

## Editorial. Editor's notes for May

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The challenge of putting together an issue of the *Journal* from scratch is not one to be taken on lightly. Most journals operate by compiling a bank of proof-ready original articles from which the Editor selects to make up an issue; hence, the often lengthy delay between an article being accepted for publication and getting into print.

The change of *Journal* editorial policy beginning in 2003, to move towards themed issues, involves a delicate balancing act of inviting specialists and experts to contribute on their topic, and ensuring that non-commissioned papers are slotted into the publication schedule without too much delay, yet maintaining the integrity of the theme.

The last issue, in March, and this issue, achieve that balance in a very special way. Both were themed on diverse issues, yet the guest editors for each have achieved superb content, and encourage debate and discussion by building on their own specialist knowledge of the topic area. The work that this has involved has been immense – as cajoling and gently encouraging colleagues, approaching authors whose work you have read but never met and working to the tight deadlines, often months in advance, is not an easy task. On top of that is dealing with reviewing, evaluating and responding to authors with tact and diplomacy, in addition to the copyright issues that are part and parcel of the editing process. And, to cap it all, is the writing of an editorial that draws the content of the issue together and poses alternative views and critique. Thus, as Editor, I am extremely grateful to Gary Rolfe and Jan Walker for not only giving of their time but also using their contacts and expertise in drawing together specialist input to create exciting and challenging issues of the *Journal* this year.

One of the challenges for me in this process, however, is finding guest editors to take on this role or assist me in creating an issue. Whilst the editorial board identify themes for the issues that really is the easy bit! The themes for 2005 are:

January: Managing and Leading a Nursing Workforce (The Editor)

March: Making a Difference – the Evolution of Nursing Roles

May: Work-based Learning in Management and Leadership Development (Guest Editor, Dr Mansour Jumaa, Middlesex University)

July: Perspectives on Leadership (The Editor)

September: Health Economics and Nursing Management (Guest Editor, Dr David Newbold, King's College, London)

November: Continuous Professional Development – a Multiperspective Approach (The Editor)

The themes for 2006 are:

January: Nursing Within the Contemporary NHS – patient power, foundation trusts, public and social policy etc.

These are working titles only and subject to change, especially if someone has a burning issue that they would like to follow-up! They are an attempt to span the original articles that arrive at the editorial office unsolicited but very welcome, with the issues arising within nursing management and leadership in the context of international health care today. I would like to invite contributions to these themes, and anyone willing to expand their experience and take part in editing the *Journal* are encouraged to contact me. The work is hard, but the personal rewards are high – if you do not believe me, ask any one of the guest editors who have given their time and expertise freely over the past 18 months!

Prof. MELANIE JASPER  
*Editor*

### Editorial. The nature and purpose of pain management

In this special issue of the *Journal of Nursing Management on Pain*, we have been fortunate to attract authors from around the world on a topic that we all feel passionate about – the effective management of pain. These papers reflect diverse interests and address a variety of issues affecting different population groups and pain problems. In this editorial, I want to select a few key issues to emerge from each of the papers on pain and use them to present my personal views on pain and its management at the start of the 21st century.

There has been a wealth of excellent research into pain and its management during the latter part of the 20th century. Quite apart from the abundance of medical research into analgesia and other medical interventions, examples of relevance to nursing include preoperative information-giving, patient control over analgesia, the development of pain assessment measures, and the introduction of educational programmes to promote self-management. But as a result of all this work, can we claim that pain is now well-managed by nurses? The answer from across the world appears not to be as well as it could be. For example, Judy Watt-Watson and her colleagues in Toronto report on an investigation into the experience of pain following day surgery. They found that, in spite of considerable pain, analgesia use was minimal and inadequate largely because patients were unable to tolerate the gastrointestinal side-effects of the drugs they were given. Perhaps more important, given the problems encountered by patients, information and education about strategies for managing pain and adverse events was reported to be inadequate. An important question to arise from these findings is the extent to which nurses have the knowledge, skill and time to meet these needs. Ewa Idvall, in Sweden, suggests that, in relation to post-operative pain, they do. She identifies an important gap between what patients and nurses report actually happens, and what nurses consider to be realistic in practice. In Idvall's study, it is notable that key areas of deficit focus on interpersonal aspects of care and communication, including postoperative negotiations about pain management, information about pain coping strategies such as breathing, and routine assessment of pain intensity.

