, B., Garfinkel, P., Streiner, D., & Gallop, R. (2001). Relationship between nurses' pain knowledge and pain management outcomes for their postoperative cardiac patients. *Journal of Advanced Nursing*, *36*, 535-545. doi: 10.1111/j.1365-2648.2001.02006.x
- Wengraf, T. (2001). *Qualitative research interviewing: Biographic, narrative and semi-structured methods*. London, England: Sage Publications Ltd.
- Werner, M. U., Soholm, L., Rotboll-Nielsen, P., & Kehlet, H. (2002). Does an acute pain service improve postoperative outcome? *Anesthesia and Analgesia* *95*, 1361-1372. doi: 10.1213/01.ANE.0000032413.30206.81
- Western Australian Department of Health. (2011). Nursing and Midwifery in Western Australia Retrieved November 11, 2011
- Wild, L. R., & Mitchell, P. H. (2000). Quality pain management outcomes: The power of place. *Outcomes Management for Nursing Practice*, *4*, 136-143.
- Williams, A., & Manias, E. (2007a). Balancing safety with effective pain control in patients with chronic kidney disease. *Journal of Evaluation in Clinical Practice*, *13*, 820-822. doi: 10.1111/j.1365-2753.2006.00744.x
- Williams, A., & Manias, E. (2007b). Pain management in hospitalised patients with chronic kidney disease and comorbidities. *Renal Society of Australia Journal*, *3*, 76-83.
- Williams, A., & Manias, E. (2008). A structured literature review of pain assessment and management of patients with chronic kidney disease. *Journal of Clinical Nursing*, *17*, 69-81. doi: 10.1111/j.1365-2702.2007.01994.x
- Williams, A. M. (1998). The delivery of quality nursing care: A grounded theory study of the nurse's perspective. *Journal of Advanced Nursing*, *27*, 808-816. doi: 10.1046/j.1365-2648.1998.00590.x
- Williams, A. M., C, T., Deas, K., Fairclough, D., Curro, K., & Oldham, L. (2011). Evaluating the feasibility and effect of using a hospital-wide coordinated approach to introduce evidence-based changes for pain management. *Pain Management Nursing*. Advance online publication. doi: 10.1016/j.pmn.2010.08.001
- Williams, A. M., Davies, A., & Griffiths, G. (2009). Facilitating comfort for hospitalized patient using non-pharmacological measures: Preliminary development of clinical practice guidelines. *International Journal of Nursing Practice*, *15*, 145-155. doi: 10.1111/j.1440-172X.2009.01739.x
- Williams, A. M., Dawson, S., & Kristjanson, L. J. (2008). Exploring the relationship between personal control and the hospital environment. *Journal of Clinical Nursing*, *17*, 1601-1609. doi: 10.1111/j.1365-2702.2007.02188.x
- Williams, A. M., & Irurita, V. F. (2004). Therapeutic and non-therapeutic interpersonal interactions: The patient's perspective. *Journal of Clinical Nursing*, *13*, 806-815. doi: 10.1111/j.1365-2702.2004.01020.x

