EXPOSING
THE COMPLEX REALITIES
OF
NURSING
UNRESPONSIVE PATIENTS' PAIN
IN
INTENSIVE CARE

A thesis submitted in fulfilment of the requirements for the award of the degree

Doctor of Philosophy

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by

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Student

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0.2 Acknowledgments - *valuing the help*

The following people have impacted greatly on the production of this thesis.

During the years of this study, my supervisors, Professor Jackie Crisp and Professor Jill White have dialogued with me, given intellectual and sustaining support, and kept me focused on the goal of completion.

Earlier in the candidature, Professor Sue Nagy provided a beautiful space to meet and assisted my progress with conversations and feedback.

My work associates listened, questioned, told me their opinions and endured my laptop and piles of paper around me on quiet night duty shifts. Especially those nurses who were willing participants in this study shared their words to allow me to see their practice and use their story in order to improve understanding. More recently nurses asking, “Have you finished yet?” spurred me to extend the necessary culminating writing effort.

My fellow post-graduate research students raised my awareness of other nursing issues and methodologies, offered valuable feedback, and generally encouraged my progress through the support of knowing that I was not alone in this endeavour.

The hospital medical library was invaluable in providing an excellent literature search and retrieval service. Other interested thinkers responded to conversations about my study by helping me to track down relevant literature.

Time to devote to this work was given to me by my parents when they cared for my son Braden and daughter Emmalene. They were generous and patient. My mother also provided considerable help in assisting me with the transcription of taped conversations between myself and the participating nurses.

My son and daughter have, up to now, only experienced their mum in ‘finishing thesis’ mode. I am grateful for their acceptance of my student role and their patience towards me. Now we can have *fun* together.

My hospital generously released me for a block of study leave in addition to a secondment in the nursing research unit which allowed me time to write. UTS gave me a grant to relieve me of some of my paid employment to help with completion. Space and the use of a computer were also provided by UTS at Broadway and the Child and Adolescent Practice Development Unit at Sydney Children's Hospital during the course of undertaking this study.

My parents were tremendously supportive. Sadly they both passed away during my candidature. Nevertheless, they always believed that I would persevere until the end and would have had great joy in celebrating the day of completion with me. My family, friends and colleagues have given me many kind words of encouragement, let their email accounts hold backups, read drafts of this thesis and offered comments and constructive criticism which greatly helped to refine my arguments and presentation.

To all of you, thankyou.

I want to acknowledge as a believer
"the LORD is my strength"
Psalm 18:2

0.3 Contents – *showing the way*

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0.6 Abstract - *glimpsing the whole*

The experience of pain is individual and subjective and only accessible to another by means of communication. Consequently assessing and managing the pain of a patient can be one of the most complex and elusive objectives of nursing practice. This is particularly the situation when critically ill patients are unresponsive as uncertainty impacts on the nursing aim of providing consistent, quality pain care. For me, as an intensive care nurse, uncertainty seemed out of place in the technological world of intricate measurement in the intensive care unit. The research work presented within this thesis focuses on making sense of and dealing with this disparity.

This study embraces both expressive and explanatory means of discovering and conveying knowledge. Nurses' propensity for storytelling inspired the development of an original, eclectic narrative method; drawing on, and extending the work of a wide range of philosophers and theorists such as: Labov and Waletsky, Gee, Agar & Hobbs, Richardson, Mishler, Johnson and Mandler, Reason & Hawkins, Ricoeur and Hegel. The research processes are comprehensively detailed in order to make apparent the realities of undertaking such work, and of accommodating the delays created by ongoing life challenges. In addition, the thesis is presented in a way that increases its accessibility to nurses working in practice, balanced with the need to work within established academic processes and structures.

While one still hopes for accurate measures of pain in unresponsive patients, the study identifies and discusses the few pain cues that nurses 'see', and the limited pain management options nurses 'do'. Furthermore, the space between 'seeing' and 'doing', where nurses 'think' and 'feel', was filled with rich complexity. Stories emerged of: learning about pain, nursing intuition and 'knowing the patient', decision making, advocacy for patients, collaboration with doctors, emotional responses of feeling stressed, frustrated, anguished and inadequate, the nursing mandates of providing comfort, care and justice, distancing from or connecting with patients.