In both of these studies, it is unreasonable to expect to eliminate postoperative pain entirely, but there is no excuse why patients should not feel adequately informed about what is likely to happen to them and the actions and choices available to them. I was reminded of people I interviewed some years ago as part of a small qualitative study into the patient experience of hospitalization, published in this journal (Walker *et al.* 1998). I was surprised during these interviews that nobody spontaneously mentioned pain, although some had clearly undergone painful procedures. Perhaps pain management was exemplary? So at the end of each interview, I started to ask participants about any pain they had experienced. Most acknowledged having pain, some quite severe, but did not seem interested in adding to the comments they had already made about their care. The bipolar themes to emerge from the study were 'feeling valued as an individual' (as opposed to deper-

sonalized), 'feeling adequately informed' (or not) about their treatment and care, and 'feeling at home' (as opposed to alienated) in the care environment. These themes each contributed to the main theme, 'having confidence, faith and trust' in the those providing care and treatment. Many patients found it difficult to make judgements about the technical competence of nursing staff. But all made judgements about interpersonal and social aspects of care, vividly recalling incidents of kindness and unkindness, caring and uncaring. These issues were similar to those identified by older people in my earlier study of pain among older people in the community (Walker 1994). These studies have substantially changed my views about the key requisites for successful pain management, particularly in institutional settings where people's coping resources are restricted.

Picking up on the issue of institutionalization, one could not help but be moved by the findings presented by Isabel Higgins and her associates based on Higgins's phenomenological study of pain and its management in nursing homes in Australia. The writing enables the reader to feel the pain and the utter sense of helplessness and hopelessness experienced by her interviewees. It is interesting to contrast these findings with my own and those of Bettina Becker in our doctoral studies of pain in older people living in community settings (Walker 1989, Becker 2001). We both interviewed people who experienced a lot of pain, but few of whom were distressed or would have described themselves as 'suffering'. The important difference between our samples and that in the Higgins study appears to lie not in the severity of pain experienced, but in the depersonalization and sense of helplessness that can attend those living in institutions. Having one's pain acknowledged, and gaining reassurance and encouragement, is an important part of the coping process, or so participants in several of my studies have told me (Walker 1994, Walker *et al.* 1998, 1999). I recall one fiercely independent man who complained bitterly and at length about various medical encounters, but was enthusiastic in his praise for a young doctor who had greeted him on admission with acute urinary retention with the words 'oh you poor thing, you must be in a lot of pain'. Acknowledging someone's physical or emotional pain is probably the supreme act of caring. But Higgins shrewdly notes the existence of a conspiracy in longer term care between patients whose task it is not to complain of pain and nurses not to notice. Is this just compassion fatigue or is it symptomatic of other problems in our current approach to pain management?

What of nursing interventions designed to improve pain management? Michael McGillion, with his colleagues in Toronto, provides a systematic review of psychoeducational interventions for chronic stable angina, in preparation for his doctoral research in this area. The UK report on the *Expert Patient* (Department of Health 2001), highlights the real need for good nurse-led programmes designed to promote self-management for those with chronic conditions. McGillion highlights the problems of conducting a systematic review of the literature on a topic where there is a dearth of good quality studies. Indeed, he and the team from Oxford highlight a number of methodological problems that attend intervention studies in the area of pain management. The randomized-controlled trial (RCT) is widely regarded as the 'gold standard' in biomedical research, but is it necessarily the gold standard for nursing research into pain management? The authors appear to think not and I have recently argued against the use of the RCT for evaluating interventions that involve a therapeutic relationship (Walker & Sofaer 2003). The whole purpose of the RCT is to isolate the effects of the 'active ingredient' (the intervention) from 'non-specific effects'. But in subscribing to this methodology, are we not in danger of ignoring the most important ingredient in pain management? Should we really place more value on the content of the intervention than on the nursing skills required to deliver the intervention? I refer here to our ability to listen, understand, empathize, advise and support. That is not to argue that the intervention itself is not important. But the outcome may depend equally on the ability of the person running the programme to motivate and inspire those participating. The RCT is deliberately designed to eliminate one of the most important aspects of nursing – the ability to establish and maintain a therapeutic relationship.

Focusing on the issue of change, Kate Seers and the team working in Oxford present the findings of a controlled trial to test the implementation of evidence-based oral postoperative analgesia by developing an agreed algorithm. A visit to the free Internet site mentioned in the article reveals a fascinating array of evidence concerning oral analgesia, showing that much of what is currently used is likely to be of little benefit for the majority of people. Therefore, using evidence-based analgesia is a logical step towards good pain control. Their findings make interesting reading. On the intervention wards, the use of evidence-based analgesia significantly increased, although pain scores remained unchanged. On the control wards, evidence-based analgesia use increased slightly, but pain scores

improved significantly during the control period. The authors speculate that this may have been because of motivated staff wishing to improve pain management. Whatever the reason, the results provide further evidence that there is more to pain management than the use of analgesia.