- Williams, A. M., & Irurita, V. F. (2006). Emotional comfort: The patient's perspective of a therapeutic context. *International Journal of Nursing Studies*, 43, 405-415. doi: 10.1016/j.ijnurstu.2005.06.004
- Willson, H. (2000). Factors affecting the administration of analgesia to patients following repair of a fractured hip. *Journal of Advanced Nursing*, 31, 1145-1154. doi: 10.1046/j.1365-2648.2000.01425.x
- Wilson, B. (2009). Can patient lifestyle influence the management of pain? *Journal of Clinical Nursing*, 18, 399-408. doi: 10.1111/j.1365-2702.2007.02091.x
- Wilson, B., & Laschinger, H. K. S. (1994). Staff nurse perception of job empowerment and organisational commitment: A test of Kanter's theory of structural power in organisations. *Journal of Nursing Administration*, 24(4S), 39-47. Retrieved from <http://journals.lww.com/jonajournal/pages/default.aspx>
- Wilson, B., & McSherry, W. (2006). A study of nurses' inferences of patients' physical pain. *Journal of Clinical Nursing*, 15, 459-468. doi: 10.1111/j.1365-2702.2006.01358.x
- Wilson, L., & Kolcaba, K. (2004). Practical application of comfort theory in the perianaesthesia setting. *Journal of PeriAnesthesia Nursing*, 19, 164-173. doi: 10.1016/j.jopan.2004.03.006
- Wiseman, T. (1996). A concept analysis of empathy. *Journal of Advanced Nursing*, 23, 1162-1167. doi: 10.1046/j.1365-2648.1996.12213.x
- Woodward, V. M. (1997). Professional caring: A contradiction in terms? *Journal of Advanced Nursing*, 26, 999-1004. doi: 10.1046/j.1365-2648.1997.00389.x
- World Health Organisation. (2006). Constitution of the World Health Organisation: Basic documents (45th ed.).
- World Health Organisation. (2012). WHO's pain ladder Retrieved January 4, 2012, from <http://www.who.int/cancer/palliative/painladder/en/>
- Wu, H., Chi, T.-S., Chen, L., Wang, L., & Jin, Y.-P. (2010). Occupational stress among hospital nurses: cross-sectional survey. *Journal of Advanced Nursing*, 66, 627-634. doi: 10.1111/j.1365-2648.2009.05203.x
- Wuest, J. (2000). Negotiating with helping systems: An example of grounded theory evolving through emergent fit *Qualitative Health Research*, 10, 51-70. doi: 10.1177/104973200129118246
- Yu, J., & Kirk, M. (2008). Measurement of empathy in nursing research: Systematic review. *Journal of Advanced Nursing*, 64, 440-454. doi: 10.1111/j.1365-2648.2008.04831.x
- Zalon, M. (1993). Nurses' assessment of postoperative patients' pain *Pain*, 54, 329-334. doi: 10.1016/0304-3959(93)90033-L

APPENDIX A



Code: ____

PATIENT CONSENT FORM

**“Caring for Patients Experiencing Episodes of Severe Pain in the Acute
Care Hospital Setting: The Nurse’s Perspective”**

I _____ have read the information on the attached letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this research but understand that I can change my mind or stop at any time

I understand that all information provided is treated as confidential.

I agree that research gathered for this study may be published provided no names or any other information that may identify me is not used.

Name: _____ Signature: _____

Date: _____

Investigator: _____ Signature: _____

APPENDIX B

Observation: _____

Record of Patient Verbal Consent

“Caring for Patients Experiencing Episodes of Severe Pain in the Acute Care Hospital Setting: The Nurses’ Perspective”

Verbal consent of be observed as part of the above research was obtained from
patient:

(Insert patient name)

_____ .

Date: _____

Time: _____

Witnessed by: _____

Investigator: _____

APPENDIX C

Short-Form McGill Pain Questionnaire (Melzack, 1987)

Date: _____

I. Pain Rating Index (PRI):

The words below describe average pain. Place a check mark (✓) in the column that represents the degree to which you feel that type of pain:

| | | None | | Mild | | Moderate | | Severe |
|-------------------|---|--------------------------|---|--------------------------|---|--------------------------|---|--------------------------|
| Throbbing | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Shooting | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Stabbing | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Sharp | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Cramping | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Gnawing | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Hot-Burning | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Aching | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Heavy | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Tender | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Splitting | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Tiring Exhausting | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Sickening | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Fearful | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| Punishing-cruel | 0 | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 | <input type="checkbox"/> | 3 | <input type="checkbox"/> |

II. Present Pain Intensity (PPI)–Visual Analogue Scale (VAS).

Tick along scale below for worst pain:

No pain |—————| Worst pain

III. Evaluative overall intensity of total pain experience.

Place a check mark (✓) in the appropriate column:

| Evaluative | | |
|------------|---------------|--|
| 0 | No pain | |
| 1 | Mild | |
| 2 | Discomforting | |
| 3 | Distressing | |
| 4 | Horrible | |
| 5 | Excruciating | |

IV. Scoring:

| | | Score |
|-------|--|-------|
| I-a | S-PRI (Sensory Pain Rating Index) | |
| I-b | A-PRI (Affective Pain Rating Index) | |
| I-a+b | T-PRI (Total Pain Rating Index) | |
| II | PPI-VAS (Present Pain Intensity-Visual Analogue Scale) | |
| III | Evaluative overall intensity of total pain experience | |

APPENDIX D

PERMISSION TO USE COPYRIGHT MATERIAL AS SPECIFIED BELOW:

Short-Form McGill Pain Questionnaire

I hereby give permission for Susan Slatyer to include the above mentioned material in her higher degree thesis for the Curtin University of Technology, and to communicate this material via the Australasian Digital Thesis Program. This permission is granted on a non-exclusive basis and for an indefinite period.