The innovative narrative situatedness schema arising from this research offers a visual map of the interrelatedness of the study's dialectic concepts. The narrative ideas of constitute/constitutive are juxtaposed with expression/explanation. Additionally, the philosophical views on epistemology/ontology, synthesised to 'voice', are dovetailed with Robbins' pairs of human needs; certainty/uncertainty, significance/connection, and

growth/contribution. Such complexity is contained within storytelling. The study promotes a new valuing of an old skill in highlighting the role of storytelling to further nursing practice development. This revealing of the complexity of nursing provides a major step towards the ongoing enhancement of patient care.

0.7 My story in two voices - *questioning my practice*

Below is a verbatim transcription showing my voice as a clinician. I was sharing with another nurse in conversation about the event that launched the journey that culminated in this thesis.

Nerilee (Registered ICU nurse)

I guess my perspective was like... I'll tell you a story. When I first started there in the unit, 'cause I've only worked in our ICU and not other units, I looked after this man who was (this is one of the reasons why I've sort of gone in this direction and decided to do this research) this man, you know how we have guys from the park or from the street, who are derelict sort of people and they'd pulled the tube on him, and he didn't have a blood pressure, and I came on, and I was like, (I don't know how long I'd been there, a couple of months or something) and there was this morphine bolus written up for PRN and he'd been given it probably about two or three times in the last shift, and then when I was handed over, it had been given sort of four times in the last hour and handed over to me to give, you know, quite frequently cause he was supposed to die in the next however long, and he had a blood pressure zero and I thought, "Oh well, what am I supposed to do here, am I supposed to give a whole lot of morphine?", and he wasn't moving, you'd turn him over and he didn't.. nothing, just nothing. So I asked the person in charge and she said "I'll leave that up to you." (Laugh) It was like, "Oh, thanks a lot." and so I didn't, I don't know whether I gave it hourly or something and he went to the ward and he didn't die straight away. But then I did a pain subject in my conversion degree and that had nothing about these sort of patients, its all 'pain is what the patient says it is' type of thing, therefore the reverse is true, that comfort is what the patient says it is, and yeah what if they can't say so, then I decided to do this.

I must admit I have a real problem with that sort of thing as well, you know, the old, - It's okay for awake patients, like that definition I think, but you know 90% of our patients can't talk (laugh) or indicate or anything, so I thought I'd do, or I actually went through all the literature and there's hardly anything in the literature as well, so that's why I thought I'd research it, but I decided to talk to nurses, 'cause it's pretty hard to talk to the patients afterwards, or during or afterwards, and anyway what they can remember is not necessarily what happened.

(excerpt from interview 2: page 10, line 28 - page 11, line 33)

Below is a written piece showing my voice as an academic student. I was writing for my supervisors about the event that launched the journey that culminated in this thesis.

Nerilee (PhD candidate)
I was a novice to intensive care nursing and one evening shift I was assigned to a dying patient of low socio-economic status whose endotracheal tube had been removed earlier that day. He was unresponsive, breathing, with no measurable blood pressure. The medication chart contained a prescription for boluses of intravenous morphine to be given as necessary. I noted that during the previous shift morphine had been administered a few times but more frequently in the last hour and the nurse handing over to me suggested I give morphine frequently. I needed clarification on the indication for the frequency of giving morphine. I asked the nurse in charge of the shift who advised me to use my own discretion. I did not want to euthanase this man and yet I also did not want him to suffer. Having a firm belief in the autonomy of patients and the subjectivity of pain experience, I was uncomfortable with the lack of available assessment cues in unresponsive critically ill patients in intensive care, in either case, whether they were recovering or dying. During the nursing degree conversion course, I undertook a subject on pain, that addressed pain assessment and management in conscious patients, and subsequently a research subject in which I searched the current nursing literature for guidelines for pain assessment in comatose patients, but without success. I dismissed the idea of trying to gain an insight into patients' experiences of pain while unresponsive as I concluded that those able to convey their memories subsequent to being a patient in intensive care would be few and this information would exclude those unable to either convey or remember, for example, the neurologically impaired, those receiving an amnesic agent, and those who had died. I also believed that the experience of pain at the time was more important than the ability to remember. Therefore, I turned my attention to the nurses I worked with, to gain insights from them, to see how they undertook pain assessment when patients were not able to tell of their experience. I continue to wonder what that man felt during my shift as he lay dying, receiving a bolus of morphine each hour along with the other routine hourly nursing activities I performed for his comfort.