The Oxford study also highlights the difficulties of implementing change. Frances Bourbonnais and her colleagues in Ottawa focus specifically on the change process in the introduction of a new pain assessment record for patients with cancer. These authors conclude that the success can be achieved by having 'champions'. It appears that evidence alone is not sufficient to improve pain management. We also need people who are willing to take a stand to improve fundamental aspects of care. Alan Breen and his colleagues in Dorset have long acted as champions for effective pain management. However, in this study, they highlight resistance to change in their qualitative study of the feasibility of introducing a community-based nurse-led service to introduce evidence-based care for people with acute back pain. They identify the main barrier as the lack of capacity to deal with multidimensional patient needs and observe that nurses may feel that they lack adequate preparation in all aspects of pain management. The effective management of acute back pain is not particularly complex, but it does require a quite different approach, based on diagnostic triage and patient education. These skills of thought and deed are transferable to the management of other painful conditions that are chronic or likely to become so. It is in this context that focusing on medical treatment, rather than self-management, leads to a sense of helplessness among nurses (Walker 1994) and increases the burden on health and social care. Our own study of the lived experience of back pain (Walker *et al.* 1999) illustrated the sense of helplessness, despair and anger caused by ineffective and inadequate systems of care that were focused on treatment and cure, rather than education and prevention. It is to be hoped, therefore that the Dorset team continue to take a stand in their endeavours to improve services for this group of patients.

Bernie Carter clearly demonstrates her willingness to take a stand by defending the use of children's narratives as sources of evidence about our effectiveness as pain management practitioners. The plea from an adolescent to 'listen to what people have to say and take notice of it' resonates with the pleas Beatrice Sofaer and I heard from our interviewees with chronic back pain, and those suppressed or 'unvoiced' in the accounts recorded by Higgins. Surely we cannot help

but be moved by these accounts and feel motivated as teachers, researchers and practitioners to continue in our endeavours to bring about improvements across the age span and across the world. Indeed, this is the challenge set by Irena Madjar, in her guest editorial.

In this issue, we are pleased to include the article by Karien Jooste on leadership because it is clear that good pain management depends on leadership that is proactive and inspires a shared vision directed towards the common goal of promoting patient well-being. In particular, Karien highlights the need for effective leaders to create a friendly environment that supports collaboration, enthusiasm and commitment.

In my view, pain management will not improve unless and until the needs of patients to feel listened to, informed and involved in choices about the management of their pain are recognized alongside their need for evidence-based pain treatments. I believe that this will not happen unless and until interpersonal aspects of nursing care are valued equally with other aspects of professional competence and skill in pain management. Effective pain management requires far more than an evidence-based 'kit'. Indeed, I would go so far as to suggest that the emphasis on tools and drugs is in part to blame for the poor quality of care that many patients appear to experience. I suggest that too much emphasis is placed in nursing on the measurement of 'pain intensity' at the expense of attention to the promotion of well-being and reduction of suffering. Pain and suffering are not the same thing. Suffering involves distress. Pain may or may not involve distress. If the goal of pain management is the relief of pain, the inevitable consequence is failure since in spite of the best efforts of the pharmaceutical industry to persuade us otherwise, analgesic drugs cannot and will not provide satisfactory relief from pain for all people in all circumstances. The increasing expectation of people in the 'developed world' that a pill will cure all sorts of pain has led increasingly to the disempowerment of patients and health care professionals. This may be an important reason why care staff are led to ignore suffering or blame patients or their failure to respond to treatment. The alternatives lie, as Breen suggests, in recognizing the multidimensional nature of pain. But multidimensional problems require multidimensional solutions. In terms of management, there are numerous alternative or complementary non-invasive methods of promoting control over pain, including warmth, massage, therapeutic touch, imagery, relaxation, exercise and distraction. These are written up in many textbooks on pain and its management but appear rarely to be used in

practice. More important, complementary methods are those that bring the nurse into closer contact with patients, enhance the therapeutic relationship and make patients feel valued and secure.