I confirm that I am the copyright owner of the specified material.

Permission to use this material is subject to the following conditions: [Delete if not applicable]

Signed: *Ronald Metzack*

Name: *RONALD Metzack*

Position: *Professor*

Date: *November 28, 2006*

Please return signed form to:

**Susan Slatyer
42 Johnston Street,
Peppermint Grove
Western Australia, 6011
AUSTRALIA.**

Fax: (IDD code) 61 8 9346 4965

APPENDIX E



Code: ____

STAFF CONSENT FORM (Observation and Interview)

“Caring for Patients Experiencing Episodes of Severe Pain in the Acute Care Hospital Setting: The Nurse’s Perspective.”

I _____ have read the information on the attached letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this research but understand that I can change my mind or stop at any time

I understand that all information provided is treated as confidential.

I agree to be observed.

I agree for any interviews to be taped.

I agree that research gathered for this study may be published provided no names or any other information that may identify me is not used.

Name: _____ Signature: _____

Date: _____

Investigator: _____ Signature: _____

APPENDIX F



Code: ____

STAFF CONSENT FORM (Interview)

**“Caring for Patients Experiencing Episodes of Severe Pain in the Acute Care
Hospital Setting: The Nurse’s Perspective.”**

I _____ have read the information on the attached letter. Any questions I have asked have been answered to my satisfaction. I agree to participate in this research but understand that I can change my mind or stop at any time

I understand that all information provided is treated as confidential.

I agree for any interviews to be taped.

I agree that research gathered for this study may be published provided no names or any other information that may identify me is not used.

Name: _____ Signature: _____

Date: _____

Investigator: _____ Signature: _____

APPENDIX G

Nurse Demographic Form

Gender:

Male: _____

Female: _____

Clinical Position: _____

Length of time on ward: _____

Highest qualification achieved: _____

Previous Pain Management education: _____

APPENDIX H

Interview Guide

What does severe pain mean to you?

How do you manage a patient in severe pain (what helps, what hinders)?

Can you tell me about this situation/a situation when you were caring for a patient who was in severe pain? (Prompts: assessment, choices, effective, coping, strategies, health care team)

What did you do?

How did you feel?

Was there anything that helped you to manage this patient's pain?

Was there anything that made it easier to manage this patient' pain?

Was there anything that made it more difficult to manage this patient's pain?

Is there anything that you feel might have helped you to manage this patient's pain more effectively?

How are you feeling now about the management of this patient's pain?

Is there anything you would like to add?

APPENDIX I



SD/fm/2006-180
Ext 2999

Thursday 15th February, 2007



Sir Charles
Gairdner Hospital

Department of Health

of *DR.*
Ms Anne Williams
Centre for Nursing Research
Sir Charles Gairdner Hospital
Hospital Avenue
NEDLANDS WA 6009

POSTED
2/2/07

Anne
Dear Ms Williams

HUMAN RESEARCH ETHICS 2006-180 Caring for patients experiencing episodes of severe pain in an acute care hospital: the nurses perspective

Please be advised that the Human Research Ethics Committee has granted ethical approval of the project. I note the study has been approved by Curtin University. The approval is for the above named protocol and participant documents. Approval is granted on the understanding that the project will commence within twelve months of the date of this letter or a new application may have to be submitted. Equally if the project is discontinued before the expected date of completion the committee must be informed and the reasons provided for the cessation.

Please be advised that this Committee complies with the National Statement on Ethical Conduct in Research involving Humans by the National Health and Medical Research Council (NH&MRC) and as such has responsibility to monitor the progress of all approved projects until completion to ensure that they continue to conform to approved ethical standards.

It is the responsibility and obligation of the researcher under the Good Clinical Practice (GCP) guidelines to advise the Committee of any departure from the original protocol that could impact on the ethical approval of the study. Please note that the attachment entitled "Reporting Guidelines for Adverse Events and Deviations from Protocol" forms part of this approval letter. Under these reporting guidelines you are required to submit formal notice of any changes to documentation, relevant information arising out of ongoing safety monitoring and annual reports on the human rights aspects of your study. An annual report form for your study will be posted to you several weeks in advance of the anniversary of the project's approval date.

As the responsibility for the conduct of the trial lies with you as the investigator, you should sign all communications to the committee.

Please quote Ethics number: 2006-180 on all correspondence associated with this study.

Yours sincerely

**DR NIK ZEPS
DELEGATE OF THE CHAIR
HUMAN RESEARCH ETHICS COMMITTEE**

APPENDIX J**Patient Demographic Form**

Gender: _____

Age: _____

Diagnosis: _____

APPENDIX K

Thesis Presentations

Conference Presentations

Slatyer, S., Williams, A.M., Michael, R. (2011). *Protecting the well-being of nurses who care for patient with severe pain: the importance of empowerment*. Back to the Future 2011, Inaugural SolarisCare Symposium, Perth, Western Australia.

Slatyer, S., Williams, A.M., Michael, R. (2011). *Care, Comfort and Chronic Pain in Hospitalised Patients: A Challenge for Nurses*. 5th International Congress on Innovations in Nursing, Perth, Western Australia.

Slatyer, S., Williams, A.M., Michael, R. (2009). *Caring for patients in severe pain: Impacts, Influences and Implications for Nurses*. 4th International Congress on Innovations in Nursing, Perth, Western Australia.

Slatyer, S., Williams, A.M., Michael, R., Kristjanson, L. (2009). *Caring for Patients Experiencing Episodes of Severe Pain in an Acute Care Hospital: The Nurses' Perspective*. 29th Annual Scientific Meeting of the Australian Pain Society, Sydney, New South Wales.

Invited Speaker Presentations

Slatyer, S. (July, 2010). *Patients with severe pain in acute care wards: the nurses' perspective*. Pain Management Department Meeting, Sir Charles Gairdner Hospital, Perth Western Australia.

Slatyer, S. (March, 2010). *Patients with severe pain in acute care wards: the nurses' perspective*. Anaesthetic Department Meeting, Sir Charles Gairdner Hospital, Perth Western Australia.

Slatyer, S. (October, 2009). *Caring for patients experiencing severe pain: The nurse's perspective*. Pain Resource Nurses Interest Group, Sir Charles Gairdner Hospital, Perth, Western Australia.

Postgraduate Presentations

Slatyer, S., Williams, A., Michael, R., Kristjanson, L. (November, 2009). *Caring for Patients Experiencing Episodes of Severe Pain in an Acute Care Hospital: the Nurses' Perspective*. Mark Liveris Health Sciences Research Student Seminar, Curtin University of Technology, Perth, WA.

Slatyer, S., Williams, A., Michael, R., Kristjanson, L. (August, 2009). *Caring for Patients Experiencing Episodes of Severe Pain in an Acute Care Hospital: the Nurses' Perspective*. WA Centre for Cancer and Palliative Care Postgraduate Student Presentation Evening, Curtin University of Technology, Shenton Park, WA.

APPENDIX L

memorandum

| | |
|---------|--|
| To | A/Prof Rene Michael Nursing and Midwifery |
| From | Dr Stephan Millett, Executive Officer, Human Research Ethics Committee |
| Subject | Protocol Approval HR 137/2006 |
| Date | 13 December 2006 |
| Copy | Susan Slatyer Nursing and Midwifery Graduate Studies Officer, Division of Health Sciences |

Curtin 
University of Technology

Office of Research and Development

Human Research Ethics Committee

TELEPHONE 9266 2784

FACSIMILE 9266 3793

EMAIL hrec@curtin.edu.au

Thank you for your application submitted to the Human Research Ethics Committee (HREC) for the project titled "Caring for Patients Experiencing Episodes of Severe Pain in an Acute Care Hospital: The Nurses' Perspective." Your application has been reviewed by the HREC and is **approved**.

- You are authorised to commence your research as stated in your proposal.
- The approval number for your project is **HR 137/2006**. Please quote this number in any future correspondence.
- Approval of this project is for a period of twelve months **12-12-2006 to 11-12-2007**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **11-12-2007**.
- If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Divisional Graduate Studies Committee.

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **FORM B** should to be completed and returned to the Secretary, HREC, C/- Office of Research & Development:

When the project has finished, or

- If at any time during the twelve months changes/amendments occur, or
- If a serious or unexpected adverse event occurs, or
- 14 days prior to the expiry date if renewal is required.
- An application for renewal may be made with a Form B three years running, after which a new application form (Form A), providing comprehensive details, must be submitted.

Regards,



Dr Stephan Millett
Executive Officer
Human Research Ethics Committee

APPENDIX M



STAFF INFORMATION SHEET (Observation and Interview)

“Caring for Patients Experiencing Episodes of Severe Pain in the Acute Care Hospital Setting: The Nurse’s Perspective.”

Investigator: Susan Slatyer

Please take time to read the following information carefully. Please feel free to ask me if anything is not clear to you or if you would like more information.

My name is **Susan Slatyer**. I am a Registered Nurse conducting this study as a requirement for the award of PhD through Curtin University of Technology. I have a scholarship from the Australian Pain Society/Australian Pain Relief Association to support this study.

I am investigating what happens when nurses are caring for patients who are experiencing severe pain. Research suggests that both nurses and patients are affected by patients’ experiences of pain. However, there has not been a thorough investigation of nurses’ experiences when caring for these patients in an acute care hospital and how this affects patient care.

The aim of this study is to increase knowledge and understanding of how nurses are affected by caring for patients in severe pain and what this means for patient care. The goal is to explain what is happening and then find ways to support nurses and improve patient care.

Do I have to participate in this study?

Your participation in this study is voluntary. If you decide to take part you may stop at any time. Whether you decide to participate or not will be kept confidential. Whatever you decide, this decision will not lead to any penalty or affect your employment at Sir Charles Gairdner Hospital.

Why have I been asked to be in this study?

You have been invited to participate in this study because you are a Registered Nurse who is caring for a patient experiencing severe pain in an acute care ward at Sir Charles Gairdner Hospital.

What will happen if I decide to be in the study?

If you decide to participate, I will observe your actions and interactions as you care for your patient who is experiencing severe pain. This observation will start when you and your patient consent to be included in the study. I will not interfere with your patient care and I will not observe you caring for any other patient. I will endeavour to be a quiet unobtrusive observer at all times.

I will continue observation until the patient's pain settles or for a period of no longer than 4 hours.

I may also take some hand-written notes about the environment, what happens and what is said as you care for your patient. Neither you nor your patient will be identified in these notes. Rather I will be looking for patterns that represent what typically goes on when nurses are caring for patients in severe pain.

You will then be invited to participate in an interview at a time convenient to you. This interview will be tape-recorded and will focus on your thoughts, feelings, choices and actions as you cared for your patient in severe pain.

When the findings of the study are being formulated, you may be contacted and invited to review and comment on these.

Are there any reasons why I should not be in this study?

You should not participate in this study if you don't wish to be included.

What are the costs to me?

There are no costs to you from being in this study.

What are the possible benefits of taking part?

You may like the opportunity to share your experience of caring for patients in severe pain. Also, by participating in this study you will help to increase what is known and understood about severe pain and how this affects nurses and patient care. This knowledge will be the basis for strategies that assist nurses and patients and improve patient care.

What are the possible side effects, risks and discomforts of taking part?

You may find that being observed makes you feel uncomfortable. If so, you may ask me to leave at any time and the observation will be stopped immediately. Your participation in this study does not prejudice any right to compensation, which you may have under statute or common law.

You may find that being interviewed makes you feel uncomfortable. You may have the interview terminated, suspended or postponed and the tape turned off at any time. The interview will be stopped immediately. You may elect to have the interview restarted or abandoned.

Will my taking part in this study be kept confidential?

Any information collected in this study will be kept private and confidential. It will be stored securely and only authorised persons who understand that it must be kept confidential will have access to it. The study records will be kept by the researcher in a locked archive for at least 6 years and may be destroyed at any time thereafter.

The result of this study will be made available to nurses and health care professionals through scientific journals or meetings, but you will not be identifiable in these

reports. There may be some feedback given to the hospital about the findings of the study. It is not intended that participants be contacted directly to convey study results.

Further Information

This research has been reviewed by the Curtin University of Technology Human Research Ethics Committee and the Sir Charles Gairdner Hospital Human Research Ethics Committee. If you would like further information about the study please feel free to contact me on 0408 953 077 or by email susanslatyer@hotmail.com If you prefer, you may contact my supervisors Dr Anne Williams on (08) 9346 3140 at Sir Charles Gairdner Hospital and Associate Professor Rene Michael (08) 9266 2058 at Curtin University of Technology

Thank you very much for your involvement in this research, your participation is greatly appreciated.

APPENDIX N



STAFF INFORMATION SHEET (Interview)

“Caring for Patients Experiencing Episodes of Severe Pain in the Acute Care Hospital Setting: The Nurse’s Perspective.”

Investigator: Susan Slatyer

Please take time to read the following information carefully. Please feel free to ask me if anything is not clear to you or if you would like more information.

My name is **Susan Slatyer**. I am a Registered Nurse conducting this study as a requirement for the award of PhD through Curtin University of Technology. I have a scholarship from the Australian Pain Society/Australian Pain Relief Association to support this study.

I am investigating what happens when nurses are caring for patients who are experiencing severe pain. Research suggests that both nurses and patients are affected by patients’ experiences of pain. However, there has not been a thorough investigation of nurses’ experiences when caring for these patients in an acute care hospital and how this affects patient care.

The aim of this study is to increase knowledge and understanding of how nurses are affected by caring for patients in severe pain and what this means for patient care. The goal is to explain what is happening and then find ways to support nurses and improve patient care.

Do I have to participate in this study?

Your participation in this study is voluntary. If you decide to take part you may stop at any time. Whether you decide to participate or not will be kept confidential. Whatever you decide, this decision will not lead to any penalty or affect your employment at Sir Charles Gairdner Hospital.

Why have I been asked to be in this study?

You have been invited to participate in this study because you are a Registered Nurse who is caring for a patient experiencing severe pain in an acute care ward at Sir Charles Gairdner Hospital.

What will happen if I decide to be in the study?

If you decide to participate, you will be interviewed at a time convenient to you. This interview will be tape-recorded and will focus on your thoughts, feelings, choices and actions as you have cared for your patients in severe pain. When the findings of the study are being formulated, you may be contacted and invited to review and comment on these.

Are there any reasons why I should not be in this study?

You should not participate in this study if you don't wish to be included.

What are the costs to me?

There are no costs to you from being in this study.

What are the possible benefits of taking part?

You may like the opportunity to share your experience of caring for patients in severe pain. Also, by participating in this study you will help to increase what is known and understood about severe pain and how this affects nurses and patient care. This knowledge will be the basis for strategies that assist nurses and patients and improve patient care.

What are the possible side effects, risks and discomforts of taking part?

You may find that being interviewed makes you feel uncomfortable. You may have the interview terminated, suspended or postponed and the tape turned off at any time. The interview will be stopped immediately. You may elect to have the interview restarted or abandoned.

Your participation in this study does not prejudice any right to compensation, which you may have under statute or common law.

Will my taking part in this study be kept confidential?

Any information collected in this study will be kept private and confidential. It will be stored securely and only authorised persons who understand that it must be kept confidential will have access to it. The study records will be kept by the researcher in a locked archive for at least 6 years and may be destroyed at any time thereafter.

The result of this study will be made available to nurses and health care professionals through scientific journals or meetings, but you will not be identifiable in these reports. There may be some feedback given to the hospital about the findings of the study. It is not intended that participants be contacted directly to convey study results.

Further Information

This research has been reviewed by the Curtin University of Technology Human Research Ethics Committee and the Sir Charles Gairdner Hospital Human Research Ethics Committee. If you would like further information about the study please feel free to contact me on 0408 953 077 or by email susanslatyer@hotmail.com If you prefer you may contact my supervisors Dr Anne Williams on (08) 9346 3140 at Sir Charles Gairdner Hospital and Associate Professor Rene Michael (08) 9266 2058 at Curtin University of Technology.

Thank you very much for your involvement in this research, your participation is greatly appreciated.

APPENDIX O



PATIENT INFORMATION SHEET

“Caring for Patients Experiencing Episodes of Severe Pain in the Acute Care Hospital Setting: The Nurse’s Perspective.”

Investigator: Susan Slatyer

Please take time to read the following information carefully. Please feel free to ask me if anything in this sheet is not clear to you or if you would like more information.

My name is **Susan Slatyer**. I am a Registered Nurse conducting this study as a requirement for the award of PhD through Curtin University of Technology. I have a scholarship from the Australian Pain Society/Australian Pain Relief Association to support this study.

I am investigating what happens when nurses are caring for patients who are experiencing severe pain. Research suggests that both nurses and patients are affected by patients’ experiences of pain. However, there has not been a thorough investigation of nurses’ experiences when caring for these patients in an acute care hospital and how this affects patient care.

The aim of this study is to increase knowledge and understanding of how nurses are affected by caring for patients in severe pain and what this means for patient care. The goal is to explain what is happening and find ways to support nurses and improve patient care.

Do I have to participate in this study?

Your participation in this study is voluntary. If you decide to take part you may stop at any time. Whatever you decide, this decision will not lead to any penalty or affect your medical care or any benefit to which you are otherwise entitled.

If you are not feeling well enough to sign the consent form immediately but would like to participate, you may tell me now and sign the consent form later when your pain has settled.

Why have I been asked to be in this study?

You have been invited to participate in this study because you are receiving nursing care in an acute care ward at Sir Charles Gairdner Hospital and are experiencing severe pain.

What will happen if I decide to be in the study?

If you decide to participate, you will continue to receive your usual care. I will observe the care that your nurse gives you to relieve your pain. This will continue until your pain is gone or for no longer than 4 hours. You may or may not choose to talk to me during this time.

I may also take some hand-written notes about your environment, what happens and what is said as your nurse cares for you. Neither you nor any staff will be identified in these notes. Rather I will be looking at what typically goes on when nurses are caring for patients in severe pain. This observation and note taking will start from when you give your permission to be included in the study. It will finish after 4 hours or earlier if your pain settles. There will be no need to contact you again.

I will look in your medical notes at information that will help me to describe the gender and age of patients in the study and some information about why and how long you have been in hospital.

Are there any reasons why I should not be in this study?

You should not participate in this study if you don't wish to be included, are under 18 years of age or cannot converse freely in English.

What are the costs to me?

There are no costs to you from being in this study.

What are the possible benefits of taking part?

You may like the opportunity to share your pain experience. Also, by participating in this study you will help to increase what is known and understood about severe pain and how this affects nurses and patient care. This knowledge will help to improve patient care in the future.

What are the possible side effects, risks and discomforts of taking part?

You may find that being observed makes you feel uncomfortable. If so, you may ask me to leave at any time and the observation will be stopped immediately.

Your participation in this study does not prejudice any right to compensation, which you may have under statute or common law.

Will my taking part in this study be kept confidential?

Any information collected in this study will be kept private and confidential. It will be stored securely and only authorised persons who understand that it must be kept confidential will have access to it. The study records will be kept by the researcher in a locked archive for at least 6 years and may be destroyed at any time thereafter.

The result of this study will be made available to nurses and health care professionals through scientific journals or meetings, but you will not be identifiable in these reports. There may be some feedback given to the hospital about the findings of the study. It is not intended that participants be contacted directly to convey study results.

Further Information

This research has been reviewed by the Curtin University of Technology Human Research Ethics Committee and the Sir Charles Gairdner Hospital Human Research Ethics Committee. If you would like further information about the study please feel free to contact me on 0408 953 077 or by e-mail susanslatyer@hotmail.com or my supervisors Dr Anne Williams on (08) 9346 3140 and Associate Professor Rene Michael (08) 9266 2058.

Thank you very much for your involvement in this research, your participation is greatly appreciated.

APPENDIX P

Slatyer, Susan

From: Dean Alston [dean.alston@wanews.com.au]
Sent: Tuesday, 24 February 2009 15:09
To: Slatyer, Susan
Subject: Re: Brief confirmation of your permission to use cartoon please

Hi Susan. My apologies for not sending you the cartoon. Of course it is fine to use it for your PhD purposes. I will send you a copy asap.
 Cheers, Dean.(Alston.)



From: Slatyer, Susan
Sent: Monday, 16 February 2009 14:12
To: 'dean.alston@wanews.com.au'
Subject: Permission to use "nurse shortage" cartoon

Hi Dean,

So nice to talk to you today and hope we catch up in person soon.

I am just confirming that I have your permission to use your cartoon about the nurse shortage that was published in the West Australian newspaper late last year - I am unsure of the publication date but the cartoon features a nurse with a teapot on her head and roller-skates.

With your permission I would like to include this cartoon in publications associated with my PhD entitled "Caring for Patients Experiencing Episodes of Severe Pain in an Acute Care Hospital: The Nurses' Perspective". These would include the completed thesis and conference presentations of my PhD findings. I would of course attribute the cartoon to you at all times.

Your cartoon succinctly illustrates one of the findings emerging in my study, about the pressures in the current health system that nurses' perceive constrain them from giving effective care. Thank you for so generously allowing me to use it.

You offered to send me an electronic copy of the cartoon and if it not to much hassle that would be much appreciated.

Thanks again Dean. Please give my best to Lisa, Deanie and Dave,

Sue Slatyer