It is easy to blame lack of time as well as lack of education for failure to engage in complementary or educational methods of pain control. But I lay much of the blame on the wholesale embrace in health care of the biomedical model and the failure of health care professionals to recognize that the agenda for pain management has been hijacked by the pharmaceutical industry whose sole motive is profit. People have always shown themselves well able to tolerate high levels of pain without the aid of potent drugs, given the choice of alternative options, and adequate informational and emotional support. The other important issue, I believe, is the necessity for those of us involved in pain research, education and practice to reach agreement with patient representatives on the goal for pain management. If the goal is the relief of pain, we will probably fail much of the time and professionals may continue to seek refuge by ignoring it or denying its existence. If the goal for pain management is the relief of suffering, this will lead us to place much more emphasis and value in nursing research, education and practice on the skills of listening, negotiation, teaching, motivating, collaboration and advocacy.

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Dr JAN WALKER  
Senior Lecturer  
School of Nursing and Midwifery  
University of Southampton  
Southampton  
UK

## Editorial. Of pain, nursing and professional leadership: some personal reflections

The invitation to write this editorial piece came with a comment that I could write freely, reflecting on my professional experience and expressing my opinions on the topic of nursing and pain management. Such open invitations are rare these days, so how could I resist indulging a passion for the topic that has been such an important part of my professional life, and the opportunity to address nurse managers and leaders? I hope that my reflections will resonate with the readers' own experiences and observations and that what I have to say will challenge us all to try harder.

I first became interested in pain as a major clinical and research problem in late 1970s, while living and working in New Zealand. The relative lack of nursing research on the topic, particularly in my part of the world, led me to conduct my first research project – a cross cultural study of patients' experience of postoperative pain. An unexpected finding of that study, that for many patients surgical wounds were not the only nor the main source of pain, eventually led to research on the patients' and nurses' experience of clinically inflicted pain in patients with cancer and those with burn trauma. My research focus on the phenomenology of illness and pain has continued to bring me close to the experience of those in pain, including adults with chronic musculoskeletal pain and older people residing in nursing homes. My research students have conducted other studies that have taught me a great deal about the problem of pain and nurses' responses to it, whether in the context of AIDS in rural Thailand or cancer in the remote islands of Tonga. So perhaps my views are biased by the kinds of questions I and my students have asked and the kinds of data we have collected.

Over some 30 years of clinical practice and clinical research I have seen major scientific progress in the understanding on pain mechanisms, development of new drugs, novel modes of drug delivery, and burgeoning of behavioural approaches and specialized

multidisciplinary clinics dedicated to better pain management. Just as critical have been shifts in thinking that have recognized the importance of the person in pain, through self-report, as a crucial contributor to pain assessment, and through patient-controlled analgesia and various cognitive-behavioural approaches, as an active participant in the management of his or her own pain. At least in the 'developed' countries, we have the knowledge, the skills, the personnel, and the resources to make pain management into a great success story. It should not be the problem that it continues to be. If pain remains a daily reality in our acute hospitals, palliative care units, nursing homes and the wider community, in part at least the reason lies with the failure of nursing to live up to its potential in this critical domain of its practice. Let me elaborate.

Like pain itself, pain management is one of the least visible of nursing activities. When done well, the patient has nothing to report, no complaints to make. The nurse has little to document and even less to show for in accounting for the time spent in various nursing activities. The patient (and the family) may be relieved, delighted, and not uncommonly, surprised – so many continue to have expectations of pain when ill or injured. Too many patients, even in the best endowed countries, continue to report levels and persistence of pain that simply should not be there, in part at least because of their own limited expectations of (and hence requests for) better pain management.<sup>1</sup>

But even when managed poorly, or not at all, and despite its ubiquity, the pain experienced by individual people does not show up in everyday hospital statistics, in budget projections, or in staffing decisions. Unlike major complications or staff errors, patients' experience of more pain than is warranted in specific circumstances seldom registers as an issue for busy managers or administrators. Systematic programmes of quality assurance in relation to pain management are still rare; documentation is often minimal, inconsistent, or not acted on; there is little surveillance of actual practices, and failures to adequately address pain relief needs of patients are seldom censured.

Clinical nurses have the opportunity to educate people about pain and the options available for its optimal management. They are the primary agents of pain assessment, pain documentation and pain management,

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<sup>1</sup>See, 'inter alia', Frich L.M. & Borgbjerg F.M. (2000) Pain and pain treatment in AIDS patients: a longitudinal study. *Journal of Pain and Symptom Management* 19, 339–347; and Svensson I., Sjöström B. & Haljamäe H. (2000) Assessment of pain experiences after elective surgery. *Journal of Pain and Symptom Management* 20: 193–